

**AUSTRALIAN HEALTH MINISTERS' ADVISORY COUNCIL
SUBMISSION TO PRODUCTIVITY COMMISSION'S STUDY ON HEALTH
WORKFORCE**

August 2005

EXECUTIVE SUMMARY

Australia's health system is experiencing health workforce shortages which impinge on its capacity to provide high quality and safe care accessible to all Australians. Many indicators suggest the problem is going to get more acute in the future. There is now some urgency to solve this problem and the Australian Health Ministers' Advisory Council (AHMAC) presents for consideration some areas where a cross-jurisdictional approach could bring improvements.

It is essential that solutions are designed to create incentives that encourage all parties to work together efficiently, effectively and cooperatively. Better integration and coordination is possible between the two levels of government and will be essential to addressing health workforce shortages. This cooperation is essential to the success of short-term improvements in the system for example in improving the interface between education and health sectors.

AHMAC's intention is to canvass possible approaches which can give rise to a health workforce and supporting structures which better enable the health workforce to adjust.

Investment in improving our knowledge of the health system workforce needs will facilitate better linkages between health needs and service skills requirements.

Demand side strategies such as health promotion and illness prevention programs should also be explored as part of any cross-jurisdictional approach to address health workforce shortages but should be considered a long term strategy.

Cooperation at the national level with the education and training sector is essential to build a more responsive education and training sector. This cooperation is central to both short term and long term approaches.

Examination of national collaborative approaches to workforce registration, accreditation and education and training has the potential to improve efficiency and bring some consistency to the regulatory system, allowing for greater flexibility and mobility of the workforce.

In Australia there will always be difficulties in ensuring health services can be provided in rural and remote and outer metropolitan locations. This submission suggests more sharing of information and evaluation and greater collaboration between jurisdictions on efforts to improve workforce distribution.

Finally, if there is agreement at some point to cross-jurisdictional approaches to this issue, an implementation plan is suggested.

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1. INTRODUCTION

The Australian Health Ministers' Advisory Council (the Health Chief Executive Officers (CEOs) of the Australian Government, State and Territory Governments) has a critical stake in health workforce issues collectively and individually. Health Ministers and CEOs are responsible for administering public health services and for health policy generally.

The delivery of health services ultimately depends on the health workforce. Shortages of key components of the health workforce are the most serious challenge to Australia's capacity to deliver high quality health care across the nation, as indicated in AHMAC's initial submission.

Over the past decade, Health Departments have increasingly been working to address growing shortages and other health workforce challenges. These challenges are shared across jurisdictions and have led to a growing focus on health workforce issues at AHMAC. This submission presents AHMAC's views about possible approaches to these challenges for the benefit of future health care in Australia.

2. BACKGROUND

Australia's health system is complex, and characterised by:

- public and private service provision;
- multiple funding sources;
- State, Territory and Australian Government policy and service delivery systems;
- State and Territory based professional regulation structures;
- Federal and State industrial relations systems;
- a multiplicity of health occupations and organisations; and
- a health education and training system that is fragmented, multi-jurisdictional, spread across public and private sectors and in many respects autonomous.

The Productivity Commission's Issues Paper (2005) recognises the complexity of the health sector and its impact on the health workforce. The paper also recognised that:

- market forces will not deliver broad access to health services expected by government for the whole community; and
- the particular market characteristics of the health sector require some government intervention to achieve essential health workforce outcomes.

Why is government intervention required?

Government intervention is required in relation to the health sector because:

- health care is a public good and is important to Australia's capacity to work productively and to the overall well-being of the community;
- the health sector is characterised by Markey imperfections due to: the information differential between consumers and providers;

- health services are often consumed at a point of illness, and are associated with risks of impairment or death;
- consumers cannot “test” health services before consumption.

Governments fund and provide for a large proportion of health care and so have a direct interest in ensuring an adequate supply of health workers for these services.

3. CRITICAL HEALTH WORKFORCE ISSUES

In the context of the health system’s inherent complexity and characteristics, AHMAC’s initial submission focused on the issues which are fundamental to achieving a system which provides the health workforce Australia needs to deliver safe, quality care.

This submission does not intend to repeat the information presented in the initial AHMAC submission which should be taken as part of this submission, or the Productivity Commission’s Issues Paper. However, for easy reference the key issues from AHMAC’s perspective are briefly summarised below. The appendices provide additional information where indicated.

Shortages and supply

Increasing workforce shortages are a major issue for the health system. Workforce shortages are not uniform, they affect different professions at different times, and in different degrees in different locations. They compromise the capacity of strategies to address current and future challenges such as the ageing population. Failure to find solutions will impact on the capacity to deliver necessary health services.

Shortages are anticipated to worsen in the future without effective solutions. They require urgent attention, given their potential to compromise service delivery and the lead time to increase workforce supply.

Evidence of current shortages are summarised in Appendix 1.

Clearly, achieving adequate health workforce supply is a critical component of strategies to address shortages. There are a number of sources of supply, including;

- increasing the numbers of people in training at all levels of the system;
- workforce re-entry;
- relocation of workers from other areas of over-supply to areas of under-supply (see distribution below)
- increasing workforce participation;
- upskilling or reskilling the existing workforce;
- the recruitment of overseas trained health professionals; and
- retention of the existing workforce.

Although all these strategies have been pursued in recent years, the health workforce shortages continue. Examples of recent initiatives to increase supply are set out at Appendix 2.

Demand

Increasing demand, new technology and new treatments, the ageing of the population and a growing incidence of chronic disease are likely to exacerbate existing and projected health workforce shortages. However, a careful assessment needs to be made of supply driven demand and what is required to meet actual health care need, and what health care can be provided within available resources. Appendix 3 presents more detailed information on the factors which are driving increasing demand for health services and the difficulty in quantifying different aspects of these drivers. Section 8.6 discusses the potential of public health programs to reduce demand for health care.

Distribution

Achieving a more equitable distribution of the health workforce is a critical issue for AHMAC. Reasonable access to health care for all Australians is dependent on workforce availability. Achieving that access for Australians living in outer metropolitan, rural and remote Australia is an ongoing challenge. As noted in the Productivity Commission's Issues Paper, access to health services in Indigenous communities remains a significant concern. Case studies demonstrating distribution issues and solutions to date can be found in Appendix 4. A further discussion of distribution can be found in section 8.2.

Productivity

Productivity increases will assist with shortages. Productivity can be improved by a range of strategies including reducing staff turnover through effective retention policies, new models of care and greater role flexibility.

These proposals are discussed further in section 8.4

Flexibility

A key issue in improving workforce flexibility is how to best align task, training and experience to ensure that scarce and expensive labour resources are deployed, and able to be deployed, as efficiently as possible.

Structural Issues

The identification of improved structures to support and facilitate solutions to health workforce issues is critical. AHMAC endorses the statement in the *Productivity Commission's Issues Paper (The Health Workforce 2005)* that:

"The most fundamental requirement for achieving better workforce outcomes seems clear. It is to create incentives and supporting institutional, funding and regulatory arrangements that encourage all parties to work efficiently, effectively and cooperatively to further the interests of patients and the wider community..." p.33.

There is scope to better support health workforce outcomes through improved structures for practitioner regulation, education and training decision making, and models of funding.

AHMAC's previous work on these issues

A range of work has been undertaken through AHMAC and the Australian Health Minister's Conference (AHMC) to address these issues.

- The establishment of a range of workforce advisory committees, such as the National Nursing and Nursing Education Taskforce, the Australian Medical Workforce Advisory Committee and the Aboriginal and Torres Strait Islander Health Workforce Working Group (see www.healthworkforce.health.nsw.gov.au).
- Engagement with the education and training sector on health workforce issues, including the VET sector, the university sector and specialist medical educators.
- Specific projects such as the joint review of medical specialist colleges with the Australian Competition and Consumer Commission.

4. FOCUS AND THEMES

A collaborative cross-jurisdictional approach

This submission focuses on issues that require collaborative, cross-jurisdictional action to address Australia's current and future health workforce challenges. This approach is consistent with AHMAC's role as a national body. More fundamentally, the submission adopts this focus because most health workforce challenges and many of the structures are national, many issues are common to all jurisdictions and the health sector itself has unifying national characteristics. For example:

- workforce shortages are experienced across all jurisdictions and internationally;
- the health workforce and consumers are mobile, and move between jurisdictions and countries;
- the health and education and training systems have significant national components, including funding and regulation; and
- many health professions and occupations operate in all jurisdictions, are nationally organised and stakeholder organisations are nationally based.

Further, without national consideration of issues and solutions, there is potential for jurisdictional approaches to compete rather than complement each other. The submission also notes where jurisdictional approaches will help achieve progress.

The following provides an overview of the AHMAC submission.

Overview of current position

To deliver high quality health care Australia requires a health workforce that	Currently	Problems can be addressed by
<ul style="list-style-type: none"> meets industry requirements in terms of availability and skill levels 	<ul style="list-style-type: none"> industry requirements are inadequately defined with dispersed accountabilities for identifying future needs 	<ul style="list-style-type: none"> better integration and coordination of Commonwealth & State responsibilities
<ul style="list-style-type: none"> is deployed to ensure reasonable access to services for all Australians 	<ul style="list-style-type: none"> shortages exist and are projected to worsen in most occupational categories 	<ul style="list-style-type: none"> “creating incentives and supporting institutional, funding and regulatory arrangements that encourage all parties to work together efficiently, effectively and cooperatively”. Productivity Commission
<ul style="list-style-type: none"> is able to adapt and develop expeditiously to accommodate emerging technologies and productivity opportunities 	<ul style="list-style-type: none"> overseas recruitment is increasingly used to fill workforce gaps workforce modernisation and productivity is constrained by <ul style="list-style-type: none"> course design and accreditation professional registration industrial agreements responsibility for addressing key drivers of workforce change is dispersed and contested arrangements for design and funding of vocational education are not sufficiently responsive to employers 	<ul style="list-style-type: none"> targeted investment in education and training with common competencies, curriculum responsive to service delivery, more efficient training and enhanced articulation

5. AIMS AND OUTCOMES

Creating a more responsive system

Many health workforce challenges would be better addressed if the health workforce could more readily adapt to change.

Ideally, a more responsive system would have the capacity to provide the right people, with the right skills, in the right place at the right time. The health workforce should be able to respond to changes in the health sector whether they relate to new treatments or technologies, patterns of disease or a need for new skills. Inbuilt system responsiveness would reduce or avoid the lags that currently occur between identifying and addressing a workforce shortage, due to the lead time of strategies such as educating new workers or reskilling existing workers.

Better health workforce outcomes

The following health workforce outcomes are important in their own right, as well as contributing to a system with greater capacity to respond to changes in the health sector.

- Improved knowledge of the workforce, including:
 - better data; and
 - better links between service and workforce planning.
- Solutions to current and future health workforce challenges, including:
 - increased supply;
 - more equitable workforce distribution;
 - greater flexibility of the existing and future workforce to take on new roles and skills;
 - increased workforce productivity;
 - supportive workplace change.
- Regulatory and decision making structures that facilitate better health workforce outcomes, including:
 - education and training decision making;
 - accreditation structures;
 - health practitioner registration; and
 - system support and adoption of innovation.

These components are interdependent, so that a coherent suite of reforms is required to achieve improved outcomes and move towards a health workforce which can more readily respond to change.

6. POSSIBLE CROSS-JURISDICTIONAL APPROACHES

The Productivity Commission should consider reforms which will support a more responsive health workforce and one which is able to respond to system changes. Many of these reforms are structural and relate to the regulation and cross sectoral decision making that apply to the health workforce.

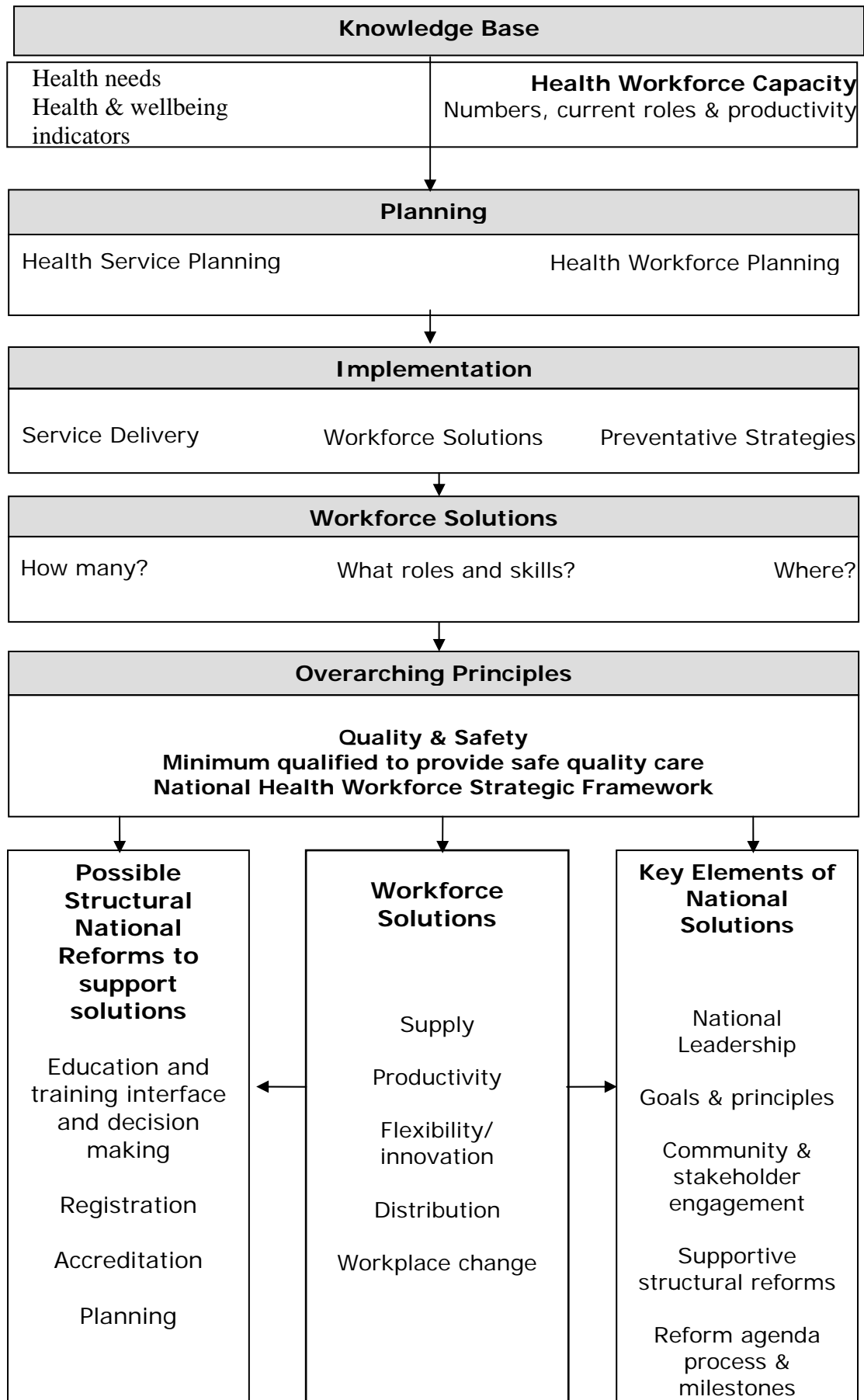
Structural flexibility to respond to workforce needs

Establishing a system with more capacity to respond to change requires a reconsideration of structural, regulatory and funding arrangements that affect the capacity for the health workforce to adapt. The minimum standards and requirements for safe practice to protect the public should be clearly defined and appropriately applied. Notwithstanding this, structural arrangements should enable, rather than impede, initiatives to meet changing workforce needs.

In particular, AHMAC is concerned that current arrangements for registering practitioners, accrediting education and training programs, and determining the availability of higher and vocational education are not sufficiently responsive to health service needs. These arrangements should be reviewed to ensure the availability of a sufficient, quality, productive, health workforce that is trained and equipped to respond flexibly to changes in health care requirements and the broader health sector.

The diagram (Figure 1 - Improving Health Workforce System) identifies a number of opportunities across the health workforce system for national actions to achieve better structural flexibility. This figure also provides the framework for the remainder of the AHMAC submission.

Figure 1. Improving Health Workforce System



Principles for reform

Any health workforce reform should be guided by key principles.

Firstly, and most importantly, that safety and quality of health care is not compromised for consumers. AHMAC considers it is possible to pursue changes to the health workforce without compromising the safety and quality of patient care and/or health outcomes.

Secondly, any workforce developments should be informed by the principles set out in the National Health Workforce Strategic Framework, see Box 1.

Thirdly, to enable the best use of scarce workforce resources, wherever possible, services should be delivered by staff with the most cost effective training and qualification to provide safe, quality care.

Potential exists to improve knowledge about the existing health workforce, its capacity and productivity on a national basis.

Similarly, improved health service planning at whatever level is a more rigorous way to inform workforce needs than a planning process based on supply and demand projections for individual professions.

Opportunities exist to provide advice on meeting the health workforce needs identified through an integrated planning process. These needs may relate to new workforce entrants from education and training, upskilling, changes to skill mix, increased productivity, new workforce roles etc.

Considering and acting on these opportunities will require supportive structures in the education and training system, in health occupation registration, in accreditation bodies and the workplace. Potential also exists for the development of authoritative and robust cross-jurisdictional approaches to most of these matters. This submission sets out key areas where national collaboration could bring about improvements in health workforce shortages in both the short and long term.

Key elements of reform process

Whatever national solutions are ultimately agreed, there are some key elements that must be part of all or any of those solutions:

- high level national leadership;
- agreed, clear objectives and principles;
- community and stakeholder engagement;
- supportive regulatory and decision-making structures (institutional, co-operative or otherwise); and
- a dedicated reform agenda with a defined process and clear milestones for reform.

These elements are discussed in section 10 of this submission.

Box No 1: NATIONAL HEALTH WORKFORCE STRATEGIC FRAMEWORK

: The National Health Workforce Strategic Framework represents Australia's first attempt to establish a comprehensive overview document to guide Australian health workforce policy, health workforce development and the prioritising of national level investment in the workforce. The Framework recognises that a collaborative, multidisciplinary approach is needed to effectively tackle health workforce issues. The timeframe covered by the framework is the next 10 years (2004-2014).

: The Vision

: Australia will have a sustainable health workforce that is knowledgeable, skilled and adaptable. The workforce will be distributed to achieve equitable health outcomes, suitably trained and competent. The workforce will be valued and able to work within a supportive environment and culture. It will provide safe, quality, preventative, curative and supportive care, that is population and health consumer focused and capable of meeting the health needs of the Australian community.

Principles

1. Australia should focus on achieving, at a minimum, national self-sufficiency in health workforce supply, whilst acknowledging it is part of a global market.
2. Distribution of the health workforce should optimise equitable access to health care for all Australians, and recognise the specific requirements of people and communities with greatest need.
3. All health care environments regardless of role, function, size or location should be places in which people want to work and develop; where the workforce is valued and supported and operates in an environment of mutual collaboration.
4. Cohesive action is required among the health, education, vocational training and regulatory sectors to promote an Australian health workforce that is knowledgeable, skilled, competent, engaged in life-long-learning and distributed to optimise equitable health outcomes
5. To make optimal use of workforce skills and ensure best health outcomes, it is recognised that a complementary realignment of existing workforce roles or the creation of new roles may be necessary. Any workplace redesign will address health needs, the provision of sustainable quality care and the required competencies to meet service needs.
6. Health workforce policy and planning should be population and consumer focused, linked to broader health care and health systems planning and informed by the best available evidence.
7. Australian health workforce policy development and planning will be most effective when undertaken collaboratively involving all stakeholders.

Source: Australian Health Ministers' Conference (2004), National Health Workforce Strategic Framework, Sydney.

7 INVESTMENT IN KNOWLEDGE AND PLANNING

Investment in knowledge and planning will enable the best use of health workforce resources, and the development and evaluation of effective strategies.

7.1 HEALTH WORKFORCE DATA

The health workforce is better understood so that strategies can be effectively targeted and evaluated.

Understanding the health workforce is critical to developing effective solutions to current challenges and moving to a more responsive system.

Why is workforce data important?

Accurate, reliable, relevant and timely data is a basic and essential requirement for successful workforce planning and strategies to address workforce issues.

Qualitative and quantitative evidence based data, collected on an on-going basis, forms the foundation for workforce planning processes. Baseline data is also critical so that workforce strategies can be evaluated.

Priority should be given to improving the timeliness and robustness of certain workforce data in collaboration with all stakeholders. At present, timely and comprehensive data on the health workforce are generally not available although there is some good data in some areas.

Data issues

Limitations that are common to the various data sources are:

- lack of comprehensive coverage of the full range of professions and support workers in the health system;
- the need for existing data sets eg human resources, education and training, to take better account of health workforce needs;
- variations of data items and definitions, and response rates between jurisdictions;
- timeliness of processing and supplying information;
- difficulties in drilling down into the data to get useful detail; and
- lack of information on specialised areas such as oncology or aged care; and
- a need for an ongoing research program to inform how people make decisions on careers and locations of work and other factors affecting workforce supply.

However, over the last five to ten years there has been an improvement in the collection of nationally consistent data and an increased understanding by all stakeholders of the need for quality and timely data. For example, work is currently being undertaken by AHMAC on a minimum health workforce data set and common terminology.

Data improvements

Access to data held by non-health sources particularly the education and training sector, is also critical, with agreements on the nature and form of the data and its accessibility being essential.

Ongoing and increased investment in health workforce data and analysis is essential as is the integrity of the data produced. In the long term, national data collection could be improved as a by-product of other national initiatives. For example, any national health occupation registration process could be developed to include the availability of current national data about registered professions.

If health workforce planning is to become more effective, or move towards a more sophisticated approach, then data requirements will change. For example, there would need to be greater investment in and commitment to the collection of appropriate national data sets across a broader range of areas.

One important area for data development is the collection and analysis of workforce productivity measures which is discussed later in the submission. See section 8.4.

7.2 PLANNING

Health workforce planning and health service planning are better linked.

Current planning

Health workforce planning, although widely practised in developed countries has some inherent challenges: by definition policy responses lag behind problem identification, as a result health systems swing between workforce surpluses and shortages (Hall 2005, Black 2004). Workforce planning often takes an estimate of demand based on current patterns of use and assesses this against supply of particular health professions to provide a number of professionals that are needed. If this planning shows a shortage it can often take many years to train sufficient numbers to address the shortage. By the time the new health workers are employed in the system, the situation may be very different.

While workforce planning will never be a perfect science, it is possible to build more sophisticated approaches. A combination of broad brush workforce planning could be used to balance supply and demand as far as possible and flexibility in the workforce can then be used to address any remaining workforce gaps.

Planning approaches - service

Service planning occurs at a number of levels. Australia's federal system means that any national service planning is based on cooperation and requires a broad approach. At the national level, service planning may involve the development of a Service Improvement Framework or a National Strategy, for example the National Mental Health Plan or National Chronic Disease Strategy. Over the medium term these national health strategies should underpin service and workforce planning processes. However in the short term there are a number of such strategies that

could be used now as the broad basis for workforce planning at the national and/or jurisdictional level.

Planning approaches - workforce

Workforce planning occurs at the national, jurisdictional and local level. Through AHMAC, a range of health profession supply and demand studies have been undertaken (for example, *The Specialist Obstetrics and Gynaecology Workforce in Australia*, *The Critical Care Nurse Workforce in Australia*). Workforce planning has also been undertaken to meet the needs of specific groups, for example Aboriginal and Torres Strait Islanders see Box 2. The Australian Government, States and Territories have also conducted their own health workforce planning (For example, *The Victorian Government has recently published Nurses in Victoria: A supply and demand analysis 2003-04 to 2011-12.*).

Planning also often occurs at the level of Area Health Service or region and sometimes even facility. An example of this is the *Northern Territory Department of Health and Community Services 2001, Framework for Action in Central Australia for Community Health Services in Remote Alice Springs*, which provides a framework for service planning and workforce development practices designed to enhance the provision of primary health services to remote communities.

Similarly to workforce planning, all Health Departments undertake health service planning.

Effectively linking health workforce planning with health service planning and supporting this linkage through other structures will build a system which is better able to match future health service needs to workforce supply. The desirability of this approach is recognised in the National Health Workforce Strategic Framework, principle 6. See Box 1.

Planning that responds to changing patterns of disease

Evidence on the major health conditions that are likely to affect a large sector of the population into the future provides a sound basis for planning, both for service and health workforce planning. For example chronic diseases presently make up more than 70% of Australia's overall disease burden and this is expected to increase to 80% by 2020 (AIHW 2002), and consequently these diseases are associated with high health care expenditure (see Appendix 3).

This change in disease patterns is a result of advances in treating and preventing infectious diseases as well as demographic changes in Australia's population. People are now living longer and the prevalence of chronic disease is strongly related to older age (draft AHMAC National Chronic Disease Strategy 2005). These changes pose some challenges for the health service system including its workforce as those with chronic diseases use health services frequently over extended periods of time and use a wide range of services in different settings. It's worth noting that today's health services were developed to respond to acute conditions such as infectious diseases and injuries and largely remain orientated to acute and short-term responses.

Box 2 Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework

The Aboriginal and Torres Strait Islander Health Workforce Working Group (ATSIHWWG) was established to oversee and support the implementation of the Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework (Workforce Strategic Framework) which was endorsed by the Australian Health Minister's Council in 2002.

The aim of the strategy is to transform and consolidate the workforce in Aboriginal and Torres Strait Islander health to achieve a competent health workforce with appropriate clinical, management, community development and cultural skills to address the health needs of Aboriginal and Torres Strait Islander peoples supported by appropriate training, supply, recruitment and retention strategies.

The Workforce Strategic Framework is designed to allow strategies to be prioritised in consultation with key stakeholders, which is especially useful where strategies propose the development of further approaches. This type of work is based on a collaborative cross-government multi-layered approach between the Australian and State and Territory Governments and the non-government sector.

Five key objectives support the aim of the Workforce Strategic Framework. These are summarised below.

1. Increase the number of Aboriginal and Torres Strait Islander people working across all the health professions.
2. Improve the clarity of roles, regulation and recognition of Aboriginal and Torres Strait Islander Health Workers as a key component of the health workforce, and improve vocational education and training sector support for training for Aboriginal and Torres Strait Islander Health Workers.
3. Address the role and development needs of other health workforce groups contributing to Aboriginal and Torres Strait Islander health.
4. Improve the effectiveness of training, recruitment and retention measures targeting both non-Indigenous Australian and Indigenous Australian health staff working within Aboriginal primary health services.
5. Include clear accountability for government programs to quantify and achieve these objectives and support for Aboriginal and Torres Strait Islander organisations and people to drive the process.

The Workforce Strategic Framework is being implemented at two levels. ATSIHWWG is responsible for implementation of strategies that require national level coordination and national consistency. The Workforce Strategic Framework is also implemented at the State/Territory level through plans developed under the State and Territory Health Forums, as established under the Framework Agreements.

Implementation plans have been developed in a number of jurisdictions which set out actions and agreed timeframes for the WSF strategies that relate to State and Territory activities. They support better coordination across sectors beyond health, human and community services, particularly into the education and training sectors.

Source: AHMAC Aboriginal and Torres Strait Islander health workforce working group.

Knowledge about changing patterns of disease should be used to inform planning for new models of care and new service delivery approaches which can inform the

competencies required of the health workforce in order to better treat, prevent and manage these chronic conditions. This information should then feed into developing national workforce planning needs and any subsequent education and training requirements.

The National Mental Health Strategy is a successful example of a more integrated approach to service and workforce planning. See Box 3.

Building the planning approach

Currently, although there are a range of national strategies and frameworks that could be used as the basis for health workforce planning, they do not comprehensively cover the field. Unless service planning at the national level were to cover the entire scope of health service delivery (in effect comprising a broad national health plan), a dual approach to workforce planning will be required.

Where national service plans are available, jurisdictions can use them as the basis for implementation planning, including workforce. Where they are not available, there will be a need for some continued national health workforce planning to identify and address current or emerging shortages in either disease-related areas or specific health occupations.

Evaluation and improvements

The planning approaches proposed by AHMAC will be strengthened if other reforms are progressed. However, AHMAC will consider whether to invest in the planning approaches proposed in any event, because of the benefits to be achieved by better linking service and workforce planning.

Current and future planning approaches should be subject to regular evaluation and improvements identified and implemented.

Box No 3: NATIONAL MENTAL HEALTH STRATEGY (NMHS)

In April 1992 all Australian Health Ministers endorsed the National Mental Health Strategy as a framework to guide mental health reform over the period 1993 to 1998. The Strategy was reaffirmed in 1998 with the *Second National Mental Health Plan* and again in 2003 with the endorsement by all Health Ministers of the *National Mental Health Plan 2003-2008*.

The Strategy provides the framework for national reform from an institutionally based mental health system to one that is consumer focused with an emphasis on supporting the individual in their community.

- The aims of the Strategy are to:
 - Promote the mental health of the Australian community;
 - To, where possible, prevent the development of mental disorder;
 - Reduce the impact of mental disorders on individuals, families and the community; and
 - Assure the rights of people with mental illness.

Funding for Reform

- Through the Australian Health Care Agreements (2003-2008) the Australian Government is providing funding of up to \$331 million to states and territories to facilitate further mental health reform under the National Mental Health Strategy.
- A further \$66 million in Commonwealth Own Purpose Outlays funding has been allocated for national reform activities under the life of the *National Mental Health Plan 2003-2008*.

Achievements under the Strategy

Formal evaluations of the NMHS have shown:

- The mental health system has strengthened its capacity to respond to the needs of people with mental illness by moving towards the provision of mental health care within the mainstream health system and through community care.
- The nature of the workforce providing mental health care has changed substantially: the role of primary health care (including general practice), is acknowledged as a critical area complementing the specialised mental health workforce. Specifically the clinical workforce employed in the public sector mental health services had increased by 25% by 2002. (However, workforce shortages are still being reported anecdotally and in terms of meeting AMWAC targets for psychiatry training places).
- Over the life of the Strategy: the distribution of clinical staff by service setting has changed substantially. The number of staff employed in residential services has increased by 128.6% and in ambulatory services by 108.7%. At the same time the number of clinical staff employed in inpatient services has decreased by 10.5%.
- The mental health agenda has broadened from a focus on treatment to incorporating the entire spectrum of interventions, including mental health promotion, mental illness prevention, early intervention, rehabilitation and recovery.

Source: National Mental Health working Group AHMAC 2005.

8 HEALTH WORKFORCE INITIATIVES

8.1 SUPPLY

Improving supply is an important component of achieving an adequate health workforce.

Health Workforce Supply

Health workforce supply can be increased through three broad ways:

1. measures to increase the total number of people in the workforce;
2. measures to boost the hours worked by those in the workforce; or
3. measures to boost the productivity of the workforce.

Increase the size of the active workforce.

Increasing the size of the workforce may be achieved through measures that:

- Increase the numbers trained in Australia;
- reduce the net migration of health workers; and
- successfully recruit qualified workers back into the health industry.

All three mechanisms have been widely utilised in Australia, by all levels of government and for most health workforces at different times. While further initiatives should continue to be pursued, the greatest gains could be achieved if such initiatives are developed and implemented within a more coordinated framework at the national level.

Moreover, such initiatives must equally address or be compatible with, wider distributional needs (see section 8.2).

Cooperative national initiatives may provide more efficient and effective outcomes, and reduce duplication of effort. Cooperative initiatives may also allow identified priority workforces for current and future health needs to be addressed. Governments need to better control the mechanisms to determine workforce supply (increases and decreases), as market mechanisms do not always achieve the desired outcomes.

Measures to increase hours of work

Increasing the participation of the existing workforce may be best achieved through initiatives that seek to encourage those working part-time to work increased hours or initiatives that facilitate the retention of health workers approaching retirement age to stay in the active workforce longer. It is of note that trends in recent times have been to work less hours in the health sector.

There is a wide body of literature on the motivating factors behind workforce participation decisions, and the possible measures to address them. The National Health Workforce Strategic Framework provides an effective guiding framework for future action and a number of existing initiatives are outlined in Appendix 2.

However, not all solutions will be either effective, or appropriate, for all workforces or in all locations and jurisdictions. While targeted additional resources may be a part of the solution, financial incentives alone are likely to be costly and in some cases possibly counter productive. Any gains flowing from targeted additional resources could be maximised if they are part of cooperative national action, which also addresses wider reforms promoting productivity gains.

Productivity increases

Productivity increases can be achieved through changes in the use of technology and in techniques, but also through role and structural reforms (see section 8.4). Productivity gains are likely to be higher in the longer term through reforms which facilitate the more rapid adjustment of national supply to meet demand changes.

8.2 DISTRIBUTION

Effective workforce distribution is essential to improve equity of access to services.

There are a range of strategies in place to influence workforce distribution. However, there is little coordination of initiatives between jurisdictions and little sharing of evaluation and identification of best practice strategies.

There are a number of factors that may influence choice of practice location or discipline, including:

- lifestyle factors
- geographic isolation
- education and employment opportunities for family members
- career prospects
- access to professional support and continuing professional development; diversity of clinical practice, including private practice opportunities; and
- remuneration

Existing approaches

Existing strategies to improve distribution include:

Professionals undergoing training

- conditional scholarships eg linked to future practice location;
- bonding requirements;

Practising professionals

- pay and conditions incentives;
- assistance with housing;
- education for family;
- location of education and training- both undergraduate and postgraduate education;
- positions for spouses/partners;
- restrictions placed on overseas trained health professionals;
- recruitment of overseas trained health professionals; and
- retention packages.

More information on existing programs to improve distribution is provided in Appendix 4.

National Coordination

Solutions have tended to focus on individual workforces and in individual locations (e.g. rural and remote vs. urban, medical vs. nursing vs. allied health).

Despite numerous programs to improve the distribution of the workforce there are still shortages in some areas including outer-metropolitan areas. These problems become more acute if the overall shortages of doctors and nurses become worse.

National “Levers”

There are a number of “structural levers” which have been effective in addressing workforce distribution. For example, the Australian Government limits the access to Medicare provider numbers of overseas trained doctors to districts of workplace shortage, which are primarily rural, regional and outer metropolitan areas of the major capital cities.

State and Territory Governments use similar processes to restrict newly arriving doctors to practice in areas of workforce shortage, including positions in their public hospitals. This operates as part of the medical registration process.

There are elements of the taxation system that also assist with the distribution of the health workforce such as concessional treatment or exemptions for Fringe Benefits Tax (FBT) including housing benefits in remote areas and for some regional employers and concessions regarding some costs associated with relocation for work purposes.

It is likely that governments and employers will need to be flexible in exploring and implementing a range of creative solutions to distribution challenges. However, care should be taken to avoid unintended consequences and the risks of distorting wider health (and other) labour markets

Evaluation of what works

An immediate step which could be implemented is collaboration between governments and private and public health services to:

- Research and evaluate distribution mechanisms; and
- Identify and share best practice.

The case study (see box 4) below is an example of program that has been designed to address distribution issues based on research finding about worker preferences.

Box No 4: RURAL UNDERGRADUATE SUPPORT AND COORDINATION PROGRAM

The Rural Undergraduate Support and Coordination (RUSC) Program commenced operation following the 1993-94 Federal Budget and is a strategic 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.

The guidelines for this program specify that Universities should aim to increase the proportion of students from rural backgrounds (as the research shows they are more likely to take up rural practice than others see Appendix 4 to this submission) 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 as increased from around 8% when the Government came to office in 1996, to over 25% in 2003." Source: informal input, Department of Health and Ageing, 2005.

8.3 WORKFORCE FLEXIBILITY

Task, training and experience should be aligned to ensure that scarce and expensive labour resources are deployed as effectively as possible.

Workforce flexibility

Workforce flexibility has the potential to enhance service delivery and productivity. More flexibility would:

- facilitate the assembly of teams of health care workers with the right range of skills and competencies to provide care in a range of health care settings and environments;
- improve the productivity of the health workforce by more closely aligning tasks with training and experience;
- assist in getting health services to remote and rural locations and in developing timely responses to new or emerging health trends; and
- Provide a more efficient and responsive means of mediating short term discrepancies between supply of, and need for, health professionals.

In general workforce flexibility includes changes in the skill mix of individuals and teams, expanded roles for existing health professionals, and the creation of new health workers.

Redesigning the workforce to better use available skills should be informed by the changing requirements of the health system. For example, as the prevalence of chronic diseases grows, it is likely more team based primary health care services will be needed. Workforce redesign should be driven by such developments as well as by using the skills available more efficiently. These changes need to link to workforce planning, for example in treating chronic diseases, “care coordinators” are likely to be a feature of providing quality care to those with chronic diseases in various settings. This role will require certain skills and competencies that may not be held by any one type of health professional and hence a new role is generated, (but not necessarily a new profession).

Best use of existing workforce - productivity

A goal is to make the best and most productive use of the available workforce so that tasks are better aligned with skills. A simple example is immunisation. A nurse can provide an immunisation injection rather than a GP. While both may have the skill to do so, it is often more efficient for a nurse or enrolled nurse to do this and to free up the more highly trained doctor to undertake the tasks requiring their distinctive skills.

The best use of the existing workforce can occur without compromising the quality of care to patients. Studies have shown that using nurses to deliver a wide range of primary health care services can be done with the same health outcomes as when the services are delivered by a doctor (Brazian 2005, Duckett 2005a). Given the large cost of training health workers and the current shortages in the workforce, more efficient ways to provide the same levels of care should be explored.

This examination of roles and closer matching to task has already begun in Australia's health care services.

The Australian Government has introduced funding for general practices to employ practice nurses in areas of workforce shortage to provide primary care services. Practice nurses can undertake a range of tasks within the practice some of which are recognised as part of the GPs claim against the Medical Benefits Schedule for services such as immunisation and wound management. Key elements of the role include:

- the provision of clinical care such as triage, health assessments, immunisations, wound management and health promotion;
- clinical organisation through for example: recall registers, maintaining clinical records, infection control, and referral management; and
- integration and collaboration within and outside the general practice through, for example: liaising and coordinating with other health professionals, patient discharge planners, and patient advocacy groups.

In a number of states and territories including remote areas of Queensland and Western Australia, nurses have been practicing using a comprehensive range of skills that may be considered expanded from that generally used by nurses. This role has been essential in ensuring that remote communities receive access to basic primary health care and emergency care.

More recently, many of the states have introduced initiatives where new roles are being defined and health workers are specifically trained to meet gaps in the system. Nurse Practitioners (NPs) (there are currently about 100 NP in Australia) are one such role. NPs are advanced level nurses who are able to provide care to a group of clients. NPs are able to order diagnostic tests, undertake diagnosis and health assessments, prescribe management therapy (including prescribing medicines) and refer to specialists. They have extended their skill set to include skills previously undertaken by other groups. NPs can provide a comprehensive service that is focused on the consumer. Rather than having to access multiple providers a consumer/client in a NP service model can receive a wide range of nursing services including some care that previously they had to see another professional to receive.

For example, NPs in emergency departments are able to assess, treat, prescribe medications, refer on patients if required or discharge appropriate patients, thus reducing waiting time and delays in emergency departments. A Nurse Practitioner led Colorectal Cancer Screening Clinic in South Australia has been established to meet a specific gap in the health service. The NP service provides bowel cancer screening (including undertaking flexible sigmoidoscopy) as well as patient counselling, health education and promotion. The NP services acts as both a referral service for above average-risk patients and a referral point for general practitioners. An evaluation of the service have demonstrated service and procedural outcomes that compared favourably with other colorectal screening services as well as a high level of patient satisfaction (Morcom 2005).

More productivity could be drawn from the existing workforce if this principle could be implemented more systematically or if the workforce were to move towards a competency-based system.

Responding to shortages through workforce flexibility

If the workforce could be trained with particular skills or to do specific tasks these could be utilised more flexibly across the health service sector.

For example, in rural or remote areas, a generic health care worker role could be developed to provide basic care that encompasses components of the services delivered by several traditional professions. Alternatively, a professional could acquire competencies in some basic elements of care relating to another profession; eg a nurse may be able to acquire more specialised foot care competencies. A nurse with these additional skills might be utilised in a remote area more readily than securing two professionals with different skills to a remote area. Other examples of how flexibility in roles can help address workforce shortages can be found in Box 4.

Structural changes to support flexibility

Workforce flexibility should be supported by the development of national competency standards applied to new roles, so that workers are assessed on common competencies.

The capacity for health workers to add to their range of skills over time is at present focussed around existing professional streams. There are barriers to the acquisition of skills and competencies across professions. Moving to a competency-based approach to education and training would facilitate the development of workforce flexibility. It is possible that a competency-based approach might also provide benefits in terms of streamlining education and training outcomes.

In the short term the Vocational Education and Training (VET) sector provides some immediate avenues to support such flexibility.

VET sector opportunities

The health workforce has traditionally been heavily focused on university trained health professionals. However, there are opportunities now available to use the VET trained workforce to help to solve current and forecast workforce shortages. This approach is already occurring to some extent based on the competencies and qualifications pathways in the Community Services and Training Packages.

The VET system has a number of advantages which could complement other sources of health workforce supply, including the following:

- its delivery mechanisms can be targeted to people already in the workforce;
- it enables people to continue working and delivering services while undergoing training and its incremental approach means that individuals can build their skills and build their role to match over extended periods;
- course timeframes are generally shorter, providing new workforce entrants more quickly;
- use of support or assistant roles could extend the service delivery capacity of university trained health professionals; eg physiotherapy assistants working with physiotherapists;
- VET sector qualifications could be marketed to the available sources of supply, such as older workers, people returning to work, or people wishing to change career while remaining in the workforce;

- the VET sector's focus on competencies and employer needs facilitates the development of "work ready staff" and is consistent with outcomes being sought for the health workforce across the education and training sector;
- the competency-based approach to qualifications facilitates the development and expansion of articulated career pathways, within and between streams of health care;
- the modular approach to education and training combined with work-friendly delivery mechanisms supports workforce flexibility; and
- the VET system is responsive to employer needs and could provide training for new roles or career pathways, facilitating workforce flexibility;

Specific VET opportunities for the Health sector

The Community Services and Health Industry Skills Council is a peak national body providing advice on industry training and skills development needs to government and industry. In providing this advice, the Skills Council works closely with industry bodies in every state and territory. The composition of the Board of Directors, public and private employers and relevant union representation, reflects the close relationship with stakeholders and ensures that industry views and needs are represented in all its work. The success of such partnerships is demonstrated in the addition of new health and community services related qualifications into training packages that meet the needs of employers and industry.

Industry representation on the National Industry Skills Committee

The health and community services industries supports a workforce of about 936,000 people or 10% of all people employed (CSHISC Industry Skills Report, 2005.) Health workforce planning issues could be improved in this sector by ensuring high level evidence based advice on workforce planning, future training priorities and other critical issues relevant to training sector is provided to the relevant advisory bodies of the national training system including the National Industry Skills Committee and the National Quality Council..

– National consistency in determining access to new apprenticeships, especially for mature age entrants to the workforce

There are a number of issues associated with how New Apprenticeship arrangements are determined and subsequently implemented at state and territory level. Whilst there has been some increase in the funding and uptake of apprenticeships and trainees within the health and community services sector, the current focus is toward more traditional trades such as plumbing, electrical and building. Opportunities exist on a number of levels to improve the number of apprenticeship opportunities in the health and community sector, namely at state and territory and Australian Government level and to increase marketing of such opportunities to mature aged workers.

Funding structures need to better support competency attainment and not "time focussed" approach.

Models of funding for incentives to employers and registered training organisations currently reward and support a time-based model of apprenticeship rather than a competency-based approach to learning (eligibility for some employer incentives for existing workers relies in part on the duration of the training contract: which is

currently two years or more). This does not apply to new entrant workers. A true competency-based approach would provide for earlier completion of training requirements as a basis for accelerated entry to the workforce while ensuring that workers have the necessary skills and competence to perform roles. The Community Services and Health Industry Skills Council also suggest this is an area where more could be done (CSHISC 2005).

Encouragement/incentives to improve 'take up' of qualifications within industry should be available

The health and community services sector has the third lowest proportion of full-time employment (CSHISC 2005). This can be explained in part by the higher proportion of mature aged female workers in the industry. Access to training for part time workers is recognised to be a substantial barrier. Funding directed to attainment of a full qualification rather than competencies is a contributing factor as is the requirement to be full time for some types of apprenticeships. Removing such barriers may increase the uptake of qualifications by these workers.

The New Apprenticeships system, including user choice for funding of training by the State and Territories, is primarily directed to new entrants and people who have few or no skills. If an employee already holds a Certificate III they cannot attract incentives unless the qualification was obtained more than seven years previously or while at school.

In addition, people should also be able to retrain from other industries into areas of shortage without their prior qualification preventing the provision of incentives whilst balancing this with skill shortages in other sectors.

Support and recognition of innovation

Currently new roles are created on an ad hoc basis, and there are limited mechanisms to facilitate their adoption in other States and Territories. A key element of a future system would be a mechanism to support and recognise workforce innovation. This would ensure that jurisdictions share successful innovations and avoid resource duplication in investing in new roles.

For example, the role of supporting and disseminating workforce innovation could be resourced and built into current AHMAC health workforce structures.

A mechanism to link the VET and tertiary sectors in generating new roles would also need to be considered.

Linking with other aspects of the system

Any increased workforce flexibility should also feed into nationally gathered data on planning and workforce characteristics. This is especially important when dealing with changes to the education and training system at the national level and to ensuring the long term portability of skills across jurisdictions and also within of the health care system.

Box No 5: EXAMPLES OF WORKFORCE FLEXIBILITY

International and Australian Examples

The United Kingdom has been introducing fundamental changes in the National Health Service to job design and work organisation in order to get a more efficient health workforce. The approach to reforms has been driven by patient demand for better quality service for example shorter waiting times but also by the need to utilise the health workforce more efficiently. The reform process has also shown how the linkage to workforce planning and service planning have gone together to introduce new ways of providing health care.

The initiatives have included changes to how health workers are paid, allowing health workers greater control over hospital equipment budgets, allowing nurses greater say in care for patients and greater control over hospital ward budgets; therapists and nurses have new powers to prescribe drugs and treat patients; staff development and training opportunities have increased and NHS employers are providing more opportunities for flexible working including better child care support.

The new payment system is designed to provide incentives to break down demarcations and change working practices by allowing staff to take on new responsibilities. The reform program is hoping that the pay reforms combined with greater flexibility will allow a growing share of the GP workload to be transferred to nurses and other health professionals, consultant workload to transfer to others and also some nurse and therapist workloads to transfer to support staff. This redesign process has been supported by access to training and up skilling for NHS staff.

While there is local level responsibility for introducing many of the workforce redesign in the UK, it has been driven by a national framework. The success of the changes are still being measured but it is worth noting that waiting times for many services have been reduced substantially since the beginning of the reform process.

Source: National Health Services – Delivering the Plan, 2002

Australia

Foot care Assistants

In response to a shortage of podiatrists and a demand for podiatry and associated foot care services some jurisdictions have introduced a new health workforce role to assist podiatrists in undertaking 'basic foot hygiene' functions. The new Foot Care Assistant role extends the capacity of available podiatrists.

Source: Tasmanian Department of Health and Human Services 2005.

Pharmacy Assistants and Technicians

In Queensland in response to a shortage of pharmacists, new roles for pharmacy assistants and technicians have been established and associated VET sector training developed. These new roles have freed pharmacists to undertake clinical pharmacy roles including safe medication management, advice to patients and to prescribers.

Source QLD Health Issues Paper for Bundaberg Hospital Commission of Inquiry: Enhanced Clinical Roles June 2005).

8.4 WORKFORCE PRODUCTIVITY

The most productive use is made of the health workforce

With the health workforce shortages being experienced across the country, many health managers and planners are looking at how we can better use the existing workforce.

Making the best use of the workforce

Making the best use of the workforce is likely to provide productivity gains. Approaches discussed elsewhere in the submission which are likely to improve workforce productivity are:

- increasing workforce flexibility;
- increasing workforce participation
- reforming practitioner regulation
- reforming accreditation of health workforce education and training
- improving decision-making at the health and education and training interface
- workplace reforms
- optimal alignment of task, training and experience
- improved teamwork
- improved technology and IT support

Any productivity gains must also maintain quality and safety.

Measuring productivity

Measuring productivity through health outcomes

Measuring and monitoring the productivity of the health workforce through improvements in health, has not been a feature of its management in Australia and elsewhere. There are probably several reasons for this.

First it is difficult to measure the “health” produced as part of a health care intervention, without this, the measurement of inputs and outputs can measure the efficiency of a particular service or activity. However this does not necessarily equal improved health outcomes and so may not be a true reflection of productivity. Also health status is strongly associated with other socio-economic factors such as employment, and education. Given these difficulties most productivity studies have focused on measuring inputs and outputs or have developed proxy health outcomes in order to measure the productivity of the workforce (Bloor and Maynard 2001).

However there are indications that productivity in the Australian health workforce can be improved.

There is high staff turnover and surveys and reports indicate that many health professionals are unhappy and unmotivated in their workplace. Both these factors are known to be associated with lower productivity (PC issues paper 2005).

High staff turnover results in vacancies which in turn impact on productivity because of the time taken to recruit and induct new staff and the time those staff take to become fully productive.

We know little about the way new technology affects productivity in the health workforce, except when it results in a shortage of workforce to apply the new technology. This is in contrast to other industries where new technology has often driven productivity increases.

Existing structures which assess new health technologies could also focus on the potential for technology to improve health workforce productivity and reduce the need for labour.

There are well documented variations in service levels for particular procedures across Australia which cannot be explained by the underlying health/disease profile of the population. This suggests that there could be more effective and appropriate utilisation of the workforce in some areas.

Improvements in measuring productivity

Because of the complexity of measuring health workforce productivity in useful terms (Bloor and Maynard 2001), and its importance to national workforce planning processes, AHMAC considers that some investment in the development of reliable measures of productivity for the Australian health workforce would improve the knowledge base and the capacity to get the most efficient use of a scarce resource.

8.5 WORKPLACE REFORM

Workplace change should support and be supported by other reforms

Obviously any redesign of the workforce will require corresponding workplace change. Other countries also dealing with health workforce issues have introduced changes to workplace arrangements to improve motivation with the intention of better retaining their workforces and introducing more flexibility in roles. For example in the United Kingdom (UK) the National Health System (NHS) reforms have provided nurse managers with greater say over ward practices and budgets and have provided more training support so that roles can be more flexible in the workplace (NHS Improvement Plan 2004). However, information is not available on the effectiveness of these changes at the present time.

Factors Inhibiting Change

One of the factors inhibiting change in the workplace is the traditional, profession based structure of the workforce. As noted earlier in the submission, the health

workforce is characterised by significant demarcations between roles, and this impedes more flexible service delivery. These roles are reinforced through the education, regulation and industrial systems.

It is worth noting that in the UK and Canada where increased flexibility in work roles has been introduced to address workforce shortages and to improve models of care, there have been some accompanying structural changes. Often this has taken the form of payment and financial incentives, and greater capacity to undertake training to learn new skills (Commission on the Future of Health Care in Canada 2002; NHS Improvement Plan 2004).

If the structural issues which contribute to inflexibility of the workforce are addressed such as moving to a more competency-based health workforce structure (as opposed to a profession based one), then workplace changes are likely to be easier to negotiate and support.

Implementing Workplace Reform

To successfully implement workplace and other changes in Australia, there will need to be in place a leadership and change management process. This has been part of the change process in other countries where health workforce reforms have been introduced (NHS 2002).

There are sectors of the Australian health workforce which are either sceptical or openly opposed to workplace reform. To introduce structural changes in this environment requires a strong commitment by governments to pursue the reforms and to provide the leadership to encourage the workforce to embrace new ways of working.

A commitment to change by all levels of government will be important to the engagement of the community and all health workforce stakeholders.

A cross-jurisdictional reform strategy will be essential to the success of such changes. A more detailed discussion of such a strategy is provided in section 10.

8.6 INVESTMENT TO IMPACT ON DEMAND

Improving health can reduce demand for health care

Opportunities to impact on demand

Improving health

Improving health has the potential to reduce demand for health services and hence reduce the need for more highly skilled health professionals. There are a range of studies that demonstrate the capacity of public health interventions to improve health outcomes (Department of Health and Ageing/Applied Economics 2003). Increasing investment in public health at jurisdictional and individual levels, could improve health while making better utilisation of available resources.

For example, reducing the rate of adult onset diabetes would reduce the need for diabetes services and the associated workforce (improving health outcomes in relation to chronic and complex conditions could ultimately impact on the need for care co-ordinators and case managers).

The Federal Department of Treasury's report *The Long Term Fiscal Implications of Raising Australian Labour Force Participation or Productivity Growth* (Gruen & Garbatt 2004) acknowledges the impact on the health sector of growing demographic and technology driven demand and supports the argument for increased investment in disease prevention/ health promotion to better manage demand.

Recent evaluation of public health investment demonstrates its potential to improve health outcomes and return a positive net benefit to the community (Department of Health and Ageing/Applied Economics 2003).

Approaches to investment in public health are currently being re-examined, for example, with regard to improving the prevention and management of chronic diseases. In May 2001, AHMAC endorsed a strategic framework for preventing chronic disease as the basis for further national collaborative action (National Public Health Partnership 2001). Further work includes the development of a draft National Chronic Disease Strategy, which aims to provide an overarching framework of national direction for improving chronic disease prevention and care across Australia. The draft Strategy broadly covers the continuum of chronic disease prevention and care.

Awareness of demand drivers

There is scope to raise community awareness about drivers of demand for health services, including issues such as new technologies and demand generated by health professionals. The impact of these factors needs research to develop deeper understanding across planners, policy makers and consumers and to identify innovative strategies. This could include work with consumers (to identify and modify demand) to promote the efficacy of particular interventions or treatments from an evidence base.

Possible approaches

Innovative solutions are needed to develop improved and better integrated public health and health care services, and to better support individuals in managing their own health to avoid or minimise the impact of disease/illness and injury. Such measures could include:

- increased investment in early intervention and prevention activities to avoid the development of illnesses or diseases or minimise their progression to an acute stage;
- increased support for self-management by individuals; and
- integrated health education and health promotion initiatives to improve the information available to health consumers and encourage them to make personal investments in preventing or better managing health conditions.

Development of these approaches will require increased across the health system and by individuals. Part of this effort will entail building workforce capacity to deliver the services required.

9. SUPPORTING STRUCTURAL REFORMS

9.1 THE EDUCATION AND TRAINING INTERFACE

Decision-making structures across the sectors should be more integrated

The initial AHMAC submission identified significant concerns regarding current arrangements for educating and training the health workforce, reflecting an inadequate interface between the health and education and training sectors. The education and training sector includes:

- tertiary education provided by universities
- vocational education and training provided by registered training organisations
- clinical education provided in health facilities
- specialist education delivered by professional colleges.

Health Departments consider that rigidities, fragmentation and disconnects in the arrangements for funding and delivery of education and training adversely affect Australia's capacity to train and deploy the health workforce needed to meet current and future service delivery requirements.

States and Territories fund and deliver a significant proportion of health service. Because of these key responsibilities, they should have the capacity to influence training numbers and curriculum content.

Decision-making structures/intersectoral engagement model

Mechanisms are needed to improve the ability of the health sector to participate in decisions in relation to the funding, structure, content and delivery of education and training for health sector occupations. In particular:

- education and training should be better targeted to health sector needs;
- the number and types of education and training places available should be better linked to anticipated workforce requirements;
- course content and modes of delivery/learning should reflect the skills and knowledge needed in the workplace, and there should be flexibility to take into account changing models of care and new roles;
- course length should be appropriate - graduates should enter the workforce as early as possible while having the educational preparation required to fulfil expected roles and evolving health workforce needs; and
- clinical placement arrangements should provide sufficient places, cover a wider range of health care settings, be appropriately funded, and take account of workforce and service delivery requirements.

Interdisciplinary learning

The National Safety and Quality Agenda makes it clear that interdisciplinary learning has significant benefits for health care but take-up by health care sectors and occupations has been limited. The education sector can play a critical role in progressing this agenda, by developing and implementing models of inter-professional educational preparation. To do this, faculties and professional bodies need to both be willing to adopt changes and have the resources available to undertake the necessary development work and deliver the programs. However, in the absence of other influences or incentives, current funding arrangements may impede universities from adopting such approaches, which may require realignment between faculties, budgets and multiple curricula (informal input, National Nursing and Nursing Education Taskforce, May 2005).

Integrated approaches across the VET and tertiary sectors

Other potential developments in educating the health workforce would require the capacity to develop integrated approaches across sectors within education, and across health sectors. For example, the development of competency and skill-based occupational roles, as adopted in the United Kingdom, could help to improve workforce flexibility and career pathways. In the current Australian context, this could require integration between the vocational education and training sector, the university sector, employment-based education and training, and registration requirements (Duckett 2005a & b).

Clinical education

Clinical education funding, roles and responsibilities

Clinical training provides an important component in the education and training of some health professionals'. Clinical training allows students to put theoretical knowledge into practice within the patient/client care environment. It is an integral part of entry-level education for health professionals as it enables students to develop clinical skills, integrate theory into practice, apply problem solving skills, develop interpersonal skills and become socialised into the formal and informal norms, protocols and expectations of the profession and the socio-political health care environment (Clare et al 2003, 2002).

However, there has been an increasing responsibility on States and Territories to provide clinical education and training for a range of health care professionals. This has occurred at a time of increased pressure for service delivery in the public hospital system where most clinical education takes place. Funding at a national, state and university level for the cost of this education is not clear noting that the Australian Government funding to Universities for medicine and nursing courses includes a loading for teaching hospital costs and practicums.

There is also a tension between the resources needed to provide clinical education and the benefits that are derived, including the availability of the future workforce and improved service capacity. These issues require a review to determine accountabilities, funding sources and ongoing capacity and sustainability of clinical

education. The review should include an exploration of alternative models of clinical education.

A change in the focus of health services delivered by the public hospital system has also resulted in a narrowing range of available clinical experience. The clinical services provided by the private sector have also changed. This potentially limits students' exposure to the full range of clinical experience.

Given the increasing role of the private sector in health care, and the shared pool of labour on which the public and private sectors draw, the private sector needs to assume a greater role in clinical education. Whilst there is work underway on expanding the range of settings for medical specialist education, and some clinical education of other health professionals already occurs in the private sector, eg nurses, there is a need to examine mechanisms to more equitably share the responsibility for provision of clinical education. This also has implications for the model of clinical education.

Some private services could not provide the scope of experience necessary to provide sufficient training or for other reasons could not provide training, yet they still benefit from the availability of trained staff. Other industries have addressed the need for equitable contribution to industry training through a scheme that enables employers to contribute by providing training or by paying a levy towards the costs of training provision. See Box 6.

Clinical education model

The model of clinical education reflects an apprenticeship approach to learning. The review of clinical education should also address the nature of the learning process. A continued focus on apprenticeship models needs to be reviewed in terms of sustainability, efficiency and effectiveness.

Opportunities in Vocational Education and Training

Section 8.3 includes discussion of the opportunities for workforce flexibility that are presented by vocational education and training sector qualifications.

National and local engagement

Solutions to education and training issues require national and local engagement, with proactive involvement of government agencies and professional bodies, and of service providers from the health and education sectors. Key stakeholders, including regulatory authorities and governments, will need to work collaboratively to agree on and strategically coordinate national activity. This collaboration will need to occur both within each jurisdiction, to allow local needs and circumstances to be taken into account and at national level, to ensure consistency with national priorities and policy objectives as agreed in the National Health Workforce Strategic Framework (AHMC 2004).

In addition to collaboration, a key question which is explored further below is the extent to which decision-making structures require reform to deliver outcomes.

Strengthening the health and education interface

Benefits from strengthening the health and education and training interface include:

- decisions about course offerings and places that better reflect health workforce needs;
- increased multi and interdisciplinary learning, facilitating team work in the workplace;
- course content that meets health sector needs and is responsive to health service delivery development, improving the work readiness of new entrants;
- increased use of competency-based and modular approaches, to support workforce flexibility, articulated career pathways and upskilling; and
- innovative and more sustainable approaches to clinical education models, funding, roles and responsibilities.

Box No 6: TRAINING LEVY

In the United Kingdom legislation (*Industrial Training Levy (Construction Board) Order 2004*) has been passed imposing a levy on employers in the construction industry for the purpose of raising money towards offering financial support to employers enabling them to invest in quality training (especially for New Entrants), leading to a more competent workforce and enhanced competitiveness meeting. The levy is used to provide a wide range of services, including setting occupational standards and developing vocational qualifications, delivering modern apprenticeships, and paying direct grants to employers to carry out training to approved standards. The payment of the industrial levy is dependant on the size of the construction company where the levy only becomes a requirement once the wages bill of a company reaches a threshold. The levy is collected and administered by the Construction Industry Training Board and the Engineering Construction Industry Training Board.

The main objective of the levy is to finance grants designed to influence the quality of training undertaken – the aim is to avoid skill gaps without over-training. They are intended to share the cost of training, especially in occupations where there is a high level of mobility. Training and Development Plans (Training Plans) were introduced four years ago and have been successful in supporting employers to develop and implement a structured approach to training and development. The Training Plan grant is the most flexible grant. It supports a wide range of activities undertaken by an employer and covers employees of any occupation who undertake at least 30 minutes of qualifying training. Grant rates have been set to reflect the urgency and importance of the training need and the associated costs of releasing employees for training.

Source: UK Parliament Draft Industrial Training Levy Order 2004)

In Australia, similar arrangements are in operation where the majority of States and Territories have some form of industry training levy in the building and construction industries designed to support training and skills development. For example, in Western Australia the Building and Construction Industry Training Fund was established to collect a small training levy from all construction projects in WA. The training levy ensures that people undertaking and paying for construction work in WA make a contribution to training the skilled people needed to carry out the work. The level provides funding to reduce training costs, helping businesses and people access training courses. The level applied to projects over \$20,000 at a rate of 0.182%.

Source: Building and Construction Industry Training Fund of WA 2005.

Possible approaches

The interface may be strengthened in different ways at different levels. Options range from strengthening opportunities for collaboration at the national level regarding the linkages between health and education policies and priorities, to moderate or major reform of related structural arrangements. While it is important that a national reform agenda be determined and implemented, there will need to be scope to address local needs and priorities at the state and territory level.

Improving collaboration and cooperation at key decision-making levels across the health and education sectors would greatly assist in progressing any structural reform agenda. Development of improved collaboration mechanisms could include formalising a process for senior health and education officials to consider issues relating to reforming health workforce education and training, reporting regularly to Health and Education Ministers on issues and options for addressing them. This

could include state, territory and Australian government representatives from both portfolios. There have been recent meetings between representatives of AHMAC and the Australian Education Senior Official Committee to discuss issues of mutual interest and with cross-sectoral implications, such as this study and the National Strategic Principles for Higher Education being developed by the Department of Education, Science and Training.

Such a group could oversee a process for collaboration between governments, public and private sector employers, professional groups and education providers to progress reform initiatives. There are existing models of collaboration which provide a possible model from which to work. However, to be effective in supporting the wider health workforce reforms envisaged, it would be important that the arrangements not repeat or reinforce existing structural impediments.

The National Nursing and Education Taskforce has been an important collaborative mechanism for progressing the development of a national perspective and policy in relation to nursing/midwifery issues. See Box 7.

There is a need for broader engagement across existing professional boundaries and across the education and health sectors. The collaborative mechanism could be used to review issues relating to current funding arrangements. Ideally, funding would need to be better targeted towards education and training programs that fulfil national policy objectives and priorities, while allowing for local needs and priorities in terms of the types, numbers, and distribution of education and training places.

It would also provide a vehicle for developing and promoting a competency-based approach across the range of education and training offered for the health workforce.

Box No. 7: NATIONAL NURSING AND NURSING EDUCATION TASKFORCE - A COLLABORATIVE APPROACH

The work of the National Nursing and Nursing Education Taskforce, established to implement and monitor a number of recommendations from the National Review of Nursing Education (2002) – Our Duty of Care report provides one model for collaboration-focused engagement. The Taskforce uniquely reports to both the Education and Health portfolios, with funding through the Australian Government’s Education, Science and Training portfolio and through AHMAC cost-sharing arrangements.

It has established communication networks with the Department of Education, Science and Training and various education and nursing profession bodies and is using these networks to progress its work. A key component of this work is to bring national consistency to dimensions of nursing/midwifery practice, education and regulation. Other key areas of work include consideration of nursing/midwifery issues related to skill mix, work organisation, augmentation, training of care assistants, funding of clinical education and research, and national education standards.

Box No 8: CASE STUDY - CORE COMPETENCIES IN ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

The Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework was implemented with the aim of transforming and consolidating the workforce in Aboriginal and Torres Strait Islander health to achieve a competent health workforce with appropriate clinical, management, community development and cultural skills to address the health needs of Aboriginal and Torres Strait Islander peoples supported by appropriate training, supply, recruitment and retention strategies.

A key initiative that has contributed to implementation of the Framework is the work through the Committee of Deans of Medical Schools on developing the Indigenous content of medical courses. A similar initiative has already occurred in relation to nursing curricula (Gettin' Em and Keepin' Em, yr). Consideration is now being given to extending this work to cover Indigenous content in allied health courses.

The development of new competencies for Aboriginal Health Workers is an important step in implementing the Framework. The new competencies cover a number of streams including generalist primary health care competencies. These cover aspects of health care currently provided by doctors such as health screening, wound management, chronic disease management, immunisation, rehabilitation and prescription of basic medications. Formal regulation and recognition of these roles would enhance health workers capacity to practice a range of skills in various settings.

Source: AHMAC Aboriginal and Torres Strait Islander Health Workforce working group 2005.

9.2 COURSE ACCREDITATION

The accreditation model should facilitate and support better health workforce outcomes

Accreditation criteria determine the theoretical and practical content of health workforce education and training. In some cases, they also influence clinical education settings, and the infrastructure provided.

Accordingly, an appropriate accreditation model is a critical component of a more responsive health workforce system.

Current accreditation approaches

There are different accreditation requirements for educational institutions offering courses leading to formal qualifications, and for hospitals and other facilities offering clinical training placements as part of those courses or vocational training. Organisations may need to satisfy a number of accrediting bodies regarding their suitability to offer different types of education or training programs and the quality of training provided.

Information asymmetry is a challenge for accreditation models. Those who have the expert knowledge to set accreditation criteria often are part of, or have influential roles in, the profession being accredited. They thus bring a particular perspective to accreditation issues. Whilst appropriate expert professional input to accreditation processes is important, the challenge is to ensure that any potential conflicts are identified and addressed and that the public interest is paramount.

Accreditation requirements can tend to reflect the traditional values and approaches of the relevant profession, rather than a broader, multi-disciplinary approach. For example, current accreditation processes do not fit easily with the expansion of scopes of practice or new workforce roles, particularly roles which might combine aspects of two or more existing professions eg a generic allied health professional.

Accreditation arrangements impose a significant administrative burden on both the organisations seeking accreditation and the accrediting bodies, at a significant cost to those who finance the accreditation process (whether through accreditation fees paid by organisations or through training fees paid by individual trainees or their employers).

An outline of some current accreditation arrangements is provided in Appendix 5. They include:

- accreditation of medical schools by the Australian Medical Council, overseen by its Medical School Accreditation Committee;
- accreditation of specialist medical colleges by the Australian Medical Council, overseen by its Specialist Education Advisory Committee;
- accreditation of hospitals to provide post-graduate medical training (for post-graduate years 1 and 2) by Postgraduate Medical Education Councils;
- accreditation of hospitals and other health facilities, or of training posts within them, for the purposes of specialist medical training programs provided by the medical colleges;
- accreditation of university courses by State and Territory Registration Boards;
- accreditation of VET courses, not covered by an endorsed training package, by State and Territory course accreditation bodies;
- accreditation of nursing education providers by the Royal College of Nursing Australia and specialist nursing and midwifery organisations;
- accreditation of allied health courses by professional associations.

Benefits of a cross-jurisdictional approach to accreditation

A cross-jurisdictional approach to accreditation could assist the system to become more responsive. Other benefits would include:

- achieving consistency of processes and approaches clearly focused on the public interest;
- broadening the perspective on accreditation criteria to reflect a whole of workforce/multi-disciplinary team approach;
- an opportunity to develop and apply nationally agreed standards.

Risks of a cross-jurisdictional approach to accreditation

- a cross-jurisdictional structure covering all health occupations may be less flexible than the current multiplicity of profession-based structures
- a cross-jurisdictional structure covering all health occupations would be more complex than individual profession-based structures

However, the above benefits could be maximised and risks could be managed by taking specific steps to maintain flexibility and the capacity to support workforce innovation in establishing the accreditation scheme. Further, ensuring appropriate governance arrangements would mitigate against these risks.

The profession-based nature of the accreditation arrangements does not provide optimal support for efforts to develop a more flexible and adaptable health workforce. Each profession-based accreditation body has developed its own criteria and processes for assessing applications for accreditation, and there is little consideration of potential overlaps with the requirements for other professions. This issue was highlighted in recent reviews of accreditation requirements that specialist medical colleges apply in accrediting clinical training placements for their training programs (ACCC/AHWOC 2005; RACS Accreditation Review 2005), see Box 9.

New accreditation models would provide an important opportunity to ensure an optimal balance of expertise and interests in governance structures. Ideally, this would ensure appropriate professional input within a multi-disciplinary team approach, whilst ensuring an ultimate focus on the public interest.

Box No 9: ACCREDITATION OF CLINICAL TRAINING PROVIDERS FOR MEDICAL SPECIALTY TRAINING

The different specialist medical colleges assess hospitals and other providers of clinical training placements using different sets of accreditation criteria. There are several common elements in those criteria, such as: education facilities and support for students/trainees; the quality of supervision, administrative systems; communication; and performance management. There are also overlaps with requirements of other accreditation processes, in particular those of the Postgraduate Medical Education Councils.

However, standards that must be met in relation to these criteria differ between colleges and other accrediting bodies. Also, information about the accreditation criteria and processes is not always widely available (if developed). Criteria are not sufficiently objective, and clear, to enable accreditation outcomes to be anticipated or understood, constraining training providers' capacity to plan training arrangements and prepare applications.

A cross-jurisdictional approach to accreditation would provide a mechanism for addressing the inefficiencies arising from this duplication of effort, by developing common standards for these common elements. Accreditation bodies (or a single national accreditation body, if adopted) could then incorporate the outcomes of accreditations performed under the common process into their assessments, without re-evaluating them.

Development of a cross-jurisdictional approach to this issue could build upon work to implement the outcomes of the ACCC/AHWOC Review of Australasian specialist medical colleges and the RACS Review of the accreditation of posts for advanced surgical training and hospitals for basic surgical training. References: ACCC/AHWOC 2005; Moss D et al 2005.

Possible approaches

Potentially significant efficiencies could be gained from developing and implementing national common accreditation criteria and processes across health education and training programs. Adopting common criteria and processes could reduce the administrative costs and service delivery time lost through separate applications and assessments, improve consistency in the application of requirements and the outcomes of assessments, and aid comparison of accreditation outcomes. Streamlining of accreditation processes could also facilitate the expansion of training into a wider range of clinical settings to accommodate changes in the health service delivery environment.

Establishing a more consistent cross-jurisdictional approach to accreditation of education and training courses would also enable a “whole of health systems and whole of health workforce” approach to be more readily adopted. Current accreditation criteria and processes tend to focus on whether education and training programs will fulfil the objectives and interests of the particular profession involved. They do not necessarily ensure that accredited programs fulfil evolving service delivery needs or produce “work-ready” graduates who can adapt to changing work requirements. The development of multi-disciplinary care teams, job redesign and new occupational roles requires that accreditation arrangements have the flexibility to accommodate approaches that cut across existing professional boundaries.

Possible national model

The adoption of a cross-jurisdictional approach to accreditation across the range of health workforce education and training would support the development of a more responsive system by reducing inconsistencies and inefficiencies within current arrangements. Depending upon the approach adopted, there is potential to remove or substantially reduce the complexities associated with having multiple accreditation systems across multiple jurisdictions. Linkages between workforce requirements and education and training could be made clearer and pathways for communication between stakeholders could be simplified.

Further the development of core competencies on a national basis would facilitate curriculum development, identify common clinical education requirements, avoid duplication of effort and resources and underpin a national registration system and mobility of the workforce.

To achieve these benefits, the new system would need to substantially replace, not add on to, existing accreditation systems.

A potential concern with the adoption of a cross-jurisdictional approach is that it may constrain the ability to develop innovative solutions to workforce issues locally, through the development of, for example, pilot courses. However, this could be easily overcome by constructing the national accreditation standards, principles and processes to support such innovation.”

The complexity of existing accreditation processes and the range of stakeholders involved mean that reform of the scale outlined could require considerable investment of resources and effort, and would take some time to achieve. There is therefore a need to identify options for short-term reform of existing arrangements as well as the medium-to-longer term structural reform outlined above.

Options for a cross-jurisdictional approach to reforming accreditation arrangements are set out below.

1. In the short-to-medium term: developing improved mechanisms for collaboration within and between professions, employer bodies and education and training providers to ensure consideration of workforce requirements in accreditation processes.

A key objective would be to encourage the development of a shared understanding of concerns about the operation of the existing accreditation arrangements and options for reform. Implementation of the outcomes of recent reviews of accreditation for medical specialist training arrangements could be progressed in this way.

2. In the medium-term: developing a national framework of principles and process guidelines, to be progressively implemented across the different accreditation processes. This framework would be adopted as the standard for development of any new accreditation requirements and progressive review of existing criteria and processes.

A key objective would be to identify areas where common criteria and processes could be adopted across all accreditation processes, to remove unnecessary duplication and reduce complexity and costs. The framework should also promote greater flexibility of accreditation processes and criteria to accommodate the development of new models of care, different work roles, and a wider range of options for service delivery.

Collaborative mechanisms developed under option 1, above, would be consolidated and enhanced to provide a vehicle for driving the accreditation reform process forward.

3. In the medium-to-longer term: establishing a single national health education and training accreditation body, responsible for revising the accreditation framework to apply across health occupations and managing related accreditation arrangements. Governance of such a body would need to be carefully designed to ensure appropriate membership, responsibilities and accountabilities.

A key objective would be for the framework to support a competency-based approach to the accreditation of health education and training programs, to support self-adjustment of the workforce. Common core competencies would be identified and reflected in applying the accreditation process across health workforce education and training programs. This would facilitate the development of new career pathways and adjustment of roles.

Structural reform of the health occupation registration arrangements would complement reform of accreditation arrangements, together with measures to make the education and training of the health workforce more responsive to workforce requirements.

9.3 REGISTRATION (AS REQUIRED FOR SAFE PRACTICE)

The registration model should facilitate and support better health workforce outcomes

Currently each State and Territory registers a range of health professions. Whilst there is significant commonality between the registered professions, there are also differences. For example, podiatrists are registered in every State and Territory except the Northern Territory.

In most States and Territories, each profession is regulated by a separate act. However, in some jurisdictions eg NT and ACT, multi-profession registration Acts have been established although the legislation retains individual professional boards and their profession specific roles. See Box 10.

Box No 10: AUSTRALIAN CAPITAL TERRITORY CHANGES TO HEALTH PROFESSIONALS REGISTRATION LEGISLATION.

The new *Health Professionals Act 2004* and the *Health Professionals Regulation 2004* were passed to enhance public protection through a more uniform, pro-active and contemporary scheme of health professional registration regulation. Increased transparency, accountability and community participation are features of the new legislation. The new legislative framework supports individual health professional board involvement in both the assessment of a health professional's initial suitability for registration and the monitoring of a registrant's ongoing standard of practice. Health professional boards may establish panels to assess and take action in relation to a registered health professional's standard of practice. The establishment of an independent Health Professions Tribunal, to hear the more serious reports about a health professional's standard of practice, is another feature of the new legislation. The new legislative framework also requires that the Community and Health Services Complaints Commissioner and the health professional boards jointly participate in the management of all reports about registered health professionals. In developing this legislation care was taken to retain those features of the existing health professional registration legislation that have proved themselves effective over time.

Profession specific schedules are being developed by the health professional boards in consultation with organisations representative of the particular profession. These schedules when allowed by the ACT Legislative Assembly will replace the current individual health professional registration Acts. The profession specific schedules will contain the provisions that are specific to that particular health profession and are the means by which the new legislative framework can accommodate registration requirements that are peculiar to particular health professions while still maintaining an overall consistency in the uniform application of current health professional standards to all health professions in the ACT.

Source: informal input, ACT Department of Health.

Accordingly, despite broad similarities in the scope and content of professional registration legislation, there are jurisdictional variations.

Issues with the current approach

Whilst recognising the importance of professional expertise in matters relating to professional practice, there are a range of issues with the current approach to professional registration:

- there is significant replication across jurisdictions in terms of the legislation and administrative structures to support registration;
- there is inconsistency in the professions registered;
- there is a lack of consistency in the requirements applied to those professions eg recency of practice, assessment of overseas-trained professionals potentially resulting in different standards;
- a profession based approach does not reflect or support the multi-disciplinary nature of health service delivery;
- a profession based approach does not facilitate the consideration of issues which cross health professions, such as new roles, expansion of scope of practice, core competencies, continuing professional development requirements;
- a jurisdictional based approach does not facilitate the compilation of national data about individual professions or the health workforce; and
- a jurisdictional based approach can impede workforce mobility.

See Box 11 for case studies and current difficulties.

Nationally consistent legislation

Health Ministers have already recognised some of the advantages of a nationally consistent approach to health profession regulation when they agreed to implement a system of nationally consistent medical registration. The Australian Health Ministers Conference announcement stated:

“Health Ministers agreed that the new arrangements would benefit the medical profession, members of the public and medical boards in each state and territory.”

Specifically, adoption of the new model would:

- *Simplify registration arrangements for practitioners who wish to practise in more than one jurisdiction;*
- *Provide a more understandable, accessible and useful medical register through the use of nationally consistent medical registration categories; and*
- *Provide clearer data on the number and distribution of doctors practising in Australia, and assist in better medical workforce planning.”*

Other benefits of the approach include the provision of information to the public.”

Key elements of the nationally consistent approach to medical registration are set out below.

- The introduction of a multi-jurisdictional/national registration system under which a doctor registered in their jurisdiction of primary practice will generally also be eligible to practise in any other jurisdiction on the basis of that registration without having to lodge a separate registration application or pay a separate fee.
- The adoption of standard and consistent medical registration categories across all jurisdictions.

- The development of an online Australian Index of Medical Practitioners which will include all current registered practitioners in Australia.
- The adoption of a uniform set of medical practitioner information items that will be available to the public in all jurisdictions. Public access will be made available online through the Australian Index of Medical Practitioners as well as through the medical boards in each state and territory.
- A platform for a greater role for state and territory Medical Boards in assessing maintenance of professional competency.

By definition, these elements do not apply to registration schemes which vary across jurisdictions.

Notwithstanding the commitment of Health Ministers, the process of enacting legislation for a nationally consistent scheme requires significant negotiation and time-consuming legislative processes.

A cross-jurisdictional approach to registration

Whilst the development of nationally consistent medical registration is an important step forward, it is an indirect way of delivering the benefits that could be achieved through a national registration scheme.

These benefits include:

- system simplicity and clarity;
- consistent requirements across all states and territories, eg in relation to assessment, orientation, supervision and mentoring of overseas trained practitioners, continuing professional education, recency of practice requirements etc;
- improving efficiency, by enabling requirements, processes and administrative arrangements to be simplified, streamlined and consolidated;
- facilitating mobility of practitioners between jurisdictions or occupational roles in response to changing workforce needs;
- reducing confusion among practitioners and consumers, as the same requirements would apply regardless of where they work or live;
- consistency in the professions registered;
- the opportunity to build a registration model which reflects and supports the multi-disciplinary nature of health service delivery;
- the opportunity to build a registration model which facilitates the consideration of issues which cross health professions, such as new roles, expansion of scope of practice, core competencies;
- the opportunity to build in the availability of current national data about health professions;
- balance of professional issues, workforce flexibility, protection of the public and the overall public interest; and
- Softening of rigid professional boundaries.

Some professions, such as law, have already recognised the benefits of moving towards national registration. A national model bill for registration of lawyers has been developed which is in various stages of implementation across the country.

In short, the model bill provides that a person holding a practising certificate issued in one Australian jurisdiction may automatically practice in another jurisdiction. The interstate practitioner cannot practise to a greater extent than a local practitioner and is also subject to any limitations imposed in his/her home jurisdiction.

The model determines where a lawyer or legal practitioner should apply for a practising certificate or renewal of a practising certificate. It provides that a person must apply for a practising certificate in their principal place of practice, unless the lawyer expects to practise predominantly in another jurisdiction, or is overseas.

Risks of a cross-jurisdictional approach to registration

A cross-jurisdictional structure covering all health occupations may, for example, be less flexible than the current multiplicity of profession-based structures eg it may be more difficult to negotiate pilot projects that have registration or scope of practice implications with a multi-profession structure; and

A cross-jurisdictional structure covering all health occupations is likely to be more complex than individual profession-based structures.

Risk management

A national registration scheme would have significant advantages in improving the consistency and efficiency of registration arrangements. There are some risks that would need to be carefully managed to ensure that a cross-jurisdictional scheme achieves the identified benefits. However, these risks could be managed by making specific provision in enabling legislation and associated documentation to support workforce flexibility and innovation. Further, ensuring appropriate governance arrangements, responsibilities and accountabilities would mitigate against any such risks.

New registration structures would provide an important opportunity to ensure an optimal balance of expertise and interests in governance structures. Ideally, membership would involve a mix of professional, legal, government and consumer representatives to ensure a balanced and appropriate focus on the public interest.

Implementation options

Pursuing a cross-jurisdictional approach across all health occupations is a major reform and may be best progressed in stages. Options are described below.

1. In the short-term: developing a national framework for health practitioner registration, to be implemented at jurisdictional level, including common principles and minimum requirements, and standard registration categories and definitions. The framework could be progressively applied to different categories of health practitioner, in line with nationally agreed priorities and timeframes.
2. In the medium-term: establishing a multi-jurisdictional/national registration system (based on the national framework), similar to the agreed model for nationally consistent medical registration, under which a practitioner registered in their jurisdiction of primary practice would generally also be eligible to practise in any other jurisdiction on the basis of that registration. The system could be progressively expanded to different categories of health practitioner, in line with nationally agreed priorities and timeframes.

3. In the longer-term: establishing a single national registration system, administered by one body (although possibly with offices in each state and territory), under which practitioners would be registered once under a single set of requirements and then be able to practise anywhere in Australia. Governance of such a body would need to be carefully designed to ensure appropriate membership, responsibilities and accountabilities.

This would be a significant structural reform, requiring thorough consideration of constitutional and legal issues, questions of accountability, and financing arrangements.

Consideration could be given to making registration a 'contestable' function, with the national body accrediting other registration bodies to undertake registration assessments/manage registration processes.

All of these models require further consideration however, the benefits and risks of this approach would need to be carefully identified.

It would also be important that the reforms be implemented in a way that supports the development of new cross-jurisdictional approaches to meeting workforce requirements and permits innovation at the local level that may have broader application. For example, there should be scope to accommodate current moves towards:

- a competency-based approach to defining practitioners' scope of practice and structuring education and training;
- team-based, multi-disciplinary models of care;
- designing new occupational roles to supplement or substitute for established roles;
- greater articulation and movement between roles, including allowing for roles to overlap.

Box No 11: Registration of Nurse Practitioners

At present, Nurse Practitioners are established in and endorsed/authorised by Nursing Registration Authorities (NRAs) in four jurisdictions (Victoria, Western Australia, New South Wales and South Australia) and implementation has now commenced in the remaining four jurisdictions.

At present, there are different NRA requirements for many aspects of NP endorsement across jurisdictions including:

- the minimum educational qualifications for NP endorsement
- provision of “equivalency” pathway in terms of qualifications
- requirements for demonstrating advanced practice capability
- areas/bands of practice recognised by NRA, and
- period of NP endorsement

: In some cases the process of endorsement is lengthy and in one jurisdiction, developments include the NRA reviewing and approving clinical practice guidelines for individual NPs that cover all clinical groups/patient cohorts for prescribing of medications. This may be many (30 or more) in the case of an emergency NP. As a result the minimum period of time for endorsement to be processed by the NRA is six months but in practice it has taken considerably longer.

: Many of the state/territory based NRA policies; do not appear to have been developed to consider Mutual Recognition and movement of NPs across sectors. Due to the small numbers of NPs, movement between jurisdictions is yet to be tested.

: In some jurisdictions there are requirements to have NP positions approved by government. Whilst this step may have merit in that it requires a health service to develop a sound business case for the role and implement it in a structured way, there are some less positive aspects.

: For example, approval for an NP position may include a requirement to develop clinical practice guidelines for the NP before a position can be advertised. These requirements mean that there are in some cases “NP without positions” or “approved positions without NPs”. This may become problematic for re-endorsement if an NP has not been able to obtain and practice in an approved position as many NRAs have a requirement to demonstrate recency (in some cases within past three years).

: There are many different medication prescribing models/scopes for NP across Australia. Whilst there is much debate about access to PBS for NP there are also jurisdictional processes that are driving undesirable variation in the NP role.

: The requirement for NPs to develop clinical practice guidelines is in effect, a mechanism for getting “approval” for prescribing by an NP. The clinical practice guidelines include the interventions/therapies that the NP may employ for a given clinical condition including the investigations and medications. They are required to be developed and or approved by a multidisciplinary team. The clinical practice guidelines (with the medications) are then put to the relevant drug advisory groups for approval. In this way the appropriate drug, poisons or controlled substances legislative requirements to enable NP prescribing can be met however, there are some perverse outcomes from this process. Drug advisory groups are largely made up of pharmacy and medical representatives resulting in other professional groups having authority to make decisions about the scope of practice of NPs. This is not the case for other prescribers.

: The case for using clinical guidelines to assist clinicians and clients to make judgements about appropriate, up to date and safe management for a given condition is well documented, however they may become a tool to determine and potentially limit the scope of practice of a “new” worker by existing groups.

: The National Nursing and Nursing Education Taskforce is working to identify the differences between jurisdictions as well as the opportunities to develop a national model.

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IMPLEMENTING NURSE RE-ENTRY

A review in each state and territory has been undertaken by The National Nursing and Nursing Education Taskforce (N³ET) to determine the following:

- the types of re-entry pathways or programs provided (including in which sector the pathway or program was provided)
- the support that was available to nurses returning to the workforce to undertake re-entry pathways or programs
- the total number of nurses/midwives completing each type of programs in 2003–04.

In addition, a review of the legislative/regulatory requirements for re-entry in each state and territory was undertaken. The review explored whether a particular approach to re-entry was legislated or was the result of discretionary practices such as nurse/midwife regulatory authority (NRA) policies, guidelines or processes.

The NRA in each state and territory sets out ways in which a nurse/midwife can meet the competency requirements for re-registration/re-enrolment through approved re-entry pathways and may exercise discretion about the type of pathways required for re-registration/re-enrolment. Nurse Re-entry Approvals (NRAs) determine whether the applicant should undertake a period of supervised practice, a structured re-entry course or a competency assessment.

The key findings of this national re-entry review were that:

- legislation regarding re-entry in each state and territory varies considerably
- despite provisions for mutual recognition, there are considerable differences in the re-entry requirements, practice and policies stipulated by the eight NRAs
- four general approaches or pathways for re-entry were identified and there were significant differences in the structure, duration, content and eligibility criteria of the different pathways in each jurisdiction

Ideally, the benefits of having an approved pathway rests on consistency, quality and certainty about the output, that is, participants achieve and can demonstrate the competency (including knowledge, skills and ethics) required for registration/enrolment. While it is recognised that differences in pathways provide for a range of learning styles and competency capabilities, there might be benefit in having greater consistency. The current lack of national consistency in re-entry requirements may call into question the confidence with which this can be accepted. Variation in requirements for re-entry may also effectively delay nurses and midwives returning to the workforce by placing unwarranted burden to demonstrate competence by completing a specified re-entry approach that may not be required in another jurisdiction.

Source: National Nursing and Nursing Education Taskforce, Australian Health Ministers Advisory Council, 2005.

10. KEY ELEMENTS OF NATIONAL REFORM STRATEGY

National co-operation and collaboration

Developing and implementing the solutions to the issues outlined in this submission will be most effective if it is done through an agreed process that incorporates the key elements as set out below.

National Leadership

National leadership will provide the impetus for all jurisdictions, and stakeholders to address issues beyond the scope of any one jurisdiction, profession or regulatory framework. Many of the largest gains from reforms will only be effectively achieved through implementation across funding, jurisdictional, professional, and regulatory boundaries.

Agreement at the national level would enable an implementation plan to be developed.

National leadership incorporating all jurisdictions at the Ministerial level will provide the necessary forum to consider change, address reform processes and provide accountability for progress.

The appropriate Ministerial forum will be one that has the power to agree reform processes and oversight implementation and reporting.

Goals and principles

A clearly articulated set of goals and principles provides the context for the reform process and a reference point to guide resolution of issues.

- Such principles facilitate the communication of the underlying rationale for reforms to stakeholders and the broader community.
- This provides the necessary commitment to engage a range of interests in support of reform.
- National leadership is important to ensure that stakeholders know that reforms are the means to improving health service delivery and not an end in themselves.

Such guiding principles have already been considered in the development of the National Health Workforce Strategic Framework. Ministerial endorsement of the framework provides a ready template for guiding the development of principles underpinning any reform agenda.

Community and stakeholder engagement

Reforms should be supported by a broad continual stakeholder engagement process that enables them to both consider the impact of change on their interests and provide input on the reforms and how they are implemented.

Given the wide variety of stakeholders with interests in the education, training, and health sectors such a process should include a coordinated cross government communications and consultation strategy.

Supportive structural reforms

Structural reforms are fundamental to building a more responsive health workforce.

These reforms may involve a variety of institutional, regulatory and legislative changes.

Reform agenda

To enable structural reform to be implemented an agreed cross-jurisdictional reform agenda should be developed. Such a reform agenda would:

- be guided by agreed goals and principles;
- adopt flexible processes to respond to changing needs;
- enable effective communication and stakeholder consultation;
- be time-limited with milestones and a reporting framework; and
- pursue reform at a national level and guide reform efforts where existing jurisdiction and regulatory structures are already best placed to implement reform.

Pursuing Reform

Pursuing these goals suggests that an informed consultative body at Ministerial level should be utilised. This will provide the appropriate national leadership and expertise in health service planning and service delivery to guide such reform.

The National Health Workforce Strategic Framework provides a starting point to guide the development of reforms.

Equally though, the need to pursue reforms which are outside the health sector necessitates that the reform agenda and process are endorsed by the Council of Australian Governments along with an appropriate reporting framework to COAG.

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APPENDIX 1

SHORTAGES IN THE HEALTH WORKFORCE

Introduction

Various measures are available to define and measure shortages. When dealing with workforce shortages the measures that are mostly analysed in this submission are the Australian Medical Workforce Advisory Committee (AMWAC) and Australian Health Workforce Advisory Committee (AHWAC) studies, Australian Department of Employment and Workplace Relations skill shortage list and existing health workforce studies. Despite the increase in the size of the Australian health workforce, there are some other important trends, and these trends highlight the challenges facing health workforce policy. In particular the nursing, medical and dental workforces are ageing and working shorter hours. Combined with increasing demand for services, these key influences have meant that shortages are common and as a result the expectation is for a continued need to expand the health workforce. Workforce distribution also remains a key concern.

Estimating Shortages

AMWAC and AHWAC

In conducting reviews so far of the specialist medical and health workforces in Australia, AMWAC and AHWAC use an indicator approach to evaluate the adequacy of supply relative to demand of health workforces. A number of indicators of shortage are available in making this assessment and their application can vary with the workforce under examination and the availability of information. Indicators can include funded vacant positions, practitioner to population ratios, service waiting times, excessive hours of work, extent of total supply provided by non-specialist staff, price, and the views of practitioners, referring practitioners, managers, carers and consumers.

Assessing the adequacy of a workforce is the most difficult part of workforce analysis. This is due to the absence of clear need benchmarks, of relevant data collections, in some cases ,or the difficulty with separating workforce effect from the effect of other factors such as funding, or with determining at what level an indicator suggests workforce surplus or shortage. Judgment is required in making many of these assessments.

In terms of providing an indication of immediate workforce shortage, unfilled hospital positions (vacancies) and the use of temporary resident overseas trained doctors is considered a reliable and clear indicator of shortage. It should also be borne in mind that if there are reported vacancies but all other indicators of adequacy suggest a workforce is at least adequately supplied, the vacancies may be more an indicator of workforce maldistribution problems rather than an overall workforce shortage. Factors influencing this could be employment conditions and a desire not to work in particular locations.

Australian Department of Employment and Workplace Relations

The Australian Department of Employment and Workplace Relations (DEWR) is the Australian Government agency with the prime portfolio responsibility for monitoring skills shortages. DEWR assesses skill shortages by a number of means including contact with employers, industry, employer and employee organisations and education and training providers. The prime focus of DEWR's agency approach is surveying employers who have recently advertised vacancies for selected skilled occupations.

In assessing skill shortages, this industry and employer intelligence is considered in conjunction with statistical information on demand and supply trends for the selected occupations. Skill shortage assessments cover Trades, Professionals and Information and Communication Technology (ICT) skills and occupations. The specific occupations and skills to be included in the annual skill shortage assessment program are determined through consultations with peak industry bodies, other key stakeholders and DEWR state offices. The program is conducted through the DEWR state offices.

Skill shortages exist when employers are unable to fill or have considerable difficulty in filling vacancies for an occupation, or specialised skill needs within that occupation, at current levels of remuneration and conditions of employment, and reasonably accessible location.

Shortages are typically for specialized and experienced workers, and can coexist with relatively high unemployment overall or in the occupation. An occupation may be assessed as in shortage even though not all specializations are in shortage. Occupations may be in shortage in particular geographical areas and not in others.

Skill shortages may exist outside those included in the skill shortage lists. For example, an occupation or skill, particularly where the number employed is very small, may not be identified in consultations with industry bodies and other key stakeholders and pockets of shortage may exist in isolated communities. In addition, variations in national or regional industry activity may cause shortages not apparent at the time when the skill shortage lists are being prepared. The lists do not include skill shortages involving skills that require only a very limited period of training and/or experience to acquire.

As noted by the DEWR, there is considerable ambiguity about the term 'skill shortages' in industry and media discussions, and in developing guidelines for training, migration, labour market programs and regional skills analysis. The term 'skill shortages' is often a surrogate for more general recruitment difficulties, or skill gaps (deficiencies in the skills of existing workers). DEWR skill shortage monitoring and assessment focuses mainly on skill shortages defined as below:

Skill shortages exist when employers are unable to fill or have considerable difficulty in filling vacancies for an occupation, or specialised skill needs within that occupation, at current levels of remuneration and conditions of employment, and reasonably accessible location. Shortages are typically for specialized and experienced workers, and can coexist with relatively high unemployment overall or in the occupation. An occupation may be assessed

as in shortage even though not all specializations are in shortage. Occupations may be in shortage in particular geographical areas and not in others.

Professions experiencing shortages

Australian Department of Employment and Workplace Relations

The following summarises recent national level information from the Australian Department of Employment and Workplace Relations.

Of the 16 occupations grouped under the category of 'professionals' in March 2004, 12 were health occupations.

Current nursing shortages on the register are:

- registered (general), accident/emergency, aged care, cardiothoracic, community, critical/intensive care, indigenous health, neonatal intensive care, neurological, oncology, operating theatre, paediatric, palliative care, perioperative, rehabilitation, and renal
- registered midwife
- mental health
- enrolled nurse

Current health specialist shortages on the register are:

- dentists
- pharmacists (hospital/retail)
- occupational therapists
- physiotherapist
- speech pathologist
- podiatrist
- diagnostic radiographer
- radiation therapist
- nuclear medicine technologist
- sonographer
- audiologist

Australian Medical Workforce Advisory Committee

Of the 25 medical workforces examined in detail by the Australian Medical Workforce Advisory Committee, in all but one, paediatrics, existing or emerging shortages have been highlighted. Key areas of shortage are:

- orthopaedic surgery;
- ear nose and throat surgery;
- obstetrics;
- pathology;
- radiology;
- oncology;
- psychiatry;
- geriatric medicine; and
- general practice.

In regard to progress with implementation of the recommendations of individual AMWAC workforce reviews the majority of disciplines are on track with nearly 90% of recommended training program adjustments in place. The two tables below outline the recommendations of AMWAC reviews and progress in meeting these.

Table 1

AMWAC medical workforce reviews, recommended increase in advanced training positions and number of training positions in 2004, by discipline				
Specialty	Number of training positions at the time of the AMWAC review ^a	Recommended increase in training positions ^b	Recommended total number of training positions ^b	2004 positions (increase)
Anaesthesia ^c	478 (2001)	34 (2003)	512 (2003)	789 (277)
Dermatology	42 (1998)	10 (2002)	52 (2002)	61 (19)
ENT surgery	40 (1997)	20 (2000)	60 (2000)	55 (15)
General surgery	176 (1997)	40 (2000)	216 (2000)	295 (119)
Ophthalmology ^d	79 (1996)	12 (2006)	91 (2006)	105 (26)
Radiology – radiodiagnosis	200 (2001)	60 (2004)	260 (2004)	241 (41)
Radiation oncology	52 (1998)	12 (2000)	64 (2000)	68 (16)
Urology	33 (1996)	9 (2006)	45 (2006)	53 (20)
<p>a - the year in brackets after the number of training positions refers to the year the workforce review was completed (using training position numbers from the previous year)</p> <p>b - the year in brackets after the number of training positions refers to the year by which the recommended increases should ideally be in place</p> <p>c - in 2004 the data provided are the number of registered, financial trainees; and because from 2004 the ANZCA training program changed to include a basic component (years 1-2) and an advanced component (years 3-5), the 2004 number is the total number of anaesthesia trainees (basic and advanced); in addition the data presented for 2004 is different from that used in previous years in preparing this summary because previous years only included trainees in years 1 to 4 as the fifth year was a provisional fellowship year under the old training requirements, whereas now the program covers the training years 1 to 5</p> <p>d - from 2004 the RACO training program changed to include a basic component (years 1-2) and an advanced component (years 3-5), the 2004 number is the total number of ophthalmology trainees (basic and advanced)</p> <p>Source: AMWAC and medical colleges</p>				
Orthopaedic surgery	32 (1999)		38 (2000), 40 (2001), 44 (2002-2006)	40
Pathology	44 (2004)		132 (2004 onwards)	44
Paediatrics ^d	58 (1998)		35 from 2001	45
Psychiatry	111 (1999)	124 (2001)	131 (2002 onwards)	115
Rehabilitation medicine	15 (1997)		Increase up to 25 (1998-2000)	29
Thoracic medicine	13 (1999)	16 (2001), increasing by 2 per year up to 24 (2006)		30

Source:

Australia's reliance on overseas trained doctors provides an indicator of the shortage of specific medical professions. In the public health system overseas trained doctors (OTDs) feature predominantly in general and/or non-accredited posts (30.2% of all doctors), Chief Medical Officers (CMOs) (15.8%), as registrars (15.4%) and GPs (15.3%). The majority of OTDs in public hospitals are working in remote centres (36.7%), other remote areas (29.5%), while the rest are evenly spread through small rural centres (14.6%), other rural areas (11%), capital cities (10.9%), large rural areas (8.9%) and other metropolitan areas (8.1%). Of the OTDs, temporary residents are mostly streamed into emergency medicine, anaesthesia and surgery, while permanent residents are streamed into psychiatry, obstetrics and gynaecology and diagnostics. Occupational trainees are mainly streamed into internal medicine, emergency medicine and anaesthesia (AMWAC 2004.3).

Nursing

In 2004 AHWAC completed a report looking at the Australian Nursing Workforce (2004b) which specifically conducted an overview of national and state and territory nursing workforce planning reports. Although each of the national nursing workforce reports differed slightly in its findings due to the various data sources and methodologies, there were consistencies in both identification of key drivers of supply and demand and findings in terms of projected supply and demand. All reports found that current student nurse numbers were inadequate to meet projected future demand. For supply to meet demand, between 10,182 and 12,270 new graduate nurses are required to enter the workforce in 2006 and between 10,712 and 13,483 in 2010. New enrolled nurse requirements are projected to be between 5,734 in 2006 and 6,201 in 2010. It should be noted that these numbers reflect completions rather than entrants to nursing undergraduate courses.

The report found that given the consistencies found across the reports analysed there is no need to commission any further national supply and demand studies on the overall nursing workforce in the short term. It is more important to develop strategies to ensure that there is an increased supply of new nurses adequately educated and supported for entry to the nursing workforce and then retained within the workforce.

Table 2

Project Title	Key Findings	Key Supply Recommendations
National		
Employment Demand in Nursing Occupations. Report by Access Economics for Australian Dept of Health and Ageing, 2004.	78% of the total 2002 nursing workforce will need to be replaced over the projection period 2003-2012. Between 2003 and 2012 and average shortfall of new nurses is estimated to be 6100 per annum (ranging from 4343 in 2003 to 8329 in 2012).	The current supply of nursing graduates from universities and VET sector are merely replacing nurses who retire or leave the occupation currently at baseline. In order for supply to meet demand, the nursing sector will have to train for growth in demand as well as increasing retirements.
Australian Nurse Supply and Demand to 2006 (Preston 2002)	In 2006, 10,182 new graduate registered nurses (RNs) will be required, with 6131 projected there will be a shortfall of 4051 graduate nurses.	For supply to meet demand, an increase of between 58.9% and 63.1% of expected new graduate nurses is required each year to 2006.
Job Growth and Replacement Needs in Nursing Occupations (Chah and Burke 2001)	Between 2001 and 2006, job openings for nurses will grow by 2.5% with a total of 31,000 jobs for new nurses over the five years (21,000 RNs, 10,000 ENs)	31,000 is the minimum training requirement over 5 years (assuming no attrition from courses and all completing students enter the nursing workforce)
The Nursing Workforce 2010 (Karmel and Li 2002)	RNs: Shortfall of 40,000 by 2010 and worsening with	RNs: Increasing graduate registered nurses by 120%

	effects of ageing of workforce to 2020. ENs: ageing effects will take place by 2010	annually will balance workforce by 2020. ENs: Increasing EN training by 17% annually will ensure balance at 2010
State and Territory	Key Findings	Key Supply Recommendation
South Australian Graduate Registered Nurse Requirements (Pratt and Rawinski 2001)	Estimated annual requirement for graduate registered nurses is between 650 and 1350 annually. However, with 1000 new graduate nurses there may still be an undersupply for over a decade.	The upper demand forecast of 1350 new graduate nurses be used when planning intakes in the short term.
South Australian Health System Enrolled Nurse Training Requirements (Lewis and Rawinski 2002)	The requirement for annual student enrolled nurse intakes is between 232 and 482 annually.	Given the shortages in the registered nurse workforce, the recommended number of enrolled nurse trainee intakes should be increased to the range of 357 to 482.
Nurse Labourforce Projections 1998-2008 (DHS 2001)	With demand held constant, graduate numbers held constant and no increase in losses, the workforce was estimated to be balanced by 2008 with 350 nurses required. With low demand growth, balance is achieved by 2008 by doubling graduates and increasing retention rates by 50% with 802 nurses required.	In light of expected shortages the report recommended: <ul style="list-style-type: none"> ➤ changing work practices and composition of the nursing workforce by identifying appropriate levels of support staff to work under the supervision of registered nurses ➤ decreasing attrition rates ➤ no increase in student numbers

Source: Table 1 in AHMAC Report 2004.2 'The Australian Nursing Workforce-An overview of workforce planning 2001-2004

Table 3 overleaf shows the recommended number of new graduate nurses and compares these with applicants who commenced, eligible applicants and number of places offered. Where the states and territories have conducted their own assessment of requirements, these have been used. Where this information was not available from the jurisdictions themselves, the work of Preston (2002) has been used.

Table 3: Undergraduate domestic nursing students 2003: recommended completions, actual completions, number of eligible applicants, number of eligible applicants offered a place and percentage of eligible applicants not offered a place by State and Territory

State	2003 Recommended new graduate nurses (RN completions)	2003 commence (DEST)	2003 complete (DEST) (awaiting data)	2003 eligible applicants (AVCC)	2003 eligible applicants offered place (AVCC)	2003 % not offered place (AVCC)
NSW/ACT	3,484 ^a	2,594		3,193	2,701	15%
Vic	2,253 ^a	1,754		4,532	2,608	58%
Qld	1,863 ^a	1,553		3,292	1,191	36%
SA	1,350 ^b	982		912	708	22%
WA	1,003 ^a	720		909	794	25%
Tas	181 ^a	216		475	335	29%
NT	99 ^a	199		N/A	N/A	N/A
Multi-state		523				
Total 2003		8,541		13,313	8,452	37%

Sources: a: Preston B. (2002). Australian Nurse Supply and Demand to 2006, a projections model and its application. A report prepared for the Australian Council of Deans of Nursing. June 2002, Melbourne.

b: South Australian Department of Human Services 2001. South Australian Graduate Registered Nurse Requirements. Prepared by Debra Pratt and Edward Rawinski. June 2001 for the South Australian Department of Human Services.

DEST¹: Department of Education, Science and Training, Commencing Domestic Students Enrolled in Courses for Initial Registration as Nurses by State, Institution, Mode of Attendance, Type of Attendance and Gender, 2003.

DEST²: Department of Education, Science and Training (Waiting for data)

AVCC: Australian Vice Chancellors Committee, Survey of Applicants for Undergraduate Higher Education Courses, 2003.

* includes non-domestic students

AHMAC has also completed two workforce reviews on the midwifery nurse workforce and the critical care nurse workforce. In regard to the midwifery workforce they identified a shortage of 1847 midwives nationally in 200x. The working party projected the required number of new entrants to the midwifery workforce up to and including 2010, producing a range of scenarios based on different rates of permanent exit from the midwifery workforce. Figures varied among jurisdictions, but nationally by 2010 there needs to be between 519 and 1752 new entrants to the midwifery workforce in order to ensure a balanced workforce depending on the permanent exit rate per annum.

The critical care nurse workforce review (2002a) found that future demand for critical care services, and thus requirements for critical care nurses, is expected to increase with population growth and ageing. As well as expanded services (in terms of bed numbers), increased productivity of critical care nurses is expected, as the throughput of patients in critical care services increases (due to technological advances).

The working party projected that the total national critical care nurse workforce was estimated to be 9,869 using AIHW data. The estimated requirement for critical care nurses as 10,386 resulting in a net shortfall of 537 nurses nationally. The total permanently employed critical care nurse workforce was estimated to be at least 5047.1 full time equivalent (FTE) nurses, with estimated vacancies (FTE) totaling 460.3. The required annual new entrants for workforce balance ranged from 722 to 1,356, depending on the workforce scenario used in the modelling.

Allied Health Professions

Data collection work has been undertaken at both the national and jurisdictional level of the medical and nursing workforces to date. The allied health workforce has not been subject to the same level of interest with the estimation of shortages being difficult due to:

- the varied number and quality of data collections;
- lack of clear and consistent consensus of which health professions constitute the Australian allied health workforce;
- registration/licensing requirements vary across jurisdiction and profession;
- data items and definitions vary between data collections, over time and between professional groups; and
- data focuses primarily on workforce supply with little evidence of robust data on workforce requirements and workforce adequacy.

To date, there has been no AHMAC workforce planning reviews conducted on the allied health professions and very few at the jurisdictional level, as such there is very little data on shortages. The major national source of shortage data is the National Skills Shortage List prepared by the Department of Employment and Workforce Relations which shows that that at March 2004 there were a number of allied health professions in shortage as shown in Table 4 below.

Table 4: National and state skill shortage lists Professions Australia -2004

Profession	Aust	NSW	VIC	QLD	SA	WA	TAS	NT
Dentists*	N	S*	R*	S		S*		S*
Pharmacist*	N	S	S*	S	S	R		D
Occupational Therapist*	N	S*	S*	S	D	D*	S	R
Physiotherapist*	N	S*	S*	S	S	S*	S	S
Speech Pathologist*	N	M	S*	S	R		S	D
Podiatrist*	N*	*	*	*	*	*	*	*
Diagnostic Radiographer*	N	S*		S			S	S
Radiation Therapist	N	S	S	S	S	S	S	
Nuclear Medicine	N	D		S		S	S	
Sonographer	N	S		S	S	S	S	S
Audiologist *1			S	S				S

Notes: 1. Not all occupations assessed in all States; * shortages may be restricted to specialist skills; N= National Shortage, M= Shortage in metropolitan areas, S= State wide shortage, R=Shortage in regional areas, D=Recruitment difficulties

Dentists: NSW shortages especially in public sector and regional/rural areas. WA shortage is greatest in rural and public health. NT shortage greatest in public sector.

Pharmacist: Vic shortages acute in retail pharmacy, rural areas and hospitals. SA shortages in retail sector.

Occupational therapist: NSW shortages in senior roles and mental health. Vic shortages in aged care, paediatrics, disability/rehabilitation services and rural practice. Qld shortages in aged care and mental health. WA shortages in aged care facilities.

Physiotherapist: NSW shortages in public sector. Victoria shortages in aged care, women's health, children with disabilities, cardio-thoracic and rural areas. Qld shortage in gerontology and locum work. SA shortage in aged care and public hospital sector. WA shortage in rural areas.

Podiatrist: National shortages are widespread.

Speech Pathologist: Victoria shortages in the area of paediatrics, education, disability services, locum services and regional and outer metropolitan areas.

Diagnostic Radiographer: NSW shortages in MRT, mammography and CT.

Source: DEWR March 2004

Any workforce planning in the allied health area needs to be cognizant of the existing capacity to collect data for specific professions. At present, this would seem to limit any detailed work to the podiatry, physiotherapy, psychology and occupational therapy workforces, as these are the only workforces where detailed labour force information is collected through the AIHW labour force survey processes.

Aged Care

At present, workforce planning data is collected on a profession specific basis with little information regarding specializations within the profession. As such, very little data exists on the health professions that are specializing in providing aged care and the shortages that are being experienced in this industry.

DEWR skill shortage data lists nurses in aged care as one of their professions experiencing shortages. Access Economics 'Employment Demand in Nursing Occupations' 2004 also identified that the demand for aged care services is projected to grow steadily with population growth and ageing, with an average increase in demand for nursing hours in aged care of 4.9% for RNs and 3.6% for ENs (above economy wide productivity gains of 1.75%). The gross replacement requirement for the nursing workforce over the projection period (2003-2012) is 117% of the 2002 RNs in aged care and 166% of the 2002 ENs in aged care.

The Senate Community Affairs Committee have recently completed a report on 'Quality and Equity in Aged Care' (June 2005) and reported that there were acute shortages of nurses in the aged care sector with the delivery of qualified care under threat from the retreat of qualified nurses, both registered nurses and enrolled nurses. Shortages of general practitioners with older persons' health expertise, geriatricians, psycho-geriatricians and allied health professions were also reported.

The report states that between 1995-96 and 1999-2000, the number of employees in residential aged care declined while the number of people being cared for increased; and between 1996 and 2001 the share of direct care provided by registered and enrolled nurses declined in both nursing homes and accommodation for the aged while the use of personal carers increased significantly.

The decline in employees in residential care was attributed to the decline in the use of staff not involved in the direct provision of care as a result of consolidation within the sector which enabled greater economies of scale; a greater reliance on outsourcing of some activities; and, greater use of multiskilling. The increase in the use of personal carers reflected both the

growing shortage of nursing staff and the development of more efficient workforce structures.

Australian Institute of Health and Welfare *Nursing Labour Force 2002* data shows that:

- in 2001 there were 19 109 registered nurses and 13 109 enrolled nurses employed in geriatrics/gerontology which represented 12 per cent of all registered nurses and 31.2 per cent of all enrolled nurses;
- between 1997 and 2001, the number of nurses working in geriatrics/gerontology declined 8.7 per cent;
- nursing homes and aged care accommodation accounted for 14.6 per cent of all nurses – the second largest proportion;
- the number of nurses working in nursing homes and aged care accommodation declined by 28.0 per cent between 1995 and 2001; and
- nurses working in nursing homes and aged care accommodation tended to be older than nurses in other work settings and they worked shorter hours.

Submissions to the Senate Report show that general practitioners, personal carers and community support workers in the aged care sector are in shortage. The Australian Medical Association (AMA) indicated that there had been a decline in the number of general practitioners visiting residential aged care facilities. The AMA stated that there were a number of barriers to health professionals visiting residential aged care facilities including the absence of appropriate Medicare Benefits Schedule items for geriatricians, the large amount of paperwork expected of GPs and staff of the facilities and the lack of integration of medical services in the aged care system.[]

The Health Services Union (HSU) and the Liquor Hospitality and Miscellaneous Union (LHMU) drew the Committee's attention to significant issues for personal carers in the aged care sector. Personal carers received relatively low wages with the hourly rate less than that of checkout operators in supermarkets but requires TAFE certificate qualifications in aged care. Carers are required to provide a range of personal care services, with minimal supervision as well as simple health needs such as wound dressing, attend to blood pressure, and temperature and pulse checks. As a result, it is extremely difficult to attract and retain younger staff.

A new trend reported also is a reluctance of people to take up work in the community sector where all States and Territories are experiencing rapid growth of community care programs in both ageing and disability and in turn increasing the demand for workers.

The National Institute of Labour Studies (NILS) report, *The Care of Older Australians: A Picture of Residential Aged Care Workforce*, stated that 'the existing level of knowledge about workers in aged care is remarkably limited' and no single data source provides an accurate and detailed appraisal of direct care employment in residential aged care, especially to inform complex workforce planning. The Report stated that, in 2003, there were

116,000 direct care employees of whom 25,000 were Registered Nurses, 15,000 were Enrolled Nurses, 67,000 were Personal Carers and 9,000 were Allied Health workers. The number of vacancies for direct care workers in aged care facilities is generally low, with relatively more vacancies for Registered Nurses than other occupations.

NILS stated that 'there are few signs that this is a labour market in crisis, or even under serious stress' but went on to note that there were some indications of stress. These included that nurses are substantially older than the typical female worker, the relatively high number of vacancies for Registered Nurses and the high levels of turnover of direct care staff. This report collected information on the distribution of aged care workers across four main occupational groups. Findings as represented in table 5 overleaf show that that staff who provide direct care in aged care facilities are predominantly personal carers and it is likely that their share of all jobs is rising: 57% of all staff and 64% of recent hires are personal carers. The next largest group is registered nurses at 22% and enrolled nurses at 13%. Diversional therapists and recreation officers are the other sizable group, comprising the bulk of the Allied Health group and about 8% of all direct care staff.

Table 5: Distribution of the Aged Care Workforce, And New Hires, By Occupation (Per Cent)

Occupation	Data from Employees		Data from Facilities	
	Whole Workforce	New Hires	Number of Persons	Equiv. Full time
Registered Nurse	21.6	18	21	21.4
Enrolled Nurse	13	11	13.1	14.4
Personal Carer	57.1	64	58.5	56.5
Allied Health	8.2	5.7	7.4	7.6
Total Number			115,660	76,006

Source: NILS The Care of Older Australians: A Picture of Residential Aged Care Workforce Table 4.2

The report also looked at employment arrangements and found that only 11% of workers overall are permanent full-time employees, with this percentage highest for Registered Nurses (18%) and lowest for personal carers (8%). The most common form of employment was permanent part-time. This accounted for over two-thirds of workers, though was less among Registered Nurses (62%). Casual or contract work accounted for 19.5% of the total workforce as shown in table 6 overleaf.

Table 6: Nature of Employment Contract of Aged Care Workers (Estimated Total Number and Per Cent)

Employment Contract	Registered Nurse	Enrolled Nurse	Personal Carers	Allied Health Workers	Total
Permanent Full time	4,344 (18.1)	2,217 (14.2)	5,257 (7.8)	1,089 (12.2)	12,907 (11.2)
Permanent Part time	14,964 (62.3)	10,944 (70.1)	48,151 (71.7)	6,194 (69.6)	80,253 (69.4)
Casual or Contract	4,711 (19.6)	2,443 (15.7)	13,735 (20.5)	1,612 (18.1)	22,500 (19.5)
Total	24,019	15,604	67,143	8,895	115,660

Source: NILS The Care of Older Australians: A Picture of Residential Aged Care Workforce Table 4.3

Department of Health and Ageing (2004) also reported that there has also been a considerable adjustment within direct care. The share of direct care provided by registered and enrolled nurses (RNs and ENs respectively) has declined in both the nursing home and accommodation for the aged industries. In contrast, the use of personal care assistants, has significantly increased. These changes reflect both the growing shortage of nursing staff and the development of more efficient workforce structures. These trends are reflected in table 7 below.

Table 7: Employment in nursing homes and accommodation for the aged, by occupation, 1996 and 2001

	Nursing homes		Accommodation for the aged	
	1996	2001	1996	2001
Registered nurses	45.0%	43.3%	35.1%	29.2%
Enrolled nurses	11.0%	7.7%	9.8%	6.1%
Personal care assistants	6.0%	17.9%	25.8%	44.6%
Nursing assistant	37.0%	30.4%	28.3%	19.2%
Physiotherapists	1.0%	0.7%	0.9%	0.9%

Source: Australian Bureau of Statistics. Census of Population and Housing, 1996 and 2001.

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SUPPLY – INITIATIVES TO INCREASE HEALTH WORKFORCE

Health workforce supply can be increased through a combination of three types of changes:

1. measures to increase the total number of people in the workforce;
2. measures to boost the hours worked by those in the workforce; or
3. measures to boost the productivity of the workforce.

Productivity increases can be achieved through changes in the use of technology and in techniques and also through reforms to the way labour is organised. Much of this sort of change happens incrementally and across a wide variety of settings. There are few case studies available and are often not appropriate to replicate.

Increasing the numbers of people in the workforce can include measures to train more or measures to attract those already trained but no longer actively working in their occupation.

Measures to increase numbers of trained health workforces

Australian Government – medical school places and GP training places

- The number of publicly funded medical places across the tertiary sector has increased by more than 30% since 2000. Five new medical schools have been established since that time and three new medical schools are expected to come on stream over the next few years. These initiatives will expand the number of Australian students completing university medical studies from approximately 1,300 in 2005 to 2,200 early next decade.
- From 2004, 150 new GP training places are being offered each year, an increase of one third. This will provide a significant addition to the GP workforce over time.
- In July 2004 the Minister for Education, Science and Training, the Hon Dr Brendan Nelson MP, announced funding of over 8,000 new higher education places for health disciplines over the period to 2008. This includes over 4,000 new nursing places as well as increased places in disciplines such as dentistry, pharmacy, physiotherapy and podiatry. This should significantly increase the number of health professionals available to work in rural and remote areas over time.

Queensland Government

Queensland has agreed to fund 235 undergraduate medical school places at Griffith University. The places are primarily aimed at recruiting doctors into rural and remote areas, Indigenous health services, and community run health services. At a total cost of \$61 million over 8 years the funding supports a complete training package for 35 students in 2006 and 50 more students in each of the next four years to 2010. This includes paying students fees, scholarships and assistance to obtain postgraduate qualifications in their respective medical specialties including the Australian College of Rural and Remote Medicine. As part of the training agreement, these graduates would be bonded for 10 years to the Queensland public system (Queensland Government 2005).

Recruiting from overseas

Australian Government – Strengthening Medicare

The Strengthening Medicare package, announced in November 2003, includes a range of initiatives to increase the opportunities for appropriately qualified overseas trained doctors to practice in Australia. These include international recruitment strategies, opportunities for doctors to stay longer or obtain permanent residency through changes to immigration arrangements, improved training arrangements and additional support programs. As a result of these initiatives, an additional 725 appropriately qualified overseas trained doctors are expected to be working in Australia by 2007 (DOHA 2004).

Mutual recognition

Australia and New Zealand have an agreement automatically recognizing each others nursing and medical practitioner qualifications (Trans-Tasman Mutual Recognition Act 1997). Australia has also identified nurses as priority immigration applicants and nurses on short holiday visas are able to apply for a change in visa status, DIMIA 2005

Case Managers for OTDs

The Western Victorian Division of General Practice developed an initiative to provide case managers for doctors recruited to rural areas. The case manager is involved in identification of potential doctors including overseas recruits, undertaking an assessment of the doctor's issues and problems, defining the doctor's goals, matching doctor and practice needs and developing an intervention plan. The case manager maintains support and regular communication before, during and after the transition to rural practice. The Division of General Practice provided the infrastructure to support this process which has been a successful adjunct to the recruitment and retention of GPs in western Victoria. Over an 18 month period the Division was able to place 17 doctors into temporary and permanent placements (Maclsaac, Snowdon et al.(2000)).

Measures to attract qualified health workers back into work

Mater Midwifery refresher program

In 2002 the Mater Mothers' Hospital developed a midwifery refresher program comprising 80 hours theoretical and a minimum of 150 hours of clinical practice. This provided a low cost entry (\$650 expenditure gained credit for the equivalent of \$1800) to postgraduate midwifery qualifications for students who wished to pursue these. Results indicate the program addressed hospitals staffing crisis in cost effective way. All participants achieved clinical competence and were subsequently offered employment. Clinicians were satisfied and felt refresher midwives required less supervision than anticipated. The project also increased links between clinical and academic staff and there is the potential for further joint work. Participants felt the program was good value for money and appreciated the opportunity to undertake unpaid supernumerary practice (Flowers & Carter 2004).

Victorian Government Nurse Recruitment & Retention Campaign.

This program provides funding of \$4000 to each hospital and \$2000 to each non-practising registered nurse undertaking a re-entry programme or accredited supervised practice programme. The provision of free refresher/re-entry/ supervised practice programs to encourage nurses to return to the workforce was a key strategy. The campaign proved to be

the most successful undertaken in Australia, with over 4,000 nurses returning to the public health system via free refresher or re-entry/supervised practice programs (Victorian Government 2003).

Practice

Nursing

Study

A practice nurse is a registered nurse or an enrolled nurse who is employed by, or whose services are otherwise retained by, a general practice.

Practice nurses assist general practitioners by contributing to a range of services, including chronic disease management and population health activities. The role is diverse and influenced by factors such as the practice population, nurses' qualifications, practice structure, professional standards and national incentives and programs. Key elements of the role include:

- the provision of clinical care such as triage, health assessments, immunisations, wound management and health promotion;
- clinical organisation through for example: recall registers, maintaining clinical records, infection control, and referral management; and
- integration and collaboration within and outside the general practice through, for example: liaising and coordinating with other health professionals, patient discharge planners, and patient advocacy groups.

The Australian Government has been supporting the work of practice nurses through a range of programs.

Strengthening Medicare

As part of the Strengthening Medicare package, the Australian Government provided funding of \$78.5 million over four years, to assist practices to employ practice nurses in urban areas of workforce shortage. This initiative enables practices to employ allied health workers such as dietitians, physiotherapists and speech therapists instead of, or in addition to, a practice nurse.

Medicare rebates are also available where practice nurses provide immunisation and wound management services, and Pap smears in rural areas, on behalf of a general practitioner. The Australian Government has committed \$104.1 million over five years to immunisation and wound management services and \$17.8 million over five years to pap smears.

Additional Practice Nurses for Rural Australia and Other Areas of Need

Through the 2001-02 and 2005-06 Federal Budgets, the Australian Government has provided \$234.0 million over eight years to improve access to medical services for patients in rural Australia and other areas of need by providing support for general practitioners to employ practice nurses.

The measure includes an incentive through the Practice Incentives Program (PIP) for eligible general practices in rural and remote areas to employ practice nurses, as well as funding for practice nurse training and professional support.

Measures which may influence hours worked

Australian Government

The After Hours Primary Medical Care Program (AHMPC)

This program was introduced as a component of new funding announced in the 2001-02 Federal Budget for \$43 million over four years. The purpose of the Program is to improve access to quality after hours primary medical care and progress systemic reform by trialing key interventions. The National Evaluation of the program assessed the effectiveness, financial sustainability and transferability of approaches taken by the individual trials, while the local evaluations were focussed on regional issues. Funding has provided for:

- Four major trials.
- 54 seeding grants.
- 12 infrastructure or IT grants.
- 19 project grants.
- 12 quality improvement projects (medical deputising services).

Services currently funded under the After Hours Primary Medical Care Programme's Service Development Grants and Trials components — including GP Assist in Tasmania and GP Access After Hours in the Hunter urban region of NSW — have had their contracts extended to June 2006. Existing services are currently undergoing a thorough evaluation (Australian Government 2004a).

Round the Clock Medicare: Investing in After Hours GP Services (IAHGPS) Program.

These initiatives extend the reach of general practice around the clock by providing for higher Medicare rebates for after-hours GP services and three new grants programmes to support after-hours general practice infrastructure:

- for operating subsidies, to a maximum of \$200,000 a year for new and recently established after hours GP services,
- for start-up grants of up to \$200,000 over two years and for the Medicare costs for new after-hours GP services, with up to five to be funded this financial year, and
- for supplementary assistance to after-hours services in outer suburban and regional areas to ensure their viability.

Together these funding components aim to encourage the development of new after hours services and assist existing services to maintain and enhance the GP care they currently provide in the after hours period. 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

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DEMAND – PROJECTED GROWTH IN DEMAND FOR HEALTH PROFESSIONALS

Introduction

The major influence governing the demand for health professionals is the demand for health care itself. Increases in the demand for health care are driven by a number of factors:

- Population growth;
- Economic growth resulting in higher real per capita incomes;
- Demographic change leading to a higher proportion of older persons in the population;
- Improvements in socio-economic status, such as education and access to health information; and
- Changes in health conditions and the burden of disease.

In considering how the demand for health will change in the future, all these factors remain relevant. Improvements in socio-economic status are difficult to predict however rates of economic growth are often used as an indication of raising living standards. Therefore, improvements in economic growth are associated with a positive increase in real demand for health care, beyond that driven by population changes and ageing.

Trends underlying demand growth

Trends in national health care expenditure and utilisation indicate that the demand for health care has been rising faster than national growth in output and is likely to increase even faster than national growth in output in the future. This has been driven by a combination of factors:

- health costs rising faster than general price rises;
- population increases;
- the ageing of the population; and
- significant growth in per person utilisation and improvements in technology (referred to as real non-demographic growth in health care expenditure).

Resource changes

Figure 1 from AIHW 2004a shows how health has increased its share of GDP, over the same period even though GDP was rising relatively faster than in previous periods.

Figure 1 Health expenditure and GDP, constant prices, 1992-93 to 2002-03

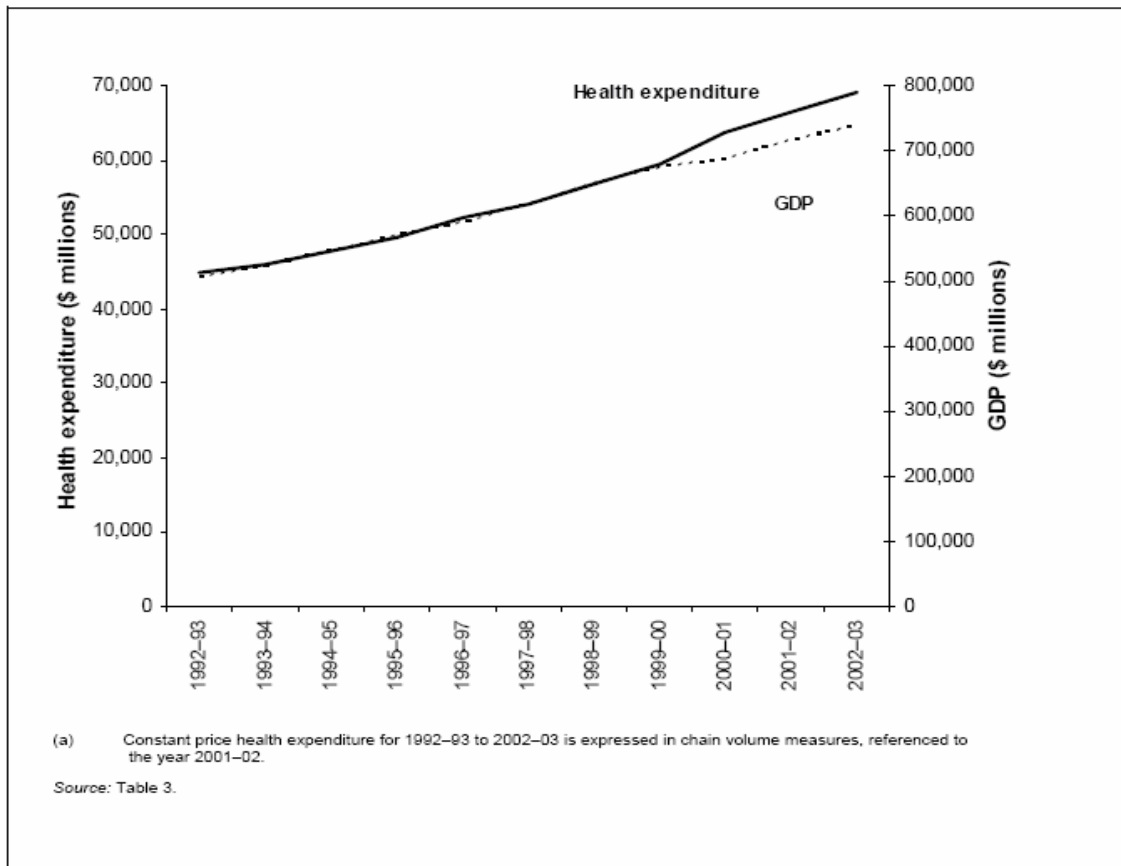


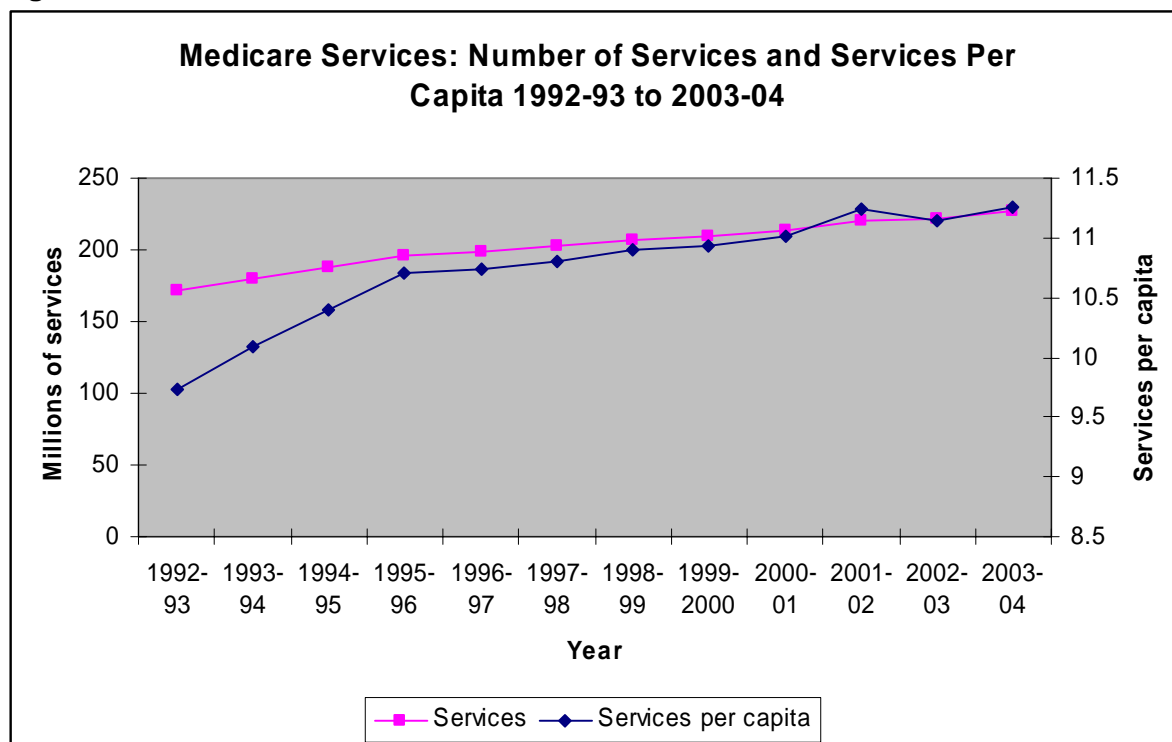
Figure 1 Source: AIHW 2004a

Trends in output of services show similar increases to expenditure growth.

Medical services

For medical services the quantity of all medical benefits paid provides an indication of changes in utilisation of medical services. Growth in the use of the Medical Benefits Schedule (MBS) over the period 1992-93 to 2003-04 as reported by DoHA 2004a is shown in Figure 2.

Figure 2 Medicare Services



Source: DoHA 2004a

Hospital services

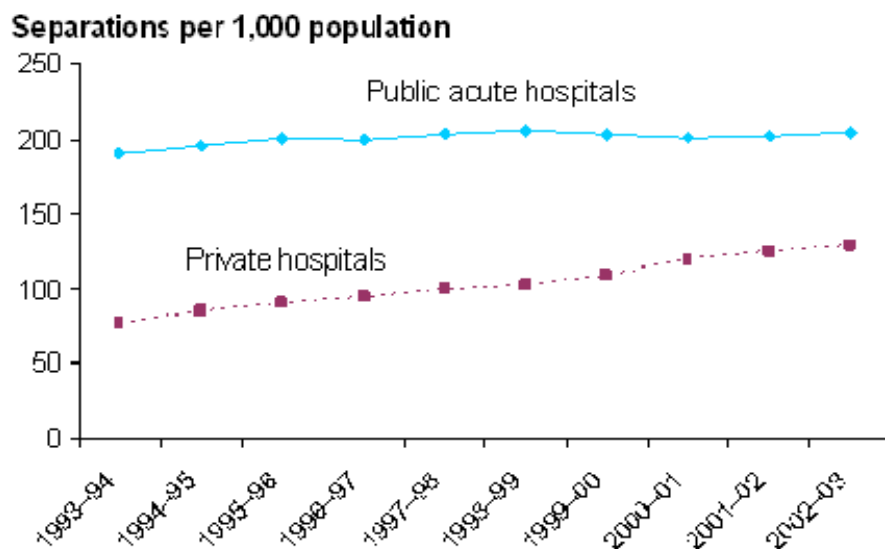
AIHW 2004b reported that separations and patient days have shown significant increases:

- between 2001–02 and 2002–03 activity increased in all hospitals with separations and patient days increasing by 4.0% and 1.5% respectively;
- between 2001-02 and 2002-03, separations increased by 3.2% for public acute hospitals and by 5.3% for private hospitals.

On a per capita basis separations per 1,000 population show similar, though much smaller increases, with a 7.6% increase for public acute hospitals between 1993-94 and 2002-03, while private hospitals increased by 66.9% over the same period.

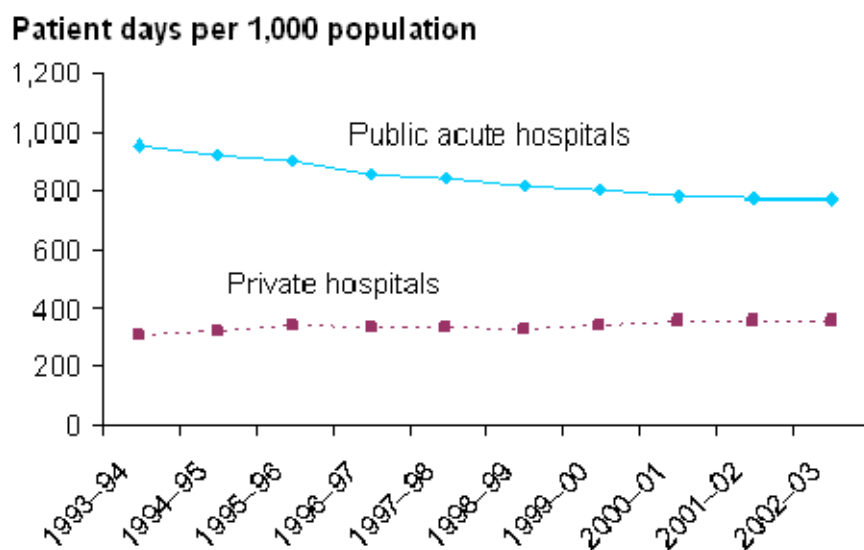
In terms of overall market share of hospital services it is notable that AIHW 2004b reports that the private sector has shown increases in patient days and separations on a total and per capita basis right through this period. In 1993–94, 71.5% of separations and 75.7% of patient days in acute care hospitals were in public acute hospitals. In 2002–03, these percentages were 62.0% and 69.2%, respectively.

Figure 3: Separations per 1,000 population, Australia, 1993–94 to 2002–03



Source: AIHW 2004b data

Figure 4: Patient days per 1,000 population, public acute and private hospitals, Australia, 1993–94 to 2002–03

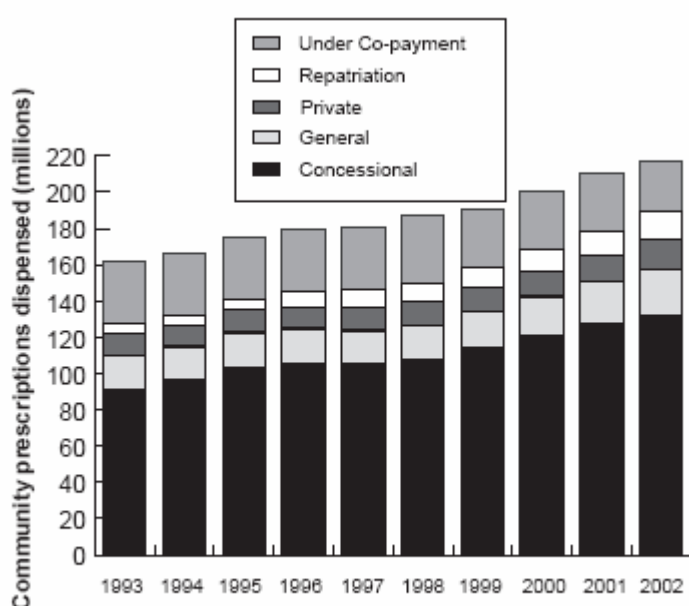


Source: AIHW 2004b

Pharmaceuticals

DoHA 2004b reports that for pharmaceuticals the rise in expenditure has been accompanied by a rising volume of medicines prescribed as illustrated by Figure 5:

Figure 5 Number of Prescriptions by type of service



Source: DoHA 2004b

Change in health care demand factors

1. Demographic change in Australia

That Australia is undergoing demographic change is well known and usually summarised as Australia having a slowly growing but ageing population. However, in the future there will be a stronger focus on obtaining (and keeping) the Australian workforce, including the health workforce.

- the key national workforce demographic change will be a much slower growth in the total number of people in employment and the total number of hours worked per year.
 - The current national workforce is projected to grow by around 320, 000 between 2003-04 and 2005-06. This is the same growth in the total national labour supply that is projected to occur over the entire twenty years from 2024-25 to 2044-45 (Productivity Commission 2005).

For the health sector there are two significant additional changes.

- The ageing of the population is expected to also affect demand by increasing the need for services and the nature of those services
 - The incidence of the burden of disease/illness will continue to move away from acute and life threatening diseases/illness to towards chronic disease.

2. New technologies and health care

Advances in health technology have always been readily incorporated into the provision of health care. These advances impact on demand, productivity and practice. The expectation

for the next twenty to thirty years and beyond is that health care advances and innovations will continue at rapid rate, with pressure from increasingly well informed consumers for their prompt uptake and universal application.

It is difficult to predict the impact of changes in health technology, although the overall expectation seems to be that the treatment of many diseases and injuries will change substantially influenced by:

- nanotechnology (the ability to assemble materials molecule by molecule);
- gene technologies (genetic screening and gene therapy and individual knowledge of their genetic profile);
- robotics; and
- e-technologies (impacting on the way care is delivered, the storage of information and data, and communication).

3. Empowered consumers

Empowered consumers will demand to know more about the treatments proposed for them, their effectiveness and the track record of the practitioners involved in their diagnosis, testing and treatment. Track record knowledge can also be expected to extend to the facility or setting in which the service and care is being provided. Consumers are also likely to seek out the most advanced, safest, lowest cost care options.

4. Socio-economic changes

Education

Australian education levels have continually risen over the last twenty years. ABS 2004b reports that the proportion of all persons with a non-school qualification increased from 39% in May 1994 to 51% in May 2004 and those with a bachelor degree or higher increased from 10% in 1993 to 19% in May 2004.

Moreover, the proportion of school students completing year 12 has significantly increased. ABS 2002b found that in 2001, the apparent retention rate of full-time school students from Year 7/8 to Year 12 was 73.4%, a significant increase from 48.7% in 1986 but slightly less than the peak of 77.1% in 1992. The Year 10 to Year 12 apparent retention rate has shown a similar trend, increasing from 51.9% in 1986 to 78.6% in 1992, and then falling slightly to 75.4% in 2001.

Income

Real national income has risen significantly over the last 30 years and in particular the last ten years. The ABS reports that real per capita income growth during the past decade has been quite strong:

“The average annual growth rate (2.8%) since 1993-94 is appreciably above the 1.7% per year recorded since the early 1970s.”

Reflecting the rise in real national income, average weekly earnings reported by the ABS 2005b have also risen significantly between May 1992-93 and November 2004 the average yearly increase in Average Weekly Full Time Adult Total Earnings has been just over 4%. On the other hand prices have risen more slowly with the average increase in the Consumer Price Index (CPI) reported by the ABS (2003a) being only 1.9% per year between 1992-93 and 2001-02.

The result has been real increases in personal income of over 2% per year, while national real income has increased by slightly less.

5. Changes in health status

According to '*Australia's Health 2004*' (AIHW 2004c), there has been significant progress in reducing overall mortality in Australia and reducing the impact of many individual diseases and conditions. Prominent features of these trends have been large reductions in infant mortality, a significant decline in deaths from communicable diseases, and, over the last four decades, shrinking rates of cardiovascular deaths.

- The crude death rate has fallen from 756 per 100,000 persons in 1982 to 680 per 100,000 persons in 2002, in spite of the ageing of the Australian population, with a crude ratio of 106 male deaths for every 100 female deaths. This gap has closed considerably over the last two decades: in 1982 the ratio was 123 to 100.

Chronic diseases are the primary health concerns for Australia, now and in the future. The evidence to support this is set out below.

- Cardiovascular disease is the leading cause of death for both males and females, despite a marked drop in death rates since the late 1960s. About one in five Australians had cardiovascular problems in 2001 and around 1.1 million have a disability as a result.
- Cancer ranks second as an overall cause of death, and although its death rates fell between 1992 and 2002, it now kills more middle-aged Australians than cardiovascular disease.
- Lung cancer caused most cancer deaths in Australia in 2002, ranking first in males and a close second to breast cancer in females.
- Diabetes prevalence has more than doubled over the past two decades and is estimated to affect around one million Australian adults. Self-reported diabetes among Aboriginal and Torres Strait Islander peoples in 2001 was almost four times as high as for other Australians. Diabetes Mellitus Type 2 is predicted to have the largest increase of the chronic diseases by 2020.
- Asthma affects about 14% of children and 10% of adults. The proportion of children with asthma increased dramatically in the 1980s and early 1990s.
- Arthritis and other musculoskeletal conditions are estimated to affect more than 6 million Australians (3 in every 10) in 2001. These cause more disability than any other medical condition, affecting about 34% of all people with a disability.

AIHW 2004c

Improvements to health outcomes have been achieved through:

- Major advances in the prevention and treatment of infectious diseases and injuries, which have reduced their incidence and prevalence.
 - Exceptions to this trend are infectious diseases such as Hepatitis B and C and HIV/AIDS, which themselves have a chronic course.

- Demographic changes, whereby people are living to much older ages and the average age of the population is substantially older.
 - The prevalence of chronic disease is strongly related to older age, and the health expenditure for people aged 65 years and over is three times that for the population as a whole.

- Lifestyle changes, which have increased exposure to risk factors for chronic disease.
 - AIHW 2004c identified seven major risk factors that impact adversely on the incidence and prevalence of many chronic diseases. About one third of the chronic disease burden can be attributed to these risk factors, most of which are increasing in prevalence:
 - Tobacco smoking;
 - Risky and high-risk alcohol use;
 - Physical inactivity;
 - Poor diet and nutrition;
 - Excess weight;
 - High blood pressure; and
 - High blood cholesterol.

Figure 6: Common Risk Factors for NHPA diseases and conditions

NHPA disease or condition	Risk factor							
	Physical inactivity	High blood cholesterol	Excess weight	Poor diet & nutrition	Tobacco smoking	Alcohol misuse	Low birth weight	High blood pressure
Type 2 diabetes	✓	•	✓	✓	•	•	✓	•
Asthma	•	•	•	•	✓	•	✓	•
Coronary heart disease	✓	✓	✓	✓	✓	✓	•	✓
Stroke	✓	✓	✓	✓	✓	✓	•	✓
Lung cancer	•	•	•	•	✓	•	•	•
Colorectal cancer	✓	•	✓	✓	•	•	•	•
Osteoarthritis	✓	•	✓	•	•	•	•	•
Osteoporosis	✓	•	•	•	✓	✓	•	•
Injury	•	•	•	•	•	✓	•	•

Source: AIHW 2004c

Chronic diseases are associated with high health care expenditure. For example, the health conditions shown in Figure 7, most of which are long-term, account for the greatest health expenditure in Australia. Together, they account for almost \$34 billion, and nearly 70% of allocated health expenditure.

Figure 7: Health care expenditure 2001

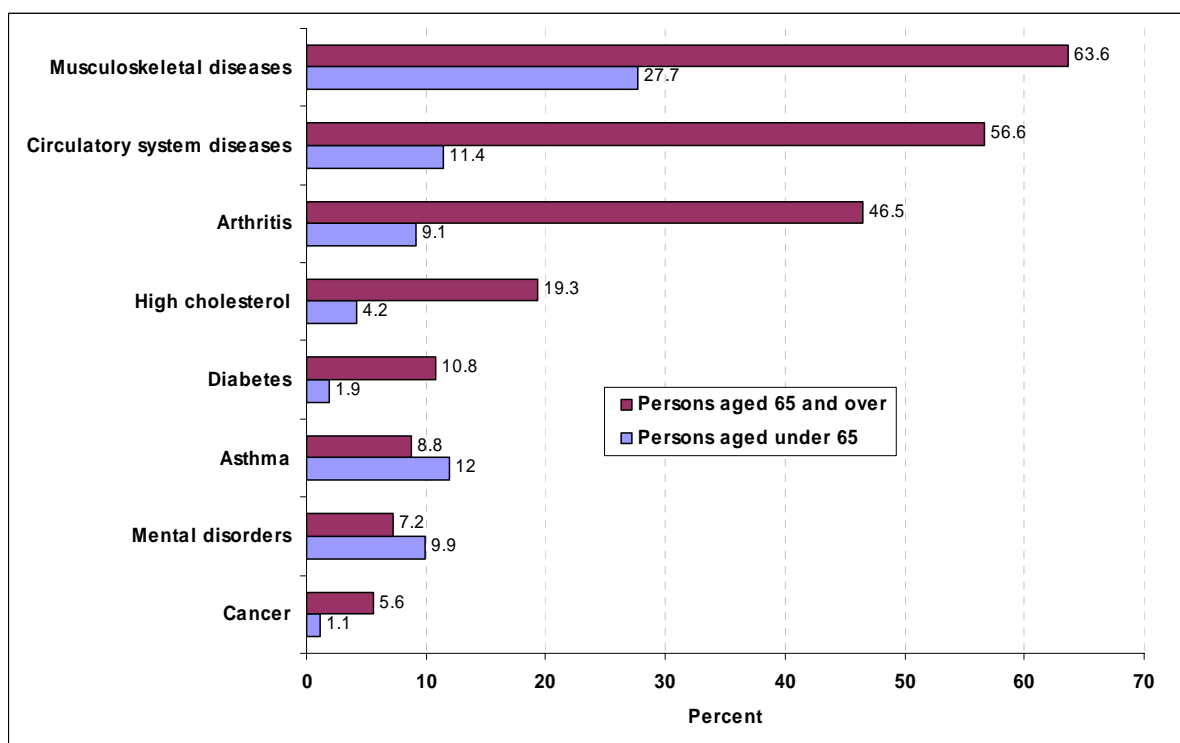
Cardiovascular diseases	\$5.5B ^(a)	10.9% ^(b)
Nervous system disorders	\$4.9B	9.9%
Musculoskeletal conditions	\$4.6B	9.2%
Injuries	\$4.0B	8.0%
Respiratory diseases	\$3.7B	7.5%
Mental disorders	\$3.7B	7.5%
Oral health	\$3.4B	6.9%
Neoplasms	\$2.9B	5.8%
Diabetes	\$0.8B	1.7

Source AIHW 2005c

AIHW 2001 found that 70% of Australia's overall disease burden was due to death, disability and diminished quality of life and this is expected to increase to 80% by 2020 according to the draft National Chronic Disease Strategy (National Public Health Partnership 2001).

Moreover the burden of these diseases falls more acutely on older population groups as per Figure 8.

Figure 8: Aged population health: prevalence of National Health Priority Area conditions, Australia, 2001



Source: ABS 2002a

Summary of changes to demand factors

Together these trends show that the Australian health care environment has been characterised by relatively higher growth in real per capita expenditure, real growth in per capita output of services, and relatively higher employment growth. It was also characterised by improvements in health outcomes through falling mortality rates for a large variety of diseases and conditions and increasing life expectancy. There were also gains to educational status and real increases in both national and personal income.

Trends in these variables are consistent with real increases in demand for health care:

- real increases in income;
- real improvements to education;
- improvements to health status;
- increases in population; and
- a relatively higher proportion of older persons.

Demand projections

A range of studies in recent years have sought to project health care demand into the future (Productivity Commission 2005, Australian Government Treasury 2002, AMWAC 2005 (forthcoming), Fitzgerald and Haebich 2002, and Richardson and Robertson 1999.) While these projections have primarily focussed on expenditure growth, they are underpinned by projections for the real non-demographic growth rate in health care demand.

- These studies suggest that real non-demographic growth rate in health care demand is likely to be in the order of 0.5% to 1% above per capita GDP growth.
- Adding in effects of ageing, and population growth suggest that the total growth in real health care expenditure projected to rise by between 4 to 4.5% per annum. (AMWAC 2005 forthcoming).

Translating the overall growth in health care demand to project demand for health professionals depends on both the productivity of health professionals and the participation rate of those professionals.

- The ABS 2003b reported on labour productivity changes across a number of industries. This shows that across all industries labour productivity increased by an average of 1.8 per cent per year between 1992-93 and 2000-01, while in the health and community services industries it increased by only 0.4 per cent.
- Over the period between 1999-2000 and 2000-01 there was an increase of 0.1% across all industries and a decrease of 3.5% in the health and community services industry. However, the figures should be read with caution because:
 - : they are based on the National Accounts and therefore are not necessarily comparable with the figures from the ABS census figures or the AIHW labour force surveys'; and
 - : for some industries including the health and community services industry, growth in volume of output is calculated using indicators of labour input '*...because of a*

lack of suitable output indicators. Therefore, for these industries there are no meaningful measures of labour productivity growth" ABS 2003b.

Given these cautions it has been assumed that labour productivity in the health care industry will grow slightly below the economy wide growth, and thus be between 1% and 1.5% per annum.

The hours worked by employees in an industry are a major influence on the output growth of that industry. Thus while employment may increase, if the average hours worked decreases then overall level of employment supply may not increase or may increase less than the growth of employment.

- There was an overall decrease between 1996 and 2001 in the average hours worked in both the health and the community services occupations from 30.9 to 30.8 per week and from 30.2 to 29.6 per week, respectively, with larger declines in the hours worked in the major employment categories of medical practitioners and nursing.
- Notwithstanding these decreases it has been assumed that the decline in hours will not continue and stabilise at present measured levels.
- It is also assumed that the present gross net employment growth continues and there will not be a significant increase in exits from the industry.

If the productivity of health labour increases by 1 to 1.5% per annum then overall health workforce growth would be in the range of 2.5 to 3 per cent per annum.

- If labour productivity growth is lower or the decline in hours continues or the older cohorts exit faster than expected, then the demand for health professionals will be even larger.

Implications of health demand changes

It is expected that together these changes will have the following implications:

- A greater demand for existing services and for new types of services flowing from new technologies and techniques/procedures;.
- A change in the way services and care are provided with new opportunities in diagnosis, testing, treatment and surveillance and the support of each of these processes:
 - The health system has moved increasingly to provide treatment & management of chronic disease, but these require significant additional system resources, including health professionals; and
 - Similarly, as part of improving the health of the population as a whole, there will be greater emphasis on promotion and prevention strategies;
- Technology improvements that enable the provision of more services and potentially even safer care;

- An ever expanding need for training and regular skills updates throughout practitioner careers:
 - the workforce imperative will be for up to date evidence-based knowledge and skills and therefore an education and training environment that effectively imparts, and promptly updates this information is essential.
- The increase in the demand for individual health professionals will not be uniform:
 - the demand for individual health professional groups is subject to a range of influences beyond the demand for health care including a variety of health policy, regulatory and expenditure decisions; and
 - Individual professional groups are at different stages of development and some newer workforces may grow significantly faster than longer established professional groups.

Meeting demand in the future

Meeting these demand changes presents a number of difficulties. Health systems are labour and technology intensive, geographically dispersed, and focused on trying to meet the community's diverse health care needs. The provision of this care is costly and whilst the provision of health care must be safe and in line with community expectations, it must also be grounded in economic and financial reality.

The development of Australian health professionals to meet demand in the future the draft national chronic disease strategy may provide an effective guide for the way forward.

To prepare for this increased burden of disease Australian Governments have agreed to develop a National Chronic Disease Strategy (NCDS) which will aim to provide an overarching framework of national direction for improving chronic disease prevention and care across Australia.

A draft NCDS (AHMAC 2005) has been developed which acts as an umbrella strategy for chronic disease, and broadly covers the continuum of chronic disease prevention and care, in particular:

- prevention across the continuum;
- early detection and early treatment;
- integration and continuity of care; and
- self-management.

The key directions in the draft Strategy reflect the need for service improvements at all levels of the health system including building workforce capacity.

Forming part of Health Ministers' health reform agenda, it is planned that the Strategy will be considered by Health Ministers later this year following national consultations. It will be

considered at the same time as the complementary disease specific National Service Improvement Frameworks (NSIFs) currently being completed.

- The NSIFs outline specific service delivery improvements relating to the conditions, and will complement the generic national chronic disease strategy. The national service improvement frameworks are at various stages of development for the following major chronic diseases:
 - cancer; asthma; osteoarthritis, rheumatoid arthritis and osteoporosis; diabetes; heart, stroke and vascular disease.

Note on Supplier- Induced Demand (SID)

The literature on SID (see box 1 at the end of this appendix) suggests that the SID hypothesis may be relevant as a factor in health workforce demand but only in a number of health care sub-markets such as return visits to General Practitioners, referrals to specialists, pathology, diagnostic imaging and hospital use. However, it is not possible to quantify how much extra services might be provided through SID. Moreover, such cases are follow-up actions – they happen after the consumer has decided to seek care. Thus the initial driver to seek care is likely to be the more basic drivers for health care. In this light projecting future demand based on SID is somewhat problematic and SID has not been included as a factor in the demand projections below.

Box 1 - Supplier- Induced Demand (SID)

The theory of supplier induced demand suggests that the health professional not only aims to look after the patient's functional health but, also has income incentives to advise the consumer to choose additional services beyond those the patient's health needs.

The Productivity Commission 2002a suggested that there were a variety of market and institutional/regulatory influences which could encourage SID:

- Substantial information asymmetries between patient and health professional; and
- Health financing systems where patients are free to choose their health care provider, and there is no contractual or employment relationship between the health professional and the insurer (government or private) and fee-for service is the income model.

Thus, where government or private health insurance is available, the monetary costs to the patient (of undergoing treatment) are transferred to the third party insurer and this may be more conducive to such agent actions taking place. Indeed the Productivity Commission 2002a suggested that:

“The design of public or private insurance in most OECD countries provides patients with little or no incentive to restrain their demand for medical services. This provides fertile ground for possible SID”. PC 2002a

However, empirical research casts doubt on its overall impact on the growth in demand for health services. Labell, Stoddart and Rice 1993 argued that the incidence of SID was not important (other than if it reduced the health of the patient) but rather whether the extra services contributed positively to increased population health status and whether society as a whole would value such an increase given the resource costs involved.

Fabbri & Monfardini 2004 suggested that testing of these SID hypotheses has found that physicians do, to some extent, actually manage demand according to economic incentives.

The Productivity Commission 2002a on the other hand found that although

“...there is arguably sufficient evidence to accept that SID can occur...There does not appear to be an robust and reliable evidence on the likely magnitude of SID... and where SID arises it is both small in absolute terms and relative to other influences on the provision of medical services.”

In summary literature suggests that the SID hypothesis is relevant in a number of health care sub-markets such as return visits to General Practitioners, referrals to specialists, pathology, diagnostic imaging and hospital use. However, it is not possible to quantify how much extra services might be provided through SID. Moreover, such cases are follow-up actions – they happen after the consumer has decided to seek care. Thus the initial driver to seek care is likely to be the more basic drivers for health care and their effects are much larger in driving the level of health care demand than SID drivers. Projecting future demand based on SID is somewhat problematic in these circumstances and for this reason SID has not been factored into the demand projections.

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WORKFORCE DISTRIBUTION

This appendix provides a study on workforce distribution in section one. Section two sets out a number of initiatives which are currently employed to address workforce distribution issues.

1 Dental health in rural and remote areas

The Australian Institute of Health and Welfare (AIHW 2005a) reports that oral health for people living in areas outside the major capital cities is significantly worse than those living in the capital cities:

- Children aged 6 years and 12 years in regional/remote areas had, respectively, about 1.3 and 1.2 times as many decayed, missing or filled teeth as their counterparts in Major Cities.

Access to an adequate oral health workforce is thus even more important for people living outside the capital cities. However, there are actually fewer dentists in these areas

- In 2000 the prevalence of dentists was higher in capital cities, where there were 55.7 dentists per 100,000 population compared with areas outside capital cities, where there were 31.4 dentists per 100,000 population.
- AIHW (2003a) reports that for all dental workers in 2001 there were 150 dental workers per 100,000 population in capital cities, but only 108 per 100,000 population in other areas.

Given this disparity in the numbers of dentists in non-metropolitan areas, efforts to attract more dentists to rural areas could be used. Coming from a rural background is often a good predictor of whether a health professional will work in a rural or remote area after graduating. However, figures indicate that those commencing dental degrees are less likely to come from outside the capital cities:

- In 2002, young people from Inner and Outer Regional, Remote and Very Remote areas were 0.1, 0.1, 0.0 and 0.0 times as likely to commence a bachelor's degree in dentistry as those from Major Cities:
 - : the number per 100,000 population being 89 in Major cities, 5 per 100,000 population in Inner Regional, and 10 per 100,000 population in Outer Regional and none in the Remote, and Very Remote Regions.

Initiatives to address distribution problems

There is strong evidence that individuals with rural connections are the most likely to fill positions in rural and remote areas. A number of studies demonstrate that the strongest predictor of entry into rural medical practice is having a rural background. Wearne and Wakerman (2004) report that rural doctors are more likely to have a rural background or have a partner or spouse with a rural background.

McDonald, et al (2002) found there are a number of variations to this finding and a number of sub-predictors were also important:

- a rural primary school education appears to be more important than secondary education;
- for rural GPs with partners the strongest independent predictor is having a partner who grew up in the country;
- having a family in a rural area has been found to be significantly associated with long-term plans to practise in a rural area;
- the view of one's partner or spouse about living in a rural area.

There is also evidence that it is possible to successfully recruit students, including urban students, to rural and remote localities through undergraduate exposure to rural practice (Vickery and Tarala, 2003, Neill and Taylor, 2002, Courtney et al., 2002, Wearne and Wakerman, 2004).

In response to this evidence a range of initiatives have been developed and evaluated at all levels of Government.

Australian Government initiatives

Medical School Places

The number of publicly funded medical places in the tertiary sector has increased by more than 30% since 2000. Five new medical schools have been established since that time and three new medical schools are being established over the next few years. These initiatives will expand the number of publicly funded students completing university medical studies from approximately 1300 in 2005 to approximately 1900 in 2010 - an increase of over 45%.

Australian General Practice Training Program

From 2004, the number of vocational training places available for GPs was expanded from 450 to 630 - an increase of one third.

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

Rural Clinical Schools

Funding provided under the 2000-01 Budget has enabled a network of 10 Rural Clinical Schools to be established across Australia. This network strengthens the rural focus in medical training and encourages medical professionals to take up a career in rural clinical practice. From the beginning of the 2004 academic year, at least 25 per cent of medical students will receive a significant proportion of their clinical training in rural and remote areas. An 11th clinical school will be established in Darwin in 2006.

There is some preliminary evidence from the University of Queensland that establishment of rural clinical schools in Rockhampton and Toowoomba in 2003 has had a positive impact on the intern workforce in allied regional hospitals. There has been an increase in the number of medical students choosing these hospitals for their internship although as the authors warn the numbers are small and the timeframe short (Wilkinson et al., 2004). The results are in keeping with other studies demonstrating the positive impact of undergraduate exposure to rural placements on the choice of rural practice.

Scholarship Schemes

By 2005, the Australian Government will have awarded over 2,900 medical scholarships, 2,000 nursing scholarships and approximately 400 allied health and pharmacy scholarships.

Medical Rural Bonded Scholarship Scheme (MRBSS) places and Bonded Medical School Places Scheme (BMSPS) . These schemes provide additional undergraduate medical school places in return for agreeing to work for a minimum of 6 years in either a rural or remote areas or areas of workforce shortage.

The MRBSS scheme was introduced in the 2000/01 Federal Budget with the first 100 scholarships awarded in 2001. It provides a scholarship of over \$20,000 per year 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 400 scholars in the scheme in 2004.

The BMSPS commenced in 2004 and provided an additional 234, places in return students accepting a BMSPS place commit to work in districts of workforce shortage for six years on completion of their Fellowship (specialist or GP qualification). The number of places has been expanded to 246 for 2005.

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.

Rural Undergraduate Support and Coordination Program

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.

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.

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.

These examples of selective admission policies through affirmative action for rural students and scholarship programs at Australian medical schools have been effective in attracting doctors to rural areas (Simeons, 2004, Pflaum, 2001). Wearne and Wakerman (2004) note that the absolute numbers of medical students with a rural background is still low, but that this is improving. For example James Cook University, like all medical schools, has a funding based requirement to take at least 25% rural and remote students (Lawson et al., 2000).

Joint rural clinical positions

Causby (2003) describes the establishment of a joint rural academic-clinical position in podiatry enabling increased rural clinical exposure for undergraduate podiatry students. The position was created as a result of collaboration between University of South Australia, the SA Centre for Rural and Remote Health and Northern and Far Western Regional Health Service. With the support of the SA joint position a mandatory five-week rural placement was introduced for final year podiatry students in 2003.

UDRH

University Departments of Rural Health (UDRH) commenced in Australia from 1996 primarily to promote recruitment and retention of health professionals in rural and remote areas. UDRHs are collaborative, multi-disciplinary, multi-level initiatives based in rural centres with smaller subsidiary sites which serve large regions. All are involved in increasing

undergraduate exposure to rural and remote health. In WA and Tasmania there are also initiatives to influence curricula to better integrate rural health (Lawson et al., 2000).

The Workforce Support for Rural General Practitioners Program

This program provides funding of \$11.24 million over four years, to 66 Divisions of General Practice with at least 5% of their population living in rural areas. Program funding is used by Divisions to support the newly arrived and existing general practice workforce in rural areas. This includes support for training; professional development; and locum coverage.

Overseas recruitment

The Strengthening Medicare package, announced in November 2003, includes initiatives to increase the opportunities for appropriately qualified overseas trained doctors to practice in Australia. These include international recruitment strategies, opportunities for doctors to stay longer or obtain permanent residency through changes to immigration arrangements, improved training arrangements and additional support programs. As a result, an additional 725 appropriately qualified overseas trained doctors are expected to be working in Australia by 2007.

Medicare Provider Number Restrictions for Overseas Trained Doctors

Since 1996, overseas trained doctors have been restricted to accessing Medicare in districts of workforce shortage. There are now more than 2,500 current approvals for overseas trained doctors to work in these areas.

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.

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.

Financial Incentives

Rural Retention Program

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:

- 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.
- 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.

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.

Practice Incentives Program (PIP)

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.

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. The PIP also provides an incentive to encourage general practices to provide procedural services. Around 4,680 general practices are participating in the PIP. These practices provide 80% of GP patient care in Australia. 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.

Nursing and Allied Health initiatives

Flinders University School of Nursing has offered a comprehensive rural and remote undergraduate program since 1998. Students have the opportunity to practice in hospital, community and remote health centres in South and Central Australia for rotations of 5-16 weeks. The School pays for immunisations, transport, accommodation and clinical preceptors and some venues assist with accommodation. Neill and Taylor (2002) argue that providing rural and remote clinical experience for undergraduate nursing students especially those from urban background can be an effective recruitment strategy.

The More Allied Health Services (MAHS) programme is a federally funded initiative managed by rural Divisions of General Practice. Funding of \$62.9 million is available over four years for this program, as part of the rural Health Strategy. Funding of \$49.5 million was made available from 2000-01 to 2003-04.

Funding goes to 66 Divisions of General Practice with at least 5% of their population living in rural areas and who are categorised as RRMA 4-7.

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 professional free-of-charge.

Nationally, in the 12 months to June 2004, MAHS funded around 210.5 full time equivalent positions, covering professionals such as psychologists, dieticians, speech pathologists and physiotherapists.

State – Government initiatives

Queensland

Queensland has agreed to fund 235 undergraduate medical school places at Griffith University. The places are primarily aimed at recruiting doctors into rural and remote areas, Indigenous health services, and community run health services. At a total cost of \$61 million over 8 years the funding supports a complete training package for 35 students in 2006 and 50 more students in each of the next four years to 2010. This includes paying students fees, scholarships and assistance to obtain postgraduate qualifications in their respective medical specialties including the Australian College of Rural and Remote Medicine. As part of the training agreement, these graduates would be bonded for 10 years to the Queensland public system.

New Advanced Nursing Scholarships

From 2006 funding is being provided to support 20 nurse practitioner scholarships. At a cost of \$160,000 per year, 20 students will receive scholarships of \$8,000 each for Master of Nurse Practitioner students. The scholarships will be awarded on merit, and will cover the full fees for new post-graduate courses. Qualified nurse practitioners will be able to perform roles including prescribing certain medications, requesting x-rays and requesting pathology tests.

Courtney, Edwards et al.(2002) describe a Rural Clinical Placement Support Scheme. The Queensland University of Technology School of Nursing has a rural undergraduate clinical nursing placement program which places over 200 students in rural and remote health services. A 12% increase in the number of students intending to seek work in a rural setting was found amongst those students who participated in a rural or remote clinical placement. This compared to a 5% increase in the students who undertook a metropolitan clinical placement.

Workforce Development schemes

Support for non-financial aspects of workforce development can be a key aspect in effective workforce distribution policies. Ashworth, Batty et al.(2004) describe the recruitment process for Allied Health Professionals to the North West Queensland Allied Health Service (Mount Isa and surrounding communities). The recruitment package included:

- line management by an allied health professional;
- salary set at a level commensurate with the demands of the position (Queensland Health PO3)
- time at base – AHPs would not work away from base in remote communities for more than 50% of the time;
- professional development allowances – attendance at two conferences per year with a budget of \$1500 per conference, access to library facilities and other training opportunities;
- orientation to remote and indigenous health practice, provided largely through the Graduate Certificate in Remote Health;
- Funded mentoring;
- Increased annual leave (6 weeks);
- Annual airfare home;
- Housing subsidy;
- Relocation costs;
- Assistance with spouse/partner employment if required
- Childcare subsidy if required;
- Retention payments after 2 years service

An evaluation of the process 3-6 months after the first cohort had been recruited found that wide level of support provided under the program was the most important element of its success, rather than the individual benefits or overall financial package provided". (Ashworth, et al.(2004 p. 5)

South Australia

Since 2001 rural health services have been able to apply for funding to support students within South Australia from the Department of Health. Students are selected 6-12 months in advance of placement on the basis of a written submission. Satisfactory clinical and academic records are required. An orientation workshop is provided by the Spencer Gulf Rural Health School. In each venue an orientation is given and in Alice Springs a comprehensive program includes Aboriginal Cultural Awareness input. Nearly 90 second and third year students have participated in the program since 1990. Of the 33 students who had Central Australian placements in 1998-99, 59% chose rural or remote practice post-graduation. A number of students change their employment intentions as a result of the placement.

Western Australia

Vickery and Tarala (2003) describe their 5 year experience of prevocational general practice placements in Western Australia. Thirty four prevocational trainees participated in the program between 1998 and 2002. The program itself aids the rural workforce with participating practices having a supply of trainees on three month rotations without the practice needing to commit to a three year vocational training program. The trainees all nominated the rural placement as one of their best for training and clinical experience. All agreed that it would encourage rural recruitment and help determine or confirm career decisions.

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OVERVIEW OF ACCREDITATION ARRANGEMENTS

The following appendix provides an overview of some health professions accreditation arrangements in Australia.

MEDICAL**Accreditation by Australian Medical Council**

The Australian Medical Council (AMC) is a national standards advisory body for medical education and training. In 1998 the AMC was invited to develop a new model for recognising and registering medical specialties. As a result the AMC developed a national process for assessing the case for medical specialties and sub-specialties to be established and formally recognised and the review and accreditation of specialists medical education and training and professional development programs. At present, all existing recognised colleges have agreed to participate in the review process with one or two reviews scheduled each year.

The AMC issues Guidelines on Accreditation of Specialist Medical Education and Training and Professional Development Programs Standards and Processes. These guidelines set out the educational principles, institutional processes, training settings and resources that the AMC regards as requirements for successful specialist medical education and training and professional development programs. The AMC's Specialist Education Accreditation Committee oversees the accreditation process, develops accreditation policy and procedures and encourages improvements in post graduate medical education in Australia that respond to evolving health needs and practices, and educational and scientific developments.

The AMC also has the responsibility of assessing Australian medical colleges for the purposes of registration of their graduates in Australia. A graduate of a medical course accredited by the AMC is eligible for registration as a medical practitioner in any State or Territory of Australia. The over-riding requirement of AMC accreditation is that medical schools produce medical practitioners who are safe and competent to practise as interns under supervision and who have an adequate basis to undertake further vocational training. The AMC's Medical School Accreditation Committee oversees the accreditation process, and develops accreditation policy and procedures including standards that emphasise the general principles regarded by the AMC as essential requirements for successful basic medical education. The standards define the goals and objectives of basic medical education, and the processes, institutional settings and resources required to achieve these objectives.

Providing that the stated objectives of the medical school are broadly consistent with those of the AMC, the assessment of the school by the AMC concentrates predominantly on the ability of the medical school to achieve the objectives it has set for itself. Accreditation can be awarded for a maximum period of ten years, available as accreditation for six years in the first instance. The AMC can grant a further four years on the basis of a report by the school

in the fifth year of accreditation that demonstrates that the medical school has maintained its standards of education and resources.

Specialist Medical Colleges - Accreditation

Medical colleges in Australia accredit health services, laboratories and hospitals for specialist medical programs to ensure minimum education and training requirements for trainees in specialist training programs. This is generally a peer review process, with members of the college reviewing facilities to determine if they meet college requirements.

There is variation between colleges about what is accredited. Colleges such as Royal Australasian College of Medical Administrators (RACMA) accredit individual learning plans of a trainee; The Australian College of Dermatologists (ACD), Royal Australian and New Zealand College of Ophthalmologists (RANZCO) and the Royal College of Physicians (RCPA) accredit individual training posts, although they also accredit the facility in which that training occurs. Other colleges including the Australian and New Zealand college of Anaesthetists (ANZCA), the Australian College of Emergency Medicine (ACEM), the Royal Australian and New Zealand College of Obstetricians and Gynecologists (RANZCOG), and Royal Australian and New Zealand College of Radiologists (RANZCR) only accredit the facility; however the accreditation standard on the ratio of supervisors to trainees has the capacity to determine training numbers.

Colleges generally have a three to five-year accreditation period and rolling programs of re-accreditation. There is some variation between colleges in the way that programs are accredited. Most colleges have developed detailed accreditation application forms that seek information on the services in which training is to be provided, including the availability of supervision, equipment, teaching programs and patient casemix.

Some colleges have criteria for accreditation and detailed policy statements supporting these requirements for supervision, secretarial and support services to departments of anaesthesia, quality assurance etc. In contrast, one college does not have specified criteria as it considers these measurements fail to take into account factors such as complexity of case load or staffing levels.

The lack of objective and measurable criteria, which reflect current service delivery practices, continues to be an issue of concern for jurisdictions. The absence of criteria means health services cannot determine if they would meet colleges standards for training and means that colleges are not able to defend the accreditation decisions they make.

Accreditation by Postgraduate Medical Education Councils

Accreditation of hospitals to provide post-graduate medical training (for post-graduate years 1 and 2) is undertaken by Postgraduate Medical Education Councils established in each State and Territory. All intern posts are assessed and accredited by the Accreditation subcommittee of the Postgraduate Medical Councils in each State and Territory. Each Council have developed review processes designed to obtain information about hospital performance of intern training against explicit standards and criteria, to ensure interns are provided with a high standard of general clinical education and training; and that the best

possible environment exists for the organisation, supervision and education and training of interns.

NURSING

Within Australia, each state and territory has its own nursing regulatory authorities and nursing legislation that provides the basis for the accreditation of courses, registration, professional conduct and practice standards. Acknowledging the differences in the various jurisdictions the Australian Nursing and Midwifery Council (ANMC), a peak national nursing and midwifery organisation that sets national standards for the regulation of nursing within Australia, have developed national competency standards of nurse regulation which have been adopted by all the nurse regulatory authorities. These are the minimum standards for nurses and provide a basic framework against which performance is evaluated. It is a legal requirement that nurses meet the competency standards developed by the ANMC to be registered or enrolled in the state and territory they are practicing in. At present, a national approach to the accreditation of nursing and midwifery courses has not been implemented but a discussion paper has been prepared by the ANMC and will report shortly. A national approach to accreditation would ensure course standards and learning outcomes of a consistent high quality nature and facilitate mutual recognition across states and territories, RCNA 2001, ANMC 2005).

The Royal College of Nursing Australia (RCNA), Australia's peak professional nursing body provides endorsement and accreditation service to education providers. Many specialist nursing and midwifery organisations have developed competency standards that can be used as the framework for the credentialing process. An example is the Australian College of Midwives Inc in Australia who have introduced self-regulation processes, such as education guidelines, competencies or practice standards, and/or accreditation processes. Areas include: independent midwifery practice, remote area, gastroenterology, diabetes education, critical care, mental health, paediatric, community, infection control and renal.

ALLIED HEALTH

The accreditation process for the allied health workforces is also profession specific with differing approaches to criteria and processes with some organisations focusing on a set of core competencies and others based on the achievement of a specific number of practice hours or other criteria. At present, there is no overarching accreditation body for allied health services as with the nursing and medical workforce.

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