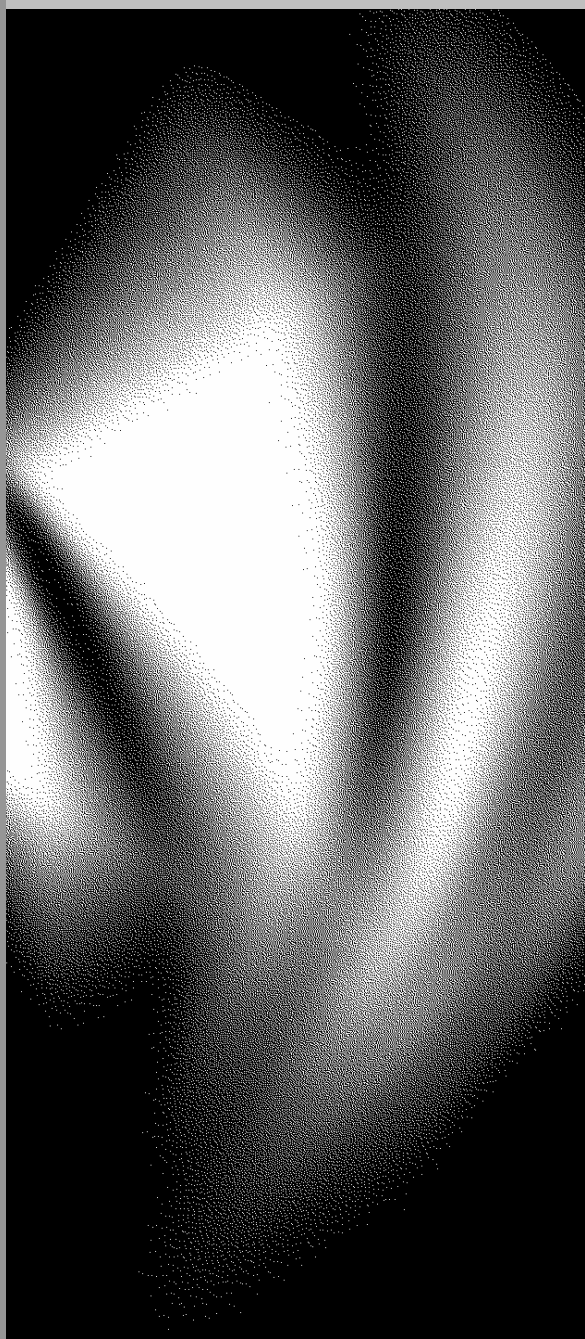
Australian Government
Productivity Commission

Australia's Health Workforce

Productivity Commission Research Report

22 December 2005



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The Productivity Commission

The Productivity Commission, an independent agency, is the Australian Government's principal review and advisory body on microeconomic policy and regulation. It conducts public inquiries and research into a broad range of economic and social issues affecting the welfare of Australians.

The Commission's independence is underpinned by an Act of Parliament. Its processes and outputs are open to public scrutiny and are driven by concern for the wellbeing of the community as a whole.

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Foreword

Australia's health care system depends heavily on the commitment and skills of a health workforce of nearly half a million people and a large group of volunteers.

Many of the arrangements under which the workforce operates are under considerable pressure, as are health workers themselves. The headline indicator of this is a workforce shortage across many professions, particularly in outer metropolitan, rural and remote areas. And these pressures are expected to intensify. In response, Governments and other stakeholders have been initiating a range of changes, but further reform is needed.

While this has not been an investigation into health care and its funding, the efficiency and effectiveness of the health workforce is inextricably linked to that broader system, and to Australia's education and training regime. The Commission considered that it could add most value by reviewing the institutional, regulatory and funding arrangements within its area of focus. It has sought to identify reforms which would produce a more sustainable and responsive health workforce, while maintaining a commitment to high quality and safe health outcomes.

In preparing its report, the Commission has drawn on evidence presented in a large number of submissions and from extensive consultations with governments, representatives of the health workforce and an array of other interested groups and individuals. The Commission is very grateful for this extensive input.

The study was overseen by Commissioners Mike Woods, Robert Fitzgerald and, in its initial stages, Helen Owens. It was undertaken by a staff research team located in the Commission's Canberra office.

Gary Banks
Chairman

December 2005

Terms of reference

PRODUCTIVITY COMMISSION ACT 1998

The Productivity Commission is requested to undertake a research study to examine issues impacting on the health workforce including the supply of, and demand for, health workforce professionals, and propose solutions to ensure the continued delivery of quality health care over the next 10 years. The study is to be undertaken in the context of the need for efficient and effective delivery of health services in an environment of demographic change, technological advances and rising health costs.

In undertaking the study, the Productivity Commission will have regard to the National Health Workforce Strategic Framework and other relevant bodies of research.

Background

Australian governments agree that the success with which health services are delivered across the nation is advanced through the commitment, care and professionalism of the Australian health workforce.

Accordingly, on 25 June 2004, the Council of Australian Governments (COAG) agreed to commission a paper on health workforce issues, including supply and demand pressures over the next 10 years. COAG also agreed that the paper should address the issue of general practitioners in or near hospitals on weekends and after hours.

For the purpose of this study, 'health workforce professional' includes the entire health workforce, from those trained in the vocational education and training (VET) sector to medical specialists. The education and training sector includes vocational, tertiary, post-tertiary and clinical education and training.

COAG Resolution

COAG agreed:

> "**HEALTH**
>
> COAG today discussed the issue of health and reiterated the importance of moving ahead on improving health services.
>
> COAG agreed to commission a paper on health workforce issues, including supply and demand pressures over the next 10 years. The paper will take a

broad, whole-of-government perspective, including health and education considerations, and will cover the full range of health workforce professionals. In considering these issues, the paper will look at the particular health workforce needs of rural areas.

It was also agreed that the paper will address the issue of general practitioners in or near hospitals on weekends and after hours.

This paper will be considered by COAG within 12 months."

Scope

In reporting on Australia's health workforce, the Productivity Commission should:

1. Consider the institutional, regulatory and other factors across both the health and education sectors affecting the supply of health workforce professionals, such as their entry, mobility and retention, including:

(a) the effectiveness of relevant government programmes and linkages between health service planning and health workforce planning;

(b) the extent to which there is cohesion and there are common goals across organisations and sectors in relation to health workforce education and training, and appropriate accountability frameworks;

(c) the supply, attractiveness and effectiveness of workforce preparation through VET, undergraduate and postgraduate education and curriculum, including clinical training, and the impact of this preparation on workforce supply;

(d) workforce participation, including access to the professions, net returns to individuals, professional mobility, occupational re-entry, and skills portability and recognition;

(e) workforce satisfaction, including occupational attractiveness, workplace pressure, practices and hours of work; and

(f) the productivity of the health workforce and the scope for productivity enhancements.

2. Consider the structure and distribution of the health workforce and its consequential efficiency and effectiveness, including:

(a) workforce structure, skills mix and responsibilities, including evolving health workforce roles and redesign, and the flexibility, capacity, efficiency and effectiveness of the health workforce to address current and emerging health needs, including indigenous health;

(b) analysis of data on current expenditure and supply of clinical and non-clinical health workers, including the development of benchmarks against which to measure future workforce trends and expenditure; and

(c) the distribution of the health workforce, including the specific health workforce needs of rural, remote and outer metropolitan areas and across the public and private sectors.

3. Consider the factors affecting demand for services provided by health workforce professionals, including:

(a) distribution of the population and demographic trends, including that of indigenous Australians;

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

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

4. Provide advice on the identification of, and planning for, Australian healthcare priorities and services in the short, medium and long-term, including:

(a) practical, financially-responsible sectoral (health, and education and training) and regulatory measures to improve recruitment, retention and skills-mix within the next ten years; and

(b) ongoing data needs to provide for future workforce planning, including measures to improve the transparency and reliability of data on health workforce expenditure and participation, and its composite parts.

In doing so, the paper should take into account existing Australian research and overseas developments that have demonstrated success in providing a flexible response to emerging trends.

5. Provide advice on the issue of general practitioners in or near hospitals on weekends and after hours, including the relationship of services provided by general practitioners and acute care.

6. Consult widely, including with peak industry, representative and community organisations, and relevant government agencies and public authorities.

7. The Commission is to produce an issues paper by 31 May 2005, provide a draft report, and produce a final report by 28 February 2006.

PETER COSTELLO

[received 15 March 2005]

Contents

Abbreviations

AHMAC	Australian Health Ministers' Advisory Council
AHMC	Australian Health Ministers' Conference
AHWAC	Australian Health Workforce Advisory Committee
AHWOC	Australian Health Workforce Officials Committee
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
AMC	Australian Medical Council
AMWAC	Australian Medical Workforce Advisory Committee
CoAG	Council of Australian Governments
DEST	Department of Education, Science and Training
DoHA	Department of Health and Ageing
GP	general practitioner
GPET	General Practice Education and Training
JWPG	Jurisdictional Workforce Planners Group
MBS	Medical Benefits Schedule
NHWSF	National Health Workforce Strategic Framework
PBS	Pharmaceutical Benefits Scheme
PC	Productivity Commission
VET	Vocational Education and Training

OVERVIEW

Key points

- Australia is experiencing workforce shortages across a number of health professions despite a significant and growing reliance on overseas trained health workers. The shortages are even more acute in rural and remote areas and in certain special needs sectors.
- With developing technology, growing community expectations and population ageing, the demand for health workforce services will increase while the labour market will tighten. New models of care will also be required.
- Expenditure on health care is already 9.7 per cent of GDP and is increasing. Even so, there will be a need to train more health workers. There will also be benefits in improving the retention and re-entry to the workforce of qualified health workers.
- It is critical to increase the efficiency and effectiveness of the available health workforce, and to improve its distribution.
- The Commission's objectives are, therefore, to develop a more sustainable and responsive health workforce, while maintaining a commitment to high quality and safe health outcomes. It has proposed a set of national workforce structures designed to:

– support local innovations, and objectively evaluate, facilitate and drive those of national significance through an advisory health workforce improvement agency;

– promote more responsive health education and training arrangements through: the creation of an independent advisory council; and a high-level taskforce to achieve greater transparency (and appropriate contestability) of funding for clinical training;

– integrate the current profession-based accreditation of health education and training through an over-arching national accreditation board that could, initially at least, delegate functions to appropriate existing entities, based on their capacity to contribute to the objectives of the new accreditation regime;

– provide for national registration standards for health professions and for the creation of a national registration board with supporting professional panels; and

– improve funding-related incentives for workforce change through: the transparent assessment by an independent committee of proposals to extend MBS coverage beyond the medical profession; the introduction of (discounted) MBS rebates for a wider range of delegated services; and addressing distortions in rebate relativities.

- Those living in outer metropolitan, rural and remote areas and in Indigenous communities, and others with special needs, would benefit from these system-wide initiatives.

– Integration of these groups into mainstream health workforce frameworks will further improve outcomes, but targeted initiatives will also be required.

– There is a need for better evaluation of various approaches to service delivery in these areas and across the health system more generally.

Overview

Australia's broad health outcomes compare favourably with those of similarly developed countries. Total spending on health care, while around 10 per cent of GDP and rising, is also comparable. In no small part, these outcomes are due to the expertise and commitment of the health workforce and to the efforts of the health and education and training sectors more generally.

Nonetheless, there continue to be poor health outcomes in particular regions and for particular groups. Workforce shortages, and inflexibilities and inefficiencies in workplace arrangements, are major contributors to these problems. Looking ahead, growing demand and tightening labour supply will add to the pressures on Australia's health system and its workforce.

This research study, commissioned by CoAG, reviews a range of workforce issues. These include: factors affecting the future supply of, and demand for, health workers; the efficiency and effectiveness with which the available workforce is deployed; and what reforms to health workforce arrangements might be undertaken to improve access across the community to quality and safe health care. The full Terms of Reference precede this Overview.

Many of the changes required to improve health workforce arrangements could only occur as part of broader health policy and health funding reforms. However, this is not the task currently before the Commission.

Moreover, the Commission does not profess expertise in relation to specific workplace requirements, matters of clinical judgment, or particular approaches to health workforce education and training. It has therefore focused on creating more efficient and effective institutional, regulatory and funding arrangements within which specific workforce initiatives can be developed and implemented by properly constituted governing bodies, supported by experts in relevant areas.

The study occurred in parallel with a review by CoAG Senior Officials of ways to improve Australia's health care system. CoAG is expected to consider both reports early in 2006.

The context for future workforce policy

There are around 450 000 paid health professionals in Australia, of whom just over 350 000 are currently employed in health service industries. Over half are nurses, with medical professionals and allied health professionals accounting for a further 12 per cent and 9 per cent of the workforce respectively (see table 1). There are also some 200 000 administrative and service workers employed in the health services area, as well as a sizeable volunteer workforce.

Table 1 **Numbers of health professionals, by occupation**

	Number of workers in 2001	*Proportion of health workforce*	*Percentage change between 1996 and 2001*
	'000	per cent	
Registered nurses/midwives	174	38.7	7.3
Enrolled nurses	19	4.3	2.7
Nursing assistants/ personal carers	51	11.2	18.8
Medical professionals	52	11.5	12.6
Dentists	8	1.9	7.9
Dental technicians/assistants	18	3.9	12.5
Pharmacists	14	3.0	13.0
Allied health workers	39	8.6	26.5
Complementary health workers	9	1.9	29.6
Medical imaging workers	8	1.8	25.0
Medical scientists	11	2.6	16.8
Ambulance officers/paramedics	7	1.5	12.5
Other	41	9.1	30.2
Total	451	100	11.6

Demand for, and supply of, health workers and the nature of the services they provide are heavily influenced by government. Collectively, the Australian and State and Territory Governments met over two-thirds of the $78 billion (9.7 per cent of GDP) spent on health care in Australia in 2003-04. Expenditure on workforce services currently accounts for about two-thirds of total health care spending. Governments also regulate, and are major employers of, health workers.

Significant problems are already evident

Though precise quantification is difficult, there are evident shortages in workforce supply — particularly in general practice, various medical specialty areas, dentistry, nursing and some key allied health areas.

These shortages persist despite the fact that the workforce has been growing at nearly double the rate of the population — though reductions in average hours worked in response to such factors as workforce ageing and greater feminisation of some professions, have partly offset this increase in numbers. Medical shortages also remain despite an increasing reliance on overseas trained doctors, who now make up 25 per cent of that workforce compared with 19 per cent a decade ago. A significant number of trained health workers do not work in the sector.

There are major workforce distribution issues. Shortages are often more significant in outer metropolitan, rural and remote areas and especially in Indigenous communities. Areas of special need such as mental health, aged care and disability services also suffer significant shortages in the face of growing demand.

And though health workforce arrangements have evolved in response to changing health care needs, including through greater reliance on multidisciplinary care, the skills of many health workers are not being used to full advantage. To a large extent this is because of various systemic impediments that prevent their competencies being fully developed, assessed, recognised and utilised. This in turn reduces job satisfaction and thereby makes recruitment, retention and re-entry more difficult.

The pressures will increase

While some of the current workforce shortages may be cyclical, a range of longer term, and largely structural, demand and supply pressures must be confronted.

- A decade hence, health workers will be dealing with a changed mix of disease burdens. For example, while the proportion of stroke victims is expected to decline, increasing numbers will be suffering Type II diabetes and dementia.
- With rising incomes, people will spend more on health care and expect timely access to high quality health services.
- As discussed in the Commission's report on the *Impacts of Advances in Medical Technology in Australia*, technological change will continue to be an important contributor to growing demand for, and spending on, health care. Different models of care and new workforce practices will be required to accommodate and utilise the wider range of treatment possibilities.
- Australia's changing age profile will significantly increase health expenditure. As outlined in the Commission's report on the *Economic Implications of an Ageing Australia*, spending on the over 65s is currently around four times more per person than on those under 65. And through its impact on the incidence of chronic disease, ageing will also be a major contributor to changing care needs.

- The average age of health workers is increasing. Service providers will be seeking to replace greater numbers of retiring workers, and to secure additional labour to meet accelerating demand, in an environment where growth in effective labour supply is expected to be slower than population growth. Given that many health services are labour-intensive, sizeable wage-related cost pressures are likely.

Collectively, these demand and supply pressures will have very significant impacts on health care spending. Indeed, by 2044-45, such spending could account for at least 16 cent of GDP, with government outlays equivalent to about 10 per cent of GDP.

Strategies for achieving improved health workforce outcomes

Four broad approaches can be employed to overcome current workforce shortages and maldistribution problems, and to address the future pressures facing the system.

- One important focus should be on reducing the underlying demand for health care through 'wellness' and preventive strategies.
- Further short term increases in education and training places may be warranted in some areas — recognising that in medicine and dentistry in particular, there are long lags between higher student intakes and increased numbers of qualified practitioners. There must also be adequate clinical training capacity.
- A greater emphasis on retention and re-entry will similarly help to stabilise, if not increase, workforce numbers — as recent initiatives in the nursing area in some jurisdictions have demonstrated.
- Improving the productivity and effectiveness of the available workforce, and its responsiveness to changing needs and pressures, will increase the level and quality of the workforce services that can be supported by any given level of spending. This in turn will help to reduce the rate of growth in future health care expenditure, without compromising safety and quality.

The first three of these approaches raise issues extending beyond the remit of this study, including a likely requirement for greater public funding. The Commission considers the study can best add value by focusing on the fourth approach — addressing systemic impediments in workplace arrangements that reduce efficiency, effectiveness and responsiveness. Notably, this has also been the focus of reform programs in many other sectors.

Impediments to sustainable and responsive workforce arrangements

In common with the rest of the health care system and systems overseas, Australia's health workforce arrangements are extraordinarily complex and interdependent.

- The Australian, State and Territory Governments are involved in all of the key parts of the health workforce system, and often at several levels.
- There are more than 20 bodies involved in accrediting health workforce education and training, and over 90 registration boards.
- A host of professional bodies administer codes of conduct which complement formal regulation, or provide for self-regulation.

Such specialisation in functions contributes to quality health outcomes, but given the interdependencies within health workforce arrangements, it can also hinder effective policy formulation and adjustment to changing care demands. Reflecting and compounding the effects of this complexity, is a range of systemic impediments to sustainable and responsive health workforce arrangements.

- The large number of entities and the resulting *fragmentation of responsibilities* result in cost and blame shifting and other inefficiencies.
- *Coordination is not always effective*, despite Principle 7 of the National Health Workforce Strategic Framework (NHWSF) which promotes the collaborative pursuit of its objectives by all stakeholders.
- Current *regulatory arrangements are often rigid* and subject to considerable influence from the professional groups concerned. This inhibits changes to workforce roles that could better meet changing health care needs.
- *Funding and payment arrangements detract from efficient outcomes.* For example, the focus of Medicare Benefits Schedule (MBS) subsidies on services provided by medical practitioners can lead to inefficient use of the workforce, as can the bias in MBS rebates in favour of procedural services.
- Entrenched *workplace behaviours* can increase resistance to worthwhile innovation, and cultural attitudes can reinforce notions of 'high status' and 'low status' work areas, exacerbating the recruitment and retention difficulties faced by mental health, disability services and aged care. Inflexible hospital management practices also affect workplace productivity.

To fully address some of these systemic impediments, reform of the broader health and education systems, and of intergovernmental policy and funding responsibilities in particular, would be required. In this regard, the Commission's *Review of National Competition Policy Reforms* proposed a 'holistic' review of Australia's health care system.

Nevertheless, considerable progress can be made within the narrower purview of this study without compromising future broader reform initiatives, including any that emerge from the parallel review by CoAG Senior Officials.

The Commission supports, as a reference point for future detailed health workforce reforms, the principles in the NHWSF (box 1). Were that framework to have endorsement by CoAG, it could also be a vehicle for improving coordination across the full range of policy areas that impact on health workforce arrangements. As part of that endorsement, CoAG should consider whether the wording of Principle 1 relating to self sufficiency is unduly restrictive given the international nature of the health workforce and, if so, how the principle should be interpreted in practice.

An integrated reform program is proposed

To address the systemic impediments to a more efficient, effective and responsive health workforce, the Commission has mapped out an integrated and coherent reform plan premised on a need to:

- maintain the provision of high quality and safe health care;
- adopt a whole-of-workforce perspective;
- recognise the interdependencies between the different elements of the health workforce arrangements and ensure that they are properly coordinated;
- establish effective governance arrangements for institutional and regulatory structures such that decision making processes are objective, informed by appropriate expert advice, transparent and reflect the public interest; and
- ensure that services are delivered by staff with the most cost-effective training and qualifications to provide safe, quality care.

The reform proposals encompass all of the linked sequential health workforce processes and arrangements, namely:

- workplace change and job innovation;
- health education and training;
- accreditation and professional registration;
- funding and payment arrangements; and
- quantitative projections of future workforce requirements.

They involve a mix of financial and other incentives to encourage desirable change and some new institutions and processes that would enhance the way that decision making occurs in key health workforce policy areas.

Box 1 **The National Health Workforce Strategic Framework**

The principles of the NHWSF focus on promoting/achieving:

- at a minimum, national self sufficiency in health workforce supply, while acknowledging Australia is part of a global market;
- a workforce distribution that 'optimises' access to health care and meets the health needs of all Australians;
- workplace environments in which people want to work;
- an appropriately skilled and competent workforce;
- the optimal use of available skills and workforce adaptability;
- a health workforce policy and planning regime that is informed by the 'best available evidence' and linked to the broader health care system; and
- collaborative pursuit of the objectives of the framework by all of the stakeholders.

The framework also outlines a non-exhaustive list of potential strategies for pursuing these principles, recognising that, in a changing workforce environment, the framework 'should evolve over time'.

Facilitating workplace change and job innovation

Principle 5 of the NHWSF supports a realignment of existing health workforce roles, or the creation of new roles, to make optimal use of skills and ensure best health outcomes. The pressures arising from changing care needs, technological advances and a tighter labour market will reinforce this need. Such reform can also improve job satisfaction and enhance retention and re-engagement.

The Commission's proposed changes to health workforce education and training structures, accreditation and professional registration and MBS arrangements (see below), would help to promote more efficient and effective workplace deployment. However, they are unlikely to be sufficient to ensure that significant workforce innovation is considered on a national, systematic and coordinated basis.

While worthwhile innovation is occurring, it most often remains at the local level. Indeed, recent experiences provide ample evidence of the problems of achieving major job redesign within the current regime. For example, the introduction of nurse practitioners to Australia — a profession which has existed in some other countries for forty years — has been a drawn out process and is still encountering resistance from parts of the medical profession. Similarly, contested issues in relation to the roles of physiotherapists, radiographers and the various levels of the nursing profession seem likely to remain intractable in the absence of institutional reform.

The Commission therefore proposes the establishment of an independent, statutory health workforce improvement agency that would:

- evaluate innovations that may have national significance;
- assess their contribution to national level efficiency and effectiveness of service delivery, while maintaining or enhancing the safety and quality of care; and
- assess the implications for education and training, accreditation and registration, government funding and private health insurance arrangements, liaising as appropriate with the various entities involved in these areas.

The agency would have governance arrangements which provide for health, education, finance and consumer expertise and would draw on expert advice as appropriate. It would report publicly, make recommendations to the Australian Health Ministers' Conference (AHMC), and be reviewed after five years. Importantly, the agency would complement rather than override other job redesign initiatives — for example, those developed in individual workplaces or initiated collaboratively between professions.

More responsive health education and training

While health workforce education and training in Australia has been evolving in response to changing requirements, the complexity of the current arrangements and the many players involved means that coordination problems abound. Moreover, health worker education and training is lengthening, lack of access to clinical training is limiting the supply of new health workers and, for some, there is insufficient preparation for the demands of the workplace.

Responsibility for the allocation of university places

There is an evident disconnect between the Department of Education, Science and Training (DEST) and State and Territory health authorities in the allocation of funding for university-based education and training. While there is little evidence that the *mix* of university-based health care places is greatly distorted, the current arrangements continue to cause much disquiet.

Several reform options to build better linkages between DEST and the health sector, and to give health care providers greater opportunity to input to allocation decisions, are canvassed in the body of the report. While all of these options have drawbacks, the Commission considers that the development of an intergovernmental undergraduate funding agreement warrants close consideration.

Facilitating change in health workforce education and training models

To provide for a systematic and integrated consideration of opportunities to further improve health workforce education and training, the Commission sees merit in a new council style arrangement. Amongst other things, such a body would:

- provide a national forum of expertise to secure agreement on new directions in the education and training of health workers and their implementation;
- facilitate consideration of issues on an integrated rather than profession-by-profession basis, further developing inter/multidisciplinary training approaches;
- consolidate various bilateral and multilateral discussions and existing committees and other structures in this area; and
- complement and support the activities of the proposed workforce improvement agency and a new national accreditation agency.

The council's membership would provide for eminent education, employer and professional input, and would have the capacity to consider the full range of perspectives involved in assessing changes to education and training arrangements.

A more sustainable clinical training regime

Restricted clinical training capacity is limiting the expansion of the workforce in various professions. Recent large increases in undergraduate intakes, directed at overcoming workforce shortages, are exacerbating these pressures.

Pro bono training services are an important contribution by health care professionals to the development of the future workforce. However, greater use of explicit payments for training infrastructure and services will be necessary to make the system more sustainable, transparent and contestable. Provision for explicit and contestable funding will be especially important in encouraging the private sector to take on a larger clinical training role and to facilitate innovation in training delivery more generally.

An important first step will be to improve data and understanding on how the clinical training regime across all health professions actually works: who is providing clinical training; where it is being provided; and how it is being funded. Accordingly, the Commission proposes that CoAG establish a high level taskforce to gather the necessary information and to recommend on how a more transparent, coordinated and contestable clinical training regime would be best introduced.

A consolidated national accreditation regime

Accreditation agencies assess and evaluate education and training courses and institutions to ensure consistency and quality of course standards. Completion of an accredited program is a cornerstone of professional registration.

Much accreditation in the health area is already nationally-based. Also, the various accreditation bodies and other stakeholders have been actively improving accreditation processes.

Nevertheless, the quality of the processes is variable and inconsistent approaches impose costs on educational and training institutions. Moreover, the current professions-based approach can reinforce traditional roles and boundaries and thus further constrain workplace innovation and job redesign.

The Commission proposes the establishment of a consolidated national accreditation regime to integrate the current profession-based system. This would encourage the timely uptake of both 'cross-professional' workplace innovations emerging from the proposed workforce improvement agency, and promote multidisciplinary and interdisciplinary learning. It would also facilitate the development of uniform national registration standards for health professionals.

Specifically, there would be an overarching statutory national accreditation board, responsible for accreditation across the health workforce. Initially at least, the board could delegate responsibility for functions to appropriate existing entities, on terms and conditions set by the board. Such entities would be selected on the basis of their capacity to contribute to the overall objectives of the new accreditation regime. Membership of the new accreditation board would provide for appropriate broad-based expertise in health and education and training matters, while being structured to reflect the wider public interest.

The proposed new national regime would encompass the training of health workers in the VET system. This would help to facilitate articulation between VET and university-based education and training. The timing of inclusion would have regard to other significant changes that are underway in the VET system.

The new national board would also be responsible for developing a national approach for the assessment of the education and training qualifications of overseas trained health workers.

A new national registration regime

State and Territory boards register most health professionals as having the appropriate qualifications, experience and 'character' to practise in their chosen field. The more than 90 boards also ensure compliance with requirements to practise and for continuing professional development.

Diversity in these state-based systems leads to variations in standards across the country, results in administrative duplication and can impede the movement of health workers across jurisdictions (notwithstanding the operation of mutual recognition). Reflecting such costs, agreement has been reached to introduce nationally consistent registration arrangements for the medical profession.

The Commission agrees with those advocating a single national registration board for all health workers — as distinct from seeking to achieve greater uniformity within the current regime, or to introduce profession-by-profession registration at the national level, outside of an overarching registration framework. Such a consolidated approach would:

- whilst generally recognising profession-specific registration, reinforce an across-profession emphasis in health workforce arrangements;
- lock in national standards based on the qualification requirements established by the national accreditation agency, and informed by advice from the workforce improvement agency in regard to expanded or new professional roles;
- provide objective evaluation of what additional professional or sub-professional registration is warranted, taking into account alternatives to formal registration, such as strengthened credentialing and delegation processes; and
- offer the prospect of administrative and compliance cost savings.

While operating across professions, the board would have a series of supporting professional panels to advise on specific requirements, monitor codes of practice and take disciplinary action. Sub-national professional units could be appointed. And the board should be able to provide conditional registration, such as for overseas trained health professionals employed in areas of need.

Modifying funding and payment mechanisms to improve incentives

The funding and payments regime is very complex and interdependent. Governments fund the majority of services, through widely varying arrangements, though private insurers also play an important role. The levels of public subsidy and patient co-payment vary significantly across individual care services.

Funding-related health workforce issues are difficult to separate from broader health care reform and could therefore only be fully addressed through the sort of holistic health care review previously proposed by the Commission. However, even within the scope of the current study, there are opportunities to modify funding and payments mechanisms to improve workforce performance and health outcomes, and to reduce the overall cost of providing any particular level and quality of care.

Three reforms are proposed. First, there is a need for a more transparently objective process for assessing proposed changes to: the range of services and health professionals (medical and non-medical) covered by the MBS; referral rights for diagnostic and specialist services; and prescribing rights under the Pharmaceutical Benefits Scheme — according to their safety, efficiency and cost-effectiveness. This would be achieved through the creation of a single, broadly-based and independent committee which would publicly advise the Minister for Health and Ageing on these matters. It would subsume those committees which currently provide advice to the Government on coverage for services provided by medical practitioners.

Secondly, as part of its current examination of payment methodologies used under the MBS, the Department of Health and Ageing (DoHA) should give priority to investigating the extent of the bias in rebates in favour of procedural over consultative services, and how any significant bias should be addressed. That work would be taken over by the new advisory committee when it is fully functioning.

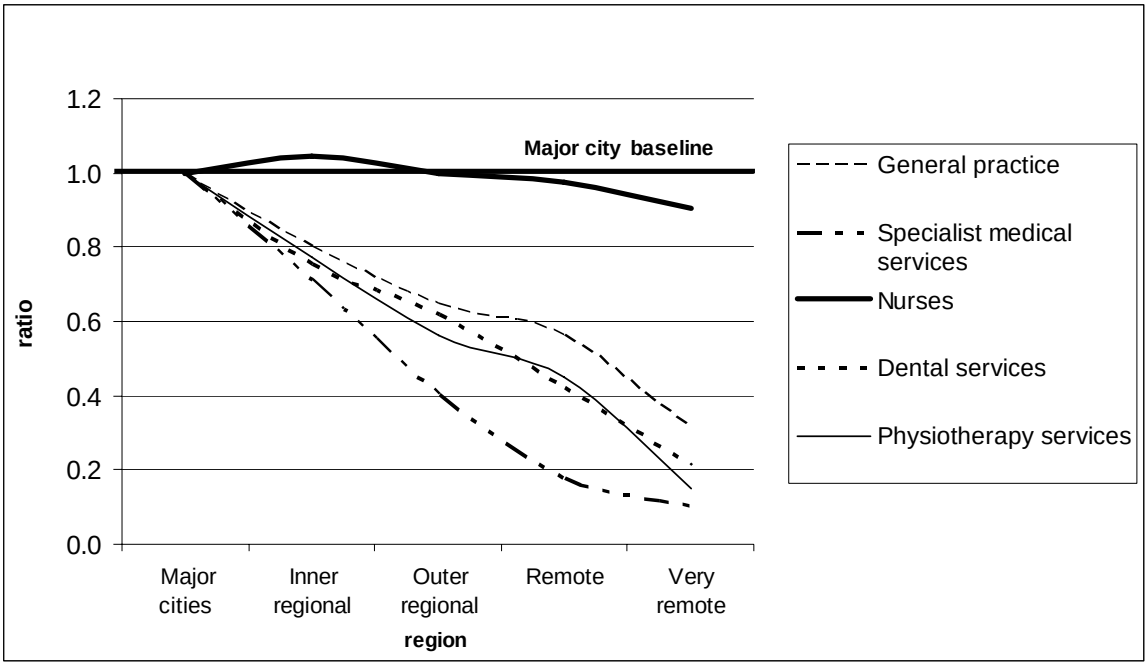
Finally, there should be MBS rebates payable for a wider range of services delegated by an approved practitioner (medical or non-medical) to another suitably qualified health professional. Those rebates should be set at a lower level than would have applied if the delegating practitioner had delivered the service, but be sufficient to maintain an incentive to delegate.

Given the potentially significant fiscal implications of greater support for delegated service provision — and of wider direct access to the MBS — the operation and impacts of the proposed new arrangements should be regularly reviewed.

Improving outcomes in rural and remote areas

As noted earlier, access to most health workers is generally poorer in rural and remote areas than in the major population centres (see figure 1). Indeed, some rural and remote communities have very limited access to even basic primary care services. And for those requiring frequent care for chronic conditions, there is also the greater disruption to employment, education and family life that results from regular travel or extended stays away from home.

Figure 1 **Practitioner to population ratios by area**



Health workers in rural and remote areas face more limited access to supporting health professionals, facilities and locum services; lesser availability of continuing professional development; lower housing standards; more restricted education and employment opportunities for other family members; and social isolation. For employers, recruitment can be difficult and staff turnover can be high, impacting on the continuity of care for patients.

In such an environment, the adverse consequences of rigidities and inefficiencies in regard to competencies, scopes of practice, and education and training for health workers, can be very significant.

Many of the initiatives arising from the system-wide reforms proposed by the Commission would enable much needed improvement in the delivery of health workforce services in rural and remote areas (see box 2). Moreover, so that the health needs of those in these areas are appropriately considered within the wider policy-making process, the Commission is proposing that AHMC ensure that all broad institutional health workforce arrangements provide for effective integration of rural and remote issues.

Box 2 **Benefits of system-wide changes for rural and remote areas**

The system-wide measures proposed by the Commission would assist those living in rural and remote areas in various ways. For example:

- The activities of the health workforce improvement agency, and the suggested changes to accreditation arrangements, would facilitate wider scopes of practice, and greater emphasis on multidisciplinary care, thereby reinforcing and augmenting the considerable innovation of this sort already occurring in the bush.
- Extensions of the coverage of the MBS to a wider range of service providers could be particularly valuable in improving access to care in those remote communities which do not have ready access to a medical practitioner.
- Greater incentives within the MBS for delegation of less complex tasks to suitably skilled, but more cost-effective, health workers and greater recognition within the registration framework of opportunities for credentialing of broader scopes of practice, would similarly support the reality of service delivery in remote locations.

At the same time, some workforce developments in rural and remote areas can be of national significance. For example, the development of new education and training and funding models and telemedicine approaches in these areas may provide the basis for system-wide changes. The proposed integration of rural and remote issues in broader health workforce frameworks would help to promote such complementarities.

Some specific approaches look especially promising

There will also be a continuing role for targeted initiatives in rural and remote areas. Many of the specific initiatives put to the Commission in this regard may well have merit. However two generic approaches warrant particular consideration.

First, a strong focus on the provision of *education and training opportunities in rural and remote areas* will be an important means of improving access to health workforce services over the medium to longer term.

- Access to such opportunities increases participation by people from rural backgrounds in health workforce education and training and encourages trainee professionals from metropolitan areas to spend more time in these areas. In turn, this can increase the number of qualified professionals who practise there.
- Local provision enables many, including senior members of Indigenous communities and adult members of households, to upgrade their skills while still fulfilling their daily responsibilities.

However, it is not clear at this time whether, overall, current initiatives in the education and training area are sufficient, or whether further investment is needed.

The Commission also considers that *block funding models* — as distinct from the provision of 'top-up' payments to individual health care providers — could potentially support the delivery of comprehensive care to a wider range of rural, remote and Indigenous communities, as well as encourage multidisciplinary models of care. Vesting control over service delivery in a single entity able to take a whole-of-workforce perspective, will help to minimise overlaps, duplication and conflicts across programs. It will also promote clearer accountability for health outcomes. Though block funding approaches are far from problem free, they are already being employed on a limited scale with some success. Accordingly, the Commission recommends that AHMC initiate further trials.

Better evaluation a pre-requisite for more effective future programs

Many innovations of potentially national significance go unheeded outside their local area. The activities of the proposed health workforce improvement agency will help to address this deficiency. However, in a rural and remote context, there is also a need for AHMC to initiate a series of cross program comparisons, to ascertain which approaches are likely to be most cost-effective in improving the accessibility, quality and sustainability of health workforce services — recognising that the very diverse nature of rural and remote Australia will continue to require tailoring of programs to meet the particular requirements of individual communities.

Addressing special needs

Effective health workforce arrangements must address the requirements of a range of groups with special needs. Indigenous Australians and those requiring mental health care, disability services and aged care face particular problems and have some specific workforce needs, as do groups such as asylum seekers and refugees.

The Commission's proposed system-wide changes should help to underpin better outcomes in these special need areas. As well, its proposed embodiment of special needs within the broader health workforce frameworks will, to an extent, guard against the marginalisation of these groups and help to promote complementarity between policies directed to their needs and more generally applicable health workforce arrangements. Notwithstanding the limited time available for the study, the Commission has also assessed several specific reforms which could enhance the health services available to Indigenous Australians.

Improving Indigenous health will require multi-faceted responses

The parlous state of Indigenous health has been extensively documented. Put simply, Indigenous Australians are likely to die at a considerably younger age and suffer more extensive health-related disability than their non-Indigenous counterparts. Improving Indigenous health will require action on a variety of broader fronts, including in regard to education and the governance of community and health services.

While many of the more specific initiatives put to the Commission were directed at increasing the level of resources directed to Indigenous health needs, others suggested ways to more productively utilise available resources. Approaches that warrant particular attention include:

- facilitating further expansion in the scopes of practice of Aboriginal Health Workers to allow them, for example, to perform injections, undertake routine X-rays, and conduct renal dialysis and midwifery functions;
- giving greater recognition to prior learning and on-the-job training — thus enhancing career pathways for Indigenous health workers;
- increasing health workforce education and training opportunities for Indigenous students in, or adjacent to, their communities;
- ensuring that training wages provide appropriate incentives for Indigenous participation in health workforce education and training; and
- making greater use of innovative health care funding mechanisms that have been found to be effective in meeting the needs of Indigenous people.

Other matters

The Commission has also commented on, and in some cases recommended changes to, a range of other policy settings that will influence the efficiency and effectiveness of future health workforce arrangements.

- *Data and research issues:* As recognised in the NHWSF, a sound information base is a critical underpinning for effective evaluation and policy formulation. Yet there is a lack of good data on many aspects of Australia's health workforce and the broader health system. In addition to endorsing current initiatives to improve data collection and dissemination, the Commission has proposed that steps be taken to improve the clinical training data base. It also intends to continue its work on developing productivity measures for the health sector.
- *Projecting future workforce needs:* While acknowledging the contribution of such projections to broader planning processes, the Commission has

recommended that there be greater emphasis on projecting needs for the major health workforce groups and on embodying a range of demand, supply and productivity scenarios. It has also proposed some rationalisation of the current arrangements for oversighting the projection process.

- *GP after hours services near hospitals:* Though recent initiatives have improved access to after hours primary care, ensuring that its provision is efficiently distributed between community and hospital settings will ultimately require more fundamental reform to health funding arrangements.
- *Medical indemnity arrangements:* Notwithstanding measures to reduce the cost of indemnity insurance, these arrangements continue to influence career choice. They also encourage 'defensive' medicine, which entails a degree of wasteful service provision and works against an open evaluative culture. Further examination of these issues is required.
- *Taxation and superannuation policies:* These influence workforce participation and exit decisions and opportunities for older health workers to continue to contribute in a part time capacity. The Commission has recommended that the evaluation of different approaches for improving health workforce outcomes in rural and remote areas should encompass FBT and superannuation incentives.

Conclusion

The Commission has mapped out a series of reforms to achieve more sustainable and responsive health workforce arrangements. The focus has been on improving the institutional, regulatory and funding frameworks within which health workforce policy formulation and decision making occurs.

In essence, the Commission is proposing an integrated set of arrangements to:

- drive reform to scopes of practice, and job design more broadly, while maintaining safety and quality;
- deliver a more coordinated and responsive education and training regime for health workers;
- accredit the courses and institutions and register the professionals in nationally consolidated and coherent frameworks; and
- provide the financial incentives to support access to safe and high quality care in a manner that promotes, rather than hinders, innovation in health workplaces.

In the Commission's view, the proposed arrangements will be most effective if the new national entities operate separately — though with strong linkages. But whatever precise organisational configuration is adopted, good governance

arrangements that promote the public interest will be essential if genuine progress is to be made. Decision making that draws on appropriate expertise, but which is objective, independent and transparent, must be the hallmark of the new regime.

The proposed reforms and their expected impacts are summarised in table 2.

Table 2 **A summary of the Commission's proposals**

Current problem	*Proposed response*	*Main benefits of change*
Enhancing the NHWSF		
Lack of wider endorsement of framework at government level impedes effectiveness. Inadequate evaluation mechanisms and an overly restrictive 'self sufficiency' principle also impede effectiveness.	CoAG to endorse the framework, and consider whether the self sufficiency principle should be modified. CoAG to commission regular reviews of progress in implementing the framework and changes emerging from this study.	Strengthen role of NHWSF as a reference point for future detailed reforms and as a vehicle for promoting coordination across the policy areas that impact on the health workforce.
Facilitating workplace innovation		
Lack of timely and objective processes to assess nationally significant job redesign, leading to lost opportunities to make better use of available health workforce skills.	Establish an advisory health workforce improvement agency to evaluate nationally significant workforce innovation opportunities, particularly those which would cross current professional boundaries.	Independent assessment of the benefits and costs of such opportunities, and identification of implications for education and training, accreditation and registration, government funding and private health insurance arrangements.
More responsive education and training arrangements		
Lack of coordination between the education and health areas of government, leading to mismatches between education and training places and service delivery requirements.	Australian Government to consider developing a health education agreement with State and Territory Governments to achieve an agreed allocation of places within each jurisdiction.	Better alignment of the mix of health course places with health needs of the community and the workforce needs of service providers.
Longstanding practice a barrier to exploration of better ways of educating and training the future health workforce.	Establish an advisory health workforce education and training council to provide for systematic and integrated consideration of different health workforce education and training models and their implications for courses and curricula.	Facilitate consideration of education and training issues on an integrated rather than profession-by-profession basis. Council to be an 'honest broker' on issues where existing interests might unduly influence outcomes under a more informal and less transparent process.
Shortages in clinical training capacity in many key areas. Current clinical training regime may not be sustainable over the longer term, due to lack of transparent and explicit funding. Insufficient opportunities for competition in training delivery.	CoAG to establish a high level taskforce to: gather the data and information necessary to improve understanding of the operation of the clinical training regime; and to recommend on how a more transparent, coordinated and contestable regime should be implemented.	Greater capacity to match training places with needs. Competition from new providers leading to more efficient delivery of training services and more innovative training models.

(continued)

Table 2 **continued**

Current problem	*Proposed response*	*Main benefits of change*
A consolidated national accreditation regime		
Profession-based accreditation impedes workplace innovation and job redesign. Inconsistent requirements across professions and accreditation bodies impose costs on education and training institutions.	Establish a single consolidated national accreditation regime, entailing an overarching statutory national accreditation board that could, at least initially, delegate accreditation functions to selected appropriate existing entities. Regime to encompass university-based education and post graduate clinical training and, over time, VET.	Facilitate timely uptake of workplace innovations emerging from the proposed workforce improvement agency, and multi-/inter-disciplinary learning. Provide a platform for uniform national standards on which to base registration. Facilitate the development of a national approach for the assessment of the qualifications of overseas trained health workers.
A consolidated national registration agency		
Current state-based regime leads to variations in standards; involves duplication of effort; impedes professional mobility; imposes costs on those practising in more than one jurisdiction. Professions-based approach can reinforce workplace rigidities.	Establish a single national registration board, with professional panels, to develop and administer nationally uniform registration standards based on qualifications established by the national accreditation agency, and informed by advice from the workplace improvement agency on new or expanded professional roles.	Promote a nationally uniform approach to the regulation of health workers. Reinforce an across-profession emphasis in health workforce arrangements. Reduce administration and compliance costs. Reduce barriers to the movement of health professionals within Australia.
Improving funding-related incentives for workplace change		
No transparent process for considering possible extension of MBS rebates to a wider range of practitioners, leading to some inefficient use of GP services and imposing additional costs on patients.	Establish an independent review committee (subsuming existing committees) to advise on services to be covered by the MBS and on referral and prescribing rules.	Facilitate transparent consideration of requests for changes in the coverage of the MBS that would help to improve workforce efficiency and effectiveness and enhance outcomes for patients.
Bias in MBS rebates towards procedural medicine that can distort provider behaviour, career choices and location decisions.	DoHA to examine extent of bias and any remedial action required.	More efficient deployment of the workforce. Over time, help to address workforce shortages in some areas.
Limited incentives in MBS for delegation of less complex tasks to less highly qualified, but more cost-effective, health professionals.	Introduce (discounted) rebates for a wider range of delegated services.	Encourage better use of available health workforce skills. Allow the community to share in cost savings from delegation.

(continued)

Table 2 **continued**

Current problem	*Proposed response*	*Main benefits of change*
Better focused and more streamlined projections of future workforce requirements		
Current projections not always well focused on major education and training needs, reducing their policy relevance.	Concentrate formal projections on the key workforce groups. Greater emphasis on projecting workforce needs for different demand, supply and productivity scenarios.	Better use of resources available to undertake projections. Greater transparency regarding the impact of policy settings on future workforce requirements.
Current institutional structure cumbersome.	Rationalise structure through abolition of AMWAC and AHWAC.	Some cost savings. Addresses any residual concerns about transparency of governance.
More effective approaches to improving outcomes in rural and remote areas		
Rural and remote issues not always properly considered as part of mainstream policy formulation.	All system-wide frameworks in the health workforce area to make explicit provision for consideration of rural and remote issues.	Better assessment of opportunities to improve workforce services in rural and remote areas through system-wide changes. Facilitate uptake of workforce initiatives in rural and remote areas that have wider application.
Limited evaluation of which specific approaches for improving outcomes in rural and remote areas work best.	A cross program evaluation to help assess the relative effectiveness of different approaches.	Better platform for determining the most cost-effective ways of enhancing health workforce outcomes in rural and remote areas.
	Further trialling of block funding models.	Help to inform cross-program evaluation exercise, as well as discussion of the more general applicability of block funding.
Assisting groups with special needs		
Workforce requirements of groups with special needs not always addressed as part of mainstream policy formulation.	All broad institutional frameworks to make explicit provision to consider the needs of these groups, with monitoring of progress made in achieving this goal.	Guard against any marginalisation of groups with special needs. Ensure that specific initiatives for these groups are compatible with generally applicable arrangements.

Recommendations

Objectives and strategies (chapter 3)

RECOMMENDATION 3.1

In its upcoming assessment of ways to improve integration within the health care system, CoAG should endorse the National Health Workforce Strategic Framework in order to enhance cohesion between the various areas and levels of government involved in health workforce policy.

RECOMMENDATION 3.2

CoAG should consider whether the current wording of the self-sufficiency principle in the National Health Workforce Strategic Framework is unduly restrictive in the context of the international nature of the health workforce and if so, how it should be interpreted.

RECOMMENDATION 3.3

CoAG, through its Senior Officials, should commission regular reviews of progress in implementing the National Health Workforce Strategic Framework and the impact of policy changes made as a result of the Commission's recommendations. Such reviews should be independent, transparent and their results made publicly available.

Workforce innovation (chapter 4)

RECOMMENDATION 4.1

The Australian Health Ministers' Conference should establish an advisory health workforce improvement agency to evaluate and, where appropriate, facilitate major health workforce innovation possibilities on a national, systematic and timetabled basis.

- ***Board membership should provide the necessary health, education, finance and consumer knowledge and experience, structured to reflect the public***

interest generally rather than represent the interests of particular stakeholders.

- *The agency should report publicly and make recommendations to the Australian Health Ministers' Conference as to appropriate workforce reforms and their implications, including for other health workforce arrangements.*
- *The agency should, as appropriate, provide advice to other national agencies or bodies recommended in this report.*
- *The agency's efficiency and effectiveness should be reviewed after five years.*

Education and training (chapter 5)

RECOMMENDATION 5.1

The Australian Government should consider developing an agreement with State and Territory Governments for the allocation of places for university-based education and training of health professionals within each jurisdiction. However, under such an agreement — which should be of at least three years duration — the Department of Education, Science and Training (in consultation with the Department of Health and Ageing) would remain responsible for determining the total quantum of funding for university-based health education and training and for negotiations with individual universities on the distribution of those places.

RECOMMENDATION 5.2

The Australian Health Ministers' Conference should establish an advisory health workforce education and training council to provide independent and transparent assessments of:

- *opportunities to improve health workforce education and training approaches (including for vocational and clinical training); and*
- *their implications for such matters as courses and curricula and accreditation requirements.*

The council should have a small board which provides for input from education, employer and professional interests, structured to reflect the public interest rather than the interests of particular stakeholders. It should report directly to the Australian Health Ministers' Conference.

RECOMMENDATION 5.3

As a matter of priority, CoAG should establish a high level independent taskforce to:

- *collect and assemble comprehensive and nationally consolidated data and information on: the demand for clinical training across all health professions; where it is being provided; how much it costs to provide; and how it is being funded; and*
- *in the light of this information, recommend specific changes to facilitate more transparent, coordinated and contestable clinical training arrangements, including through:*
  - *a more appropriate allocation of clinical training costs according to the benefits accruing to the various parties;*
  - *greater reliance on explicit payments to those providing infrastructure support or training services, within the context of a system that will continue to rely on, and benefit from, considerable pro bono provision; and*
  - *removal of regulatory or other barriers that impede the development of contestable delivery or otherwise impede the efficiency and effectiveness of clinical training outcomes.*

Accreditation (chapter 6)

RECOMMENDATION 6.1

The Australian Health Ministers' Conference should establish a single national accreditation board for health professional education and training.

- *The board would assume statutory responsibility for the range of accreditation functions currently carried out by existing entities.*
- *VET should be included as soon as feasible, although there are grounds for excluding it until the new arrangement is implemented and operating successfully in other areas.*
- *Collectively, board membership should provide for the necessary health and education knowledge and experience, while being structured to reflect the public interest generally rather than represent the interests of particular stakeholders.*
- *Initially, at least, the board could delegate responsibility for functions to appropriate existing entities, on terms and conditions set by the board. Such entities should be selected on the basis of their capacity to contribute to the overall objectives of the new accreditation regime.*

RECOMMENDATION 6.2

The new national accreditation board should assume statutory responsibility for the range of accreditation functions in relation to overseas trained health professionals currently carried out by existing profession based entities.

Registration (chapter 7)

RECOMMENDATION 7.1

When a health professional is required to be registered to practise, that should be on the basis of uniform national standards for that profession.

- ***Education and training qualifications recognised by the national accreditation board should provide the basis for these national registration standards.***
- ***Any additional registration requirements should also be standardised nationally.***
- ***Flexibility to cater for areas of special need, or to extend scopes of practice in particular workplaces, could be met through such means as placing conditions on registration, and by delegation and credentialing.***

RECOMMENDATION 7.2

The Australian Health Ministers' Conference should establish a single national registration board for health professionals.

- ***Pending the development and adoption of national registration standards by the new board, the board should subsume the operations of all existing registration boards and entities, including the authority to impose conditions on registration as appropriate.***
- ***The new board should be given authority to determine which professions to register and which specialties to recognise.***
- ***Initially, however, the new board should cover, at a minimum, all professions which currently require registration across the eight jurisdictions.***
- ***Membership of the board should contain an appropriate mix of people with the necessary qualifications and experience, and be constituted to reflect the broader public interest rather than represent the interests of particular stakeholders.***
- ***Profession specific panels should be constituted within the board to handle matters such as the monitoring of codes of practice and those disciplinary functions best handled on a profession specific basis.***

RECOMMENDATION 7.3

The new national registration board should consider and determine the circumstances in which more explicit specification of practitioner delegation arrangements would be appropriate.

Payment mechanisms (chapter 8)

RECOMMENDATION 8.1

The Australian Government should establish an independent standing review committee to advise the Minister for Health and Ageing on:

- ***the safety, effectiveness and cost-effectiveness of proposals for changes to:***
  - ***the range of services (by type and provider, whether medical or non-medical) covered under the MBS (including the rebate to apply);***
  - ***referral arrangements for diagnostic and specialist services subsidised under the MBS; and***
  - ***prescribing rights under the PBS; and***
- ***other relevant matters referred to it by the Minister.***

The new committee should subsume the relevant functions of the Medical Services Advisory Committee, the Medicare Benefits Consultative Committee and related committees, and report publicly on its recommendations to the Minister and the reasoning behind them.

RECOMMENDATION 8.2

The Department of Health and Ageing should, as a matter of priority, determine the extent of the bias in the MBS in favour of procedural services, and how any significant bias should be addressed.

That assessment should be taken over by the proposed independent review committee when it is fully functioning.

RECOMMENDATION 8.3

The Australian Government should increase the range of MBS services for which a rebate is payable when provision is delegated by the (medical or non-medical) practitioner to another suitably qualified health professional. Where delegation occurs:

- ***the service would be billed in the name of the delegating practitioner; and***

- ***rebates would be set at a lower rate, but still sufficiently high to provide an incentive for delegation in appropriate circumstances.***

Implementation should have regard to the fiscal impacts, with the arrangements reviewed after three years and again after a further five years.

Workforce planning (chapter 9)

RECOMMENDATION 9.1

Current institutional structures for numerical workforce planning should be rationalised, in particular through the abolition of the Australian Medical Workforce Advisory Committee and the Australian Health Workforce Advisory Committee. A single secretariat should undertake this function and report directly to the Australian Health Ministers' Advisory Council.

RECOMMENDATION 9.2

Numerical workforce projections undertaken by the secretariat should be directed at advising governments on the implications for education and training of meeting differing levels of health services demand. To that end, those projections should:

- ***be based on a range of relevant demand, supply and productivity scenarios;***
- ***concentrate on institutional entry for the major health workforce groups, while recognising that projections for smaller groups may be required from time to time; and***
- ***be updated regularly, consistent with education and training planning cycles.***

Rural and remote issues (chapter 10)

RECOMMENDATION 10.1

The Australian Health Ministers' Conference should ensure that all broad institutional health workforce frameworks make explicit provision to consider the particular requirements of rural and remote areas. Progress in achieving this objective should be monitored as part of the proposed regular evaluations of the National Health Workforce Strategic Framework (see recommendation 3.3).

RECOMMENDATION 10.2

To provide input to the proposed cross program evaluation of rural and remote health workforce policies (see recommendation 10.3), and to help assess the general applicability of block funding models, the Australian Health Ministers'

Conference should initiate further trials of these models in rural and remote areas. Specifically these trials should involve:

- ***pooling of government funding available to support primary and acute care services in the trial areas;***
- ***allocation of responsibility for distributing that funding and oversighting service delivery to an agreed entity; and***
- ***establishment of evaluation protocols, involving as appropriate the proposed health workforce improvement agency.***

RECOMMENDATION 10.3

The Australian Health Ministers' Conference should initiate a cross program evaluation exercise designed to ascertain which workforce policies, or mix of policies, are likely to be most cost-effective in improving the sustainability, quality and accessibility of health services in rural and remote Australia. Amongst other things, it should compare and/or examine:

- ***the provision of financial incentives through the MBS rebate structure versus other means such as practice grants and FBT and superannuation concessions;***
- ***'incentive-driven' approaches versus 'coercive' mechanisms such as requirements for particular health workers to practise in rural and remote areas; and***
- ***whether the current and planned level of investment in regionally-based education and training is sufficient, relative to investment in other policy initiatives.***

Addressing special needs (chapter 11)

RECOMMENDATION 11.1

The Australian Health Ministers' Conference should ensure that all broad institutional health workforce frameworks make explicit provision to consider the particular workforce requirements of groups with special needs, including: Indigenous Australians; people with mental health illnesses; people with disabilities; and those requiring aged care. Progress in achieving this objective should be monitored as part of the proposed regular evaluations of the National Health Workforce Strategic Framework (see recommendation 3.3).

1 About the study

Australia's health system has many strengths. Overall health outcomes compare quite favourably with those in other developed countries. For example, Australians have among the highest life expectancies in the world — including when 'disability adjusted' for years of 'good health'. Yet total spending on health care as a percentage of GDP and per capita is not overly high by advanced OECD country standards (AIHW 2004a).

These outcomes are due in no small measure to the expertise and commitment of Australia's health workforce and that of the various professional and representative bodies in the health, education and training sectors which contribute both directly and indirectly to the delivery of health services.

To a considerable degree, the system has managed to respond to growing financial pressure and changing community health needs. However, the sustainability of the system is under increasing pressure in various respects. There are poor health outcomes for particular groups in the community and difficulties in accessing services for some care needs and in some parts of Australia. Workforce shortages are contributing to these problems.

Further, continuing strong growth in demand — reflecting rising incomes and community expectations, technological advances and an ageing population — will only serve to increase the pressure on the current health care system and its workforce. It is far from clear that present arrangements will be able to cope with this pressure, in turn raising questions about the sustainability of Australia's health care goals. Not surprisingly, therefore, the focus of much policy attention has been on how to increase workforce supply and improve the efficiency and effectiveness of that workforce.

This particular research study by the Commission provides an opportunity for the review of health workforce arrangements in this context — and in light of the adoption of the *National Health Workforce Strategic Framework* (NHWSF) by Australian Health Ministers in 2004 (see chapter 3). The study was requested by the Australian Government in March 2005 in response to a decision by the Council of Australian Governments (CoAG) in June 2004.

At its subsequent June 2005 meeting, CoAG agreed that 'Australia has one of the best health systems in the world', but noted that there is room to discuss a number of areas for improvement (box 1.1). Consequently, Senior Officials were asked to consider ways to improve Australia's health system and report back in December 2005 on a plan of action to progress reforms in a number of areas, including the supply, flexibility and responsiveness of the health workforce. CoAG also asked the Commission to report by December 2005 so that it could consider the Commission's views along with the action plan from CoAG Senior Officials.

1.1 Scope and focus of the study

Wide scope of issues

The scope of this study is broad, with the terms of reference potentially covering any relevant factor affecting, or likely to affect, the demand for and availability of health workers and the services they provide over the next 10 years or so. In summary, the Commission has been asked to:

- consider factors affecting the supply of health workforce professionals;
- consider the structure and distribution of the health workforce and the consequences for its efficiency and effectiveness;
- consider factors affecting demand for services provided by health workforce professionals;
- consider the specific health workforce needs of rural, remote and outer metropolitan areas and issues of Indigenous health;
- provide advice on the identification of, and planning for, Australian health care priorities and services; and
- provide advice on the issue of general practitioners in or near hospitals on weekends and after hours.

Coverage of professions and services

The study adopts an expansive definition of the health workforce, with the term 'health workforce professional' defined to cover 'the entire health professional workforce', from a number of education and training backgrounds, including vocational, tertiary, post-tertiary and clinical. Without attempting to be exhaustive, examples of relevant occupations covered include: doctors, nurses, midwives, physiotherapists, podiatrists, pharmacists, psychologists, occupational therapists,

dentists, radiographers, optometrists, Aboriginal Health Workers, ambulance officers and paramedics. Generally, people must be registered before they can practise in most of these occupations.

Box 1.1 **Extract from the CoAG Communiqué of 3 June 2005 relating to Australia's health system**

CoAG agreed that Australia has one of the best health systems in the world. However, there is room for governments to discuss areas for improvement, particularly in areas where governments' responsibilities intersect.

The Australian, State and Territory Governments recognised that many Australians, including the elderly and people with disabilities, face problems at the interfaces of different parts of the health system. Further, the governments recognised that the health system can be improved by clarifying roles and responsibilities, and by reducing duplication and gaps in services.

Ways in which the health system could be improved include:

- simplifying access to care services for the elderly, people with disabilities and people leaving hospital;
- helping public patients in hospital waiting for nursing home places;
- helping younger people with disabilities in nursing homes;
- improving the supply, flexibility and responsiveness of the health workforce;
- increasing the health system's focus on prevention and health promotion;
- accelerating work on a national electronic health records system;
- improving the integration of the health care system;
- continuing work on a National Health Call Centre Network; and
- addressing specific challenges of service delivery in rural and remote Australia.

CoAG agreed that Senior Officials would consider these ways to improve Australia's health system and report back to it in December 2005 on a plan of action to progress these reforms. It was also agreed that where responsibilities between levels of government need to change, funding arrangements would be adjusted so that funds would follow function.

Health Workforce Study

CoAG noted that an issues paper has been prepared for public discussion by the Productivity Commission on the health workforce study. CoAG will ask the Productivity Commission if it can report by December 2005, so that CoAG can consider this report along with the action plan from CoAG Senior Officials.

Source: CoAG (2005).

The terms of reference do not restrict the scope of the study to any particular health care settings. Indeed, health care professionals work in a range of settings, extending from mainstream primary and acute care, to aged care, mental health, disability services and the provision of community services more generally (with many working in a voluntary rather than paid capacity). Although the Commission has focused on the work of health care professionals (as defined above) in mainstream care, its analysis and conclusions also have relevance for other settings (including those where the volunteer workforce plays a central role). This wider applicability is particularly relevant given that the boundaries between services are becoming less clearly defined, and many health workforce issues increasingly range across those services.

Defining 'workforce planning'

Many of the issues discussed in this study involve an element of 'workforce planning', as they broadly concern how best to make provision for future workforce needs. Thus, the term is used in the paper as a shorthand way of describing efforts to determine the appropriate nature and extent of government involvement in the health system in relation to the health workforce (see below).

Sometimes, however, the term has a narrower interpretation, being used to describe the processes employed by the Australian Medical Workforce Advisory Committee and the Australian Health Workforce Advisory Committee in their more focused consideration of the *numbers* of workforce professionals of various descriptions likely to be required to sustain service delivery in future. Chapter 9 of this paper adopts that interpretation.

1.2 The Commission's approach

Taking account of broad health care objectives

Although this study is centred on the health workforce, the issues examined and the Commission's proposals need to be seen in the context of the community's desire for a health system which meets a number of specific objectives. These can be expressed in several different ways, but the summary set out in the most recent Report on Government Services is helpful (SCRGSP 2005b). It portrays the overall objectives of the health system as follows:

- efficiently and effectively protecting and restoring the health of the community by:

– preventing or detecting illness through the provision of services that can achieve improved health outcomes at relatively low cost;

– caring for ill people through the use of appropriate health and medical intervention services;

– providing appropriate health care services that recognise cultural differences among people;

– providing equitable access to these services; and

– achieving equity in terms of health outcomes.

Chapter 3 adapts these broad objectives to more specifically focus on the health workforce. It also notes the role for performance criteria against which changes that affect the workforce can be assessed. Throughout this paper, the Commission has been mindful that changes that affect the health workforce need to support the overall objectives of the health system, including that they should maintain, or preferably *enhance* the quality and safety of care provided in any particular context.

Assessing the nature and extent of government involvement

The characteristics of health care services (and indeed of many other human services) are such that the scope to give competitive market forces free rein is often less than in markets for most other goods and services. These characteristics justify significant government involvement in health care. For instance:

- There are strong equity grounds for ensuring that low income should not preclude people from accessing appropriate health care services.
- Consumers do not always willingly 'choose' to purchase health care in the same way as most other goods or services, but do so because of need, or in response to circumstances beyond their control.
- There is a lack of, and asymmetric, information. People can have difficulty in judging their own best health care interests, the competence of practitioners and the merits of their recommendations. The consequences for consumers of inappropriate purchasing decisions can be very severe.
- The likely future cost of health care for most individuals is highly uncertain, but can involve a risk of high expenditure. As such, insurance arrangements can be effective in helping individuals make sufficient financial provision for their health care contingencies. But the pooling nature of insurance requires collective governance, and a measure of government regulation to deal with information asymmetry, moral hazard and similar concerns.
- There are important spillovers from the consumption of health care. Health care services have the capacity to contribute to the physical, emotional, social and

intellectual wellbeing of consumers and their families. Their consumption can have significant flow-on benefits for broader community welfare. Access to effective health care services is also important for a productive workforce. And there are public benefits from a well trained health workforce, in addition to the spillovers from education more generally.

Governments thus contribute to health services funding, deliver some core health services, regulate the provision of health services, including by health workers, and regulate insurance arrangements. As well, governments are heavily involved in the education and training sector through funding courses and, sometimes, in their provision. As such, governments have far reaching impacts on the numbers, types and skills of health workers available and on their delivery of health services.

In this study, the Commission has taken as given these broad rationales for government intervention in relation to health services provision in general and the health workforce in particular. However, the actual nature and extent of intervention in particular situations is a matter for judgment — to be assessed against efficiency, effectiveness, quality and safety criteria. This is at the heart of much of this paper.

Adding value through this report

In meeting CoAG's request to bring forward the reporting date for this study, the Commission has focused its analysis and proposals on a relatively small number of high level issues which it views as central to achieving more efficient and effective health workforce arrangements over the longer term. And in seeking to expedite the process, the study has traversed lightly through much of the background that is well known to most.

Many of the previous studies, analyses and reports into health workforce issues, both in the Australian and international contexts, have focused on particular professions, processes, regions or short-term crises. Even within such a narrow purview, many of these issues are inherently complex; they are often interrelated; they range over both the health and education sectors; and they play out in an environment of rapid and significant change.

The Commission's remit, in contrast, is to encompass the whole of the health workforce, both paid and volunteer, to consider both supply and demand issues, and to look out over a timeframe of a decade or more. Thus, while drawing on previous work where relevant, and on particular professions and practices for illustration, it has focused its efforts primarily at a system-wide level. Specifically, it has endeavoured to identify the reform frameworks and principles that would enable the institutions, regulatory and funding processes and the workforce itself to be

responsive to emerging problems and challenges, so as to continue to deliver high quality, safe, efficient, effective and financially sustainable health services.

The Commission considers that it would add little value by way of replicating the assessment of the numerical workforce requirements in any of the individual professions, by critiquing the technical content of training curricula, or by attempting to prescribe the optimal deployment of the available workforce across geographical regions. However, the systemic changes proposed by the Commission in this report should facilitate the detailed consideration of such matters by relevant stakeholders and appropriate technical experts.

Finally, this is not a study into the adequacy of existing health budgets or the appropriate levels of future health expenditure. However, in the face of escalating demand for services, per capita expenditure on health care in general and on the health workforce will inevitably continue to increase (chapter 2). Indeed, part of the package of measures required to deliver better health workforce outcomes over the medium term will necessarily include initiatives to boost educating and training places and to address recruitment, retention and re-entry problems (chapter 3). That said, and while commenting on these issues, the Commission considers that the area where it can make the greatest contribution is to advise on how to deliver any given bundle of health services in a more efficient and effective way than is currently the case.

Providing opportunity for extensive public input

To the maximum extent possible within the time available, the Commission has provided opportunity for public input into this study.

Upon receiving the terms of reference for the study, the Commission released an Issues Paper (PC 2005c) and invited written submissions on the matters under review. In response, and prior to the release of the Position Paper (see below), the Commission received almost 180 submissions from a wide cross-section of individuals, service providers, professional associations, regulatory bodies, government agencies, special needs groups, regional and community interests.

Over the period March to April 2005, discussions and roundtables were held with around 90 organisations and individuals covering a range of interests across all jurisdictions in metropolitan, rural, regional and remote locations.

In September 2005, the Commission released a Position Paper (PC 2005a) outlining its preliminary analysis and proposals for health workforce reform. To elicit views on the Position Paper, the Commission held roundtable discussions in Sydney,

Melbourne, Brisbane, Canberra and Alice Springs during October and November. Some 60 organisations and individuals participated in discussions at those roundtables. In addition, meetings with all State and Territory governments were held.

The Commission also received around 190 further written submissions, responding specifically to the analysis and draft proposals in the Position Paper. Together, this very valuable input has shaped the Commission's thinking on how best to implement its proposals. Accordingly, it has modified and embellished the draft proposals presented in the Position Paper and also provided greater detail on the operational features of its final proposals.

More information on the inquiry processes is provided in appendix A, including lists of those with whom the Commission met, those who made submissions and those who participated at the roundtable discussions. The Commission thanks all the organisations and individuals who contributed to the study. The debate is much richer for their time, effort and wisdom.

2 Context for policy development

Key points

- Health workforce pressures will escalate in the future as increasing incomes and community expectations, technological advances and population ageing strongly stimulate demand for health services, while supply constraints tighten.
- Without action, these influences will add to the current problems facing the health workforce and thereby detract from health outcomes.
- There will need to be a greater emphasis on improved community health, preventive measures and on managing the consequences of chronic diseases.
- It will be necessary to train more health workers and improve the recruitment, retention and re-entry of health workers into care delivery.
- Productivity-enhancing improvements to health workforce arrangements are critical to ensuring a sustainable health care system, particularly given the constraints on government funding for health care.
- The health workforce system is inherently complex and interdependent and a number of systemic impediments will need to be overcome if the workforce is to be able to effectively respond to current and emerging challenges, including:
  - the fragmented roles and responsibilities of governments and other stakeholders and the inadequate coordination between them at a number of levels;
  - inflexible and inconsistent regulatory practices;
  - perverse funding and payments incentives; and
  - entrenched custom and practice, including the maintenance of traditional professional barriers.

To a considerable degree the health care system, as noted in chapter 1, has responded to changing community health needs within the constraints imposed by growing financial pressures. There are, however, significant problems and many participants in this study have understandably concentrated on workforce issues of immediate concern.

Given the forward looking nature of this study, while considering these current issues, the Commission has also looked across the array of new issues and challenges for the health workforce that might arise over the next decade and beyond.

Of course, attempting to predict the future is fraught with danger. While broad trends can be identified, the ways in which these trends will interact and play out are often unclear. In the face of such uncertainty, what is required is a health workforce with the capacity to respond to those issues and challenges in a sustainable manner.

After briefly summarising key workforce trends and current issues raised by participants, this chapter discusses the challenges likely to be important in shaping the future health workforce and the way in which it delivers care. It then highlights the systemic impediments to workforce adjustment and change, with the following chapters taking up particular themes in more detail.

2.1 Key workforce trends

The health workforce has changed considerably in recent years. To set the context for the study, the Commission has identified the following key workforce trends, both current and emerging, likely to have important implications for future policy.

- Aggregate health expenditure has grown strongly over the last decade or so to some $78 billion in 2003-04. The annual real growth rate has averaged about 4.8 per cent, significantly higher than population growth of about 1.2 per cent. As a consequence, over the period, the ratio of health expenditure to GDP has increased from 8.3 per cent to 9.7 per cent. Expenditure on workforce services has also been growing strongly and, while it is difficult to be precise, it currently accounts for about two thirds of overall spending.
- The nursing group of occupations makes up more than 50 per cent of the health workforce of about 450 000 people, with the medical group accounting for about 12 per cent. Allied health workers in total account for about 9 per cent.
- Workforce numbers for most professions, with the possible exception of nurses and dentists, have been growing significantly faster than population growth. Between 1996 and 2001, the overall health workforce increased by over 11 per cent, nearly double population growth of 6 per cent. Over that period, the numbers of allied and complementary health workers grew by more than 25 per cent.
- Although workforce numbers have increased significantly, several key trends are affecting workforce participation and availability. They include:
  - workforce ageing;
  - feminisation across a wider range of professions;
  - lower average working hours;

  - increasing specialisation in a number of professions;
  - issues of job satisfaction and other factors which result in a considerable number of health workers not practising in their profession; and
  - changing models of care and service delivery.
- Policy, funding and payment arrangements in recent years have reinforced a trend towards the provision of services in the private health sector.
- Changes in the education and training sector directed at enhancing qualifications and skills have had the side effect of lengthening the training pipeline.
- The health system has become increasingly reliant on overseas trained professionals, particularly for the medical occupations. For example, overseas trained doctors now make up 25 per cent of the overall medical workforce compared to 19 per cent a decade ago.

Appendix B sets out the relevant characteristics of the Australian health workforce and the key institutional and regulatory settings within which it works.

2.2 Current workforce issues

Many of the current issues of concern have been well canvassed in other documents and forums, including the Commission's own Issues Paper (PC 2005c). Several are explored in some detail below so as to lay in place a foundation for the proposals contained in this report.

Workforce shortages

Identifying 'shortages' in workforce supply is not straightforward, especially given the difficulty of establishing underlying health care demand and an appropriate level of workforce response, and the extensive involvement of governments in delivering or otherwise influencing the level of resources provided to meet that demand. Furthermore, the focus on 'professions' rather than health workforce competencies can distort the conclusions about the capacity of the current workforce to meet health care needs. Nevertheless, there is evidence that there are shortages in overall numbers across a range of the medical, nursing, dental and allied health professions (see box 2.1).

Box 2.1 **Perspectives on health workforce shortages**

Recognising that any interpretation of workforce shortage estimates needs to be mindful of issues such as the model of health care delivery and population dispersion, a number of recent studies have pointed to shortages and maldistribution in many areas of the health workforce. For example, recent quantitative work undertaken by the Australian Medical Workforce Advisory Committee (AMWAC) and the Australian Health Workforce Advisory Committee (AHWAC) found:

- an estimated shortage of between 800 to 1300 GPs in 2002 (or around 4 to 6 per cent of the current GP workforce) (AMWAC 2005);
- an estimated shortfall of between 10 000 to 12 000 nurses in 2006 and between 10 000 and 13 000 in 2010 — requiring at least a doubling of current graduate completions (AHWAC 2004a); and
- current and emerging shortages in the majority of medical specialities which led to recommendations for increases in training intakes (AMWAC 2004).

In other health occupations, the Department of Employment and Workplace Relations (DEWR) has recently identified shortages in a number of occupations including dentists, hospital and retail pharmacists, occupational therapists, physiotherapists, speech pathologists, podiatrists, diagnostic radiographers, radiation therapists, nuclear medicine technologists, pathologists, psychiatrists, registered nurses and sonographers (DEWR 2005).

As well as overall shortages, there are even more pronounced shortages in rural and remote areas and in Indigenous communities, reflecting the concentration of many highly trained professionals in major cities (see appendix B). AMWAC and AHWAC have noted particular concerns in relation to access to GPs and certain medical specialities in rural and remote areas. The Australian Divisions of General Practice drew attention to the decline in the number of Aboriginal Health Workers in the Northern Territory (sub. 135). Submissions from allied health groups to this study, such as OT Australia (sub. 21), also advised that shortages of many of these workers are particularly acute in rural and remote areas.

Some of these shortages may be short term. Where the training is of short duration (such as in some allied health and nursing programs) and there are no other constraints on student entry or interest, workforce numbers can respond relatively quickly. Improving retention and re-entry outcomes can similarly serve to alleviate the extent of the problem (see below). Indeed, most health professions operate in an environment where many of the signals that dictate behaviour in less regulated markets still come into play. Hence, workforce shortages will often allow an upward drift of remuneration levels, with the higher financial rewards in turn attracting more workforce entrants — though underlying impediments such as fiscal constraints, distortionary payment arrangements, or inappropriate limits on scopes of practice can limit the benefits of such increases in supply.

But in other areas, workforce shortages can persist for much longer periods, particularly where the duration of education and training is lengthy and where there is less scope for retention and re-entry initiatives to boost supply. While there has been an increasing reliance on overseas trained health professionals to address shortages, ethical issues associated with recruitment from countries with significant health care needs have focused debate on the sustainability of this supply source. This means that part of the solution to health workforce problems will inevitably involve educating and training more health workers locally.

Current shortages have already engendered explicit policy responses — for example, the Australian Government has significantly increased the number of undergraduate and vocational education places and nursing has been declared a national priority area. Specifically, the number of university places in medicine will rise by 30 per cent between 2001 and 2009 and additional funding will be provided for 4800 nursing places and 3600 allied health places by 2008 (see chapter 5). However, some participants considered that little government recognition has been given to current and projected shortages in other areas, including dental and allied health services.

Such supply responses have limits. As the Queensland Health Systems Review recently stated:

> Longer term innovative ways of delivering health services are needed to provide health care sustainability. Simply providing more doctors, more nurses, more beds and more money is unlikely to be sustainable. (QHSR 2005, p. xi)

International comparisons of the ratio of health workers to population (see appendix B) suggest that there are considerable efficiency gains to be made. For example, the Australian Divisions of General Practice (sub. 135, p. 15), citing AIHW data for 2002, suggested that while the United Kingdom's general practitioner workforce was 30 per cent higher than Australia's, it was servicing a population base three times the size. This was argued to primarily reflect differences in the models of primary care between the two countries.

Workforce distribution

It is widely recognised that the geographic spread of the health workforce does not reflect the distribution of the population. In particular, apart from nurses, the relative number of health professionals diminishes for communities located further away from major centres. Thus in 'remote' areas, for example, the GP to population ratio is slightly over half of that in the cities, for physiotherapists it is less than a half and for specialists it is under one-fifth (see chapter 10).

That said, the outlook for the health workforce outside of the major cities is far from universally negative. Access to health workers in a number of the major regional centres, although not always satisfactory, is not greatly different to that in the cities and their outer metropolitan suburbs in particular. Those regional centres are in turn providing a service base for residents in surrounding communities. Also, there are examples of smaller communities that have successfully implemented innovative programs to improve their access to health workers and health services. A range of government initiatives, including financial incentives, bonding arrangements and alternative remuneration structures, have also been introduced to improve access to health workers in rural and remote areas. Those initiatives are discussed in chapter 10.

Making the best use of existing competencies

Using the skills of the existing workforce in the most efficient and effective way possible is an obvious way to lessen the impact of workforce shortages and distribution problems. In this respect, many concerns were expressed about impediments affecting allowable scopes of work, appropriate mixes of competencies and job redesign and substitution. Representatives of registered nurses, physiotherapists and pharmacists, for example, considered that their training and skills suited them for 'higher level' tasks. Many submissions called for greater development of an 'assistant in' stream of workers to take over some of the less skilled tasks — including from those whose scope of practice would be directly affected (such as physiotherapists).

However, such specific proposals for change require detailed consideration, including of their likely impacts on the quality and safety of service provision. That said, as succinctly stated by AHMAC, the guiding principle to enable the best use of scarce workforce resources should be that:

> … wherever possible, services should be delivered by staff with the most cost effective training and qualification to provide safe, quality care. (sub. 166, p. 9)

Against this background, a key component of the Commission's proposals involves the establishment of a mechanism to enable objective and transparent assessment of such opportunities. This mechanism is discussed in chapter 4.

Education and training

Education and training arrangements are adapting to the changing health services needs of the community and the consequent changing requirements for the health

workforce. Nonetheless, there were various references by participants to rigidities, fragmentation and disconnects in the system. The major issues raised were:

- a lack of coordination between health planners and those responsible for allocating the number of university places across the various health professional areas, resulting in gaps between health service needs and the numbers of appropriately trained professionals;
- inadequate availability of funding of clinical training which, according to participants, also fails to expose students to the full range of health care settings; and
- a failure to consider the clinical training implications of increases in the number of undergraduate university places.

Many curriculum issues were also canvassed, as was the nature of the postgraduate professional year (for nursing, in particular) needed to make graduates 'job-ready'. However, in contrast to their views on university-based health workforce training, a few participants commented favourably on features of the VET sector including its competency-based focus. Education and training issues are discussed in chapter 5.

Funding and payment arrangements

Current arrangements for funding and payment of the services provided by the health workforce detract in a number of ways from its effectiveness and also serve to inhibit workforce change (see section 2.4). For example:

- The division of funding responsibility for different services across two levels of government has created incentives for cost shifting.
- There have been ongoing disputes between state and territory health departments and specialist colleges over funding for clinical placements.
- Supply side controls to contain costs, such as restricted access to MBS provider numbers, may not pay sufficient attention to the need to match appropriate workforce skills to health needs.
- Greater provision of health care in private settings, particularly private hospitals, has led to an associated shift in patient load and workforce and put more pressure on clinical training in public teaching hospitals.
- Some relativities in payment schedules do not appropriately reflect differences in the complexity and intrinsic value of services to the community.
- The structure of the MBS, coupled with the fee-for-service model, may also increase practitioner resistance to job redesign.

Many participants considered that levels of remuneration and inadequate funding were the underlying causes of many current problems and called for additional government support to be provided. Without question, if funding was substantially increased, many of these problems could be reduced. Nevertheless, as outlined above, funding is already increasing significantly in real per capita terms. And, as discussed below, the future challenges facing the workforce will only magnify these expenditure pressures.

The Commission has focused much of this study on practical, financially responsible ways to make best use of the health workforce within the context of whatever expenditure levels are set by governments and the community. Improvements to funding and payment arrangements to address the distortions outlined above are considered in chapter 8.

Job satisfaction and retention

Many participants commented on a range of factors that adversely affect the job satisfaction of workers and thus their productivity and, ultimately, their willingness to remain in or re-enter the health workforce. This problem should not be underestimated. The Department of Health and Ageing indicated that around 10 per cent of currently registered or enrolled nurses are not working as nurses and that there are almost as many formerly registered and enrolled nurses as there are currently registered and enrolled nurses (sub. PP293, p. 3). In addition, a high proportion of new graduates either choose not to practise nursing or leave the profession after just a few years of employment. The significance of this issue, however, varies considerably across jurisdictions and even across hospitals within the same jurisdiction.

In New South Wales, for example, one estimate put the number of registered nurses not working in the profession at 30 000 with a lack of job satisfaction, poor pay and conditions viewed as key causes (sub. 133, p.1). In Queensland, attrition rates for nurses are as high as 40 per cent in the first two years of employment (Queensland Government 2005, p. 5). In Victoria, on the other hand, the extent of these problems is much lower with only around 1300 Division 1 and 2 nurses (registered and enrolled) not working in the nurse labour force in 2003 (sub. 155, p. 24).

Job satisfaction issues are not confined to the nursing profession, with a number of participants pointing to particular problems across allied health and in some medical fields. For example, the Pharmacy Guild of Australia noted that 5000 registered pharmacists are not working in the profession and speculated that possible causes include long working hours and a switch to more attractive career alternatives (sub. 165, p. 31). OT Australia, citing Department of Employment and Workplace

Relations estimates, mentioned that 19 per cent of the occupational therapy workforce leaves the occupation each year (sub. 54, p. 8). The gender and age profile of the workforce, as well as a trend to specialise in a narrow range of fields, were viewed as the main drivers.

The nature of the problems in medical fields such as psychiatry is somewhat different with the Royal Australian and New Zealand College of Psychiatrists noting that the stigma associated with the profession was causing problems as was 'an environment perceived as being continually in crisis mode: highly stressful, unrewarding and unsafe' (sub. 79, p. 7). And in the area of general practice, the Australian College of non-VR General Practitioners said that because of the differential treatment of their members (that account for 10 per cent of the total GP workforce) who receive less than 70 per cent of the Medicare rebate available to vocationally registered GPs:

> Non VR GPs have been leaving general practice … and moving into other sub specialities such as women's health, cosmetic surgery, skin clinics, insurance companies and workcover clinics where the rate of pay is more attractive. (sub. 128, p. 1)

The Commission notes that recent initiatives provide a higher rebate for non-VR GPs providing after hours services and those working in areas of need.

Retention problems are particularly acute in smaller jurisdictions. For example, the Northern Territory Government noted that around 30 per cent of its nursing workforce is highly mobile and that the associated costs of employee separation and recruitment are between 50 and 100 per cent of the annual salary for each employee (sub. PP182, p. 13).

In recognition of the importance of these issues, State and Territory Governments have implemented a variety of occupation-specific retention and re-entry initiatives in their attempts to address workforce shortage problems (see chapter 3).

2.3 Emerging challenges

As well as dealing with current problems, health workforce policy will need to grapple with the implications of changes in the nature and quantum of demand for health services, and with important workforce supply side factors.

Per capita demand will increase strongly

Future health care demand will depend on many factors, including technological advances, higher incomes and expectations and ageing. Their impacts will play out against the backdrop of a substantial change in the burden of disease.

Changes in the burden of disease

The nature of future health care demand is expected to change in line with anticipated changes in the burden of disease facing the community. This will fundamentally affect the models of care employed in service delivery, the number and types of health care workers that will be required, and the development of multidisciplinary approaches to care (see box 2.2).

Of particular importance in this context will be the increase in the incidence of chronic disease as the population ages (fuelling a shift in demand from episodic acute care to ongoing team-based management and care in community settings). For example:

- The Victorian Department of Human Services and Health (HSV 1999) estimated that by 2016:
  - dementia will replace ischaemic heart disease as the most prevalent disease condition affecting females (it ranked fourth in 1996);
  - type II diabetes will become the second most common condition affecting males (fifth in 1996);
  - prostate cancer will become the third most prevalent condition affecting males (eighth in 1996) and lung cancer the fifth most common condition in females (eleventh in 1996); and
  - the incidence of stroke is expected to fall significantly from being the second most common disease for both males and females to ninth and tenth respectively.
- The New South Wales Department of Health estimates that between 2001 and 2026: the incidence of diabetes will increase by 176 per cent, dementia by 107 per cent, vision disorders by 93 per cent, hearing loss by 87 per cent and chronic musculoskeletal disorders by 79 per cent (NSW Health 2005, p. 4).

Box 2.2 **Some participants' views on future health needs**

Professor Wayne Gibbon:

> Hospitals and health service structures, as they currently exist were defined to meet the needs of the past. New technologies and treatment modalities, and changing demographics provide both the requirement and the opportunity to establish contemporary models of care that are more attuned to the needs of contemporary society. It is an economic and social imperative that we establish models of care that are community based and that enable people to be cared for and managed within the community. (sub. 48, p. 1)

Committee of Deans of Australian Medical Schools:

> … the growing provision of health care by teams rather than individuals, particularly for the aged and chronically ill, has presented the as yet largely unrealised challenge of interprofessional education and learning … suggested a different paradigm of medical practice, one which was more community-based and more generalist. (sub. 49, p. 6)

Australian Health Policy Institute:

> At present, patients with complex health issues are typically managed in the same way as patients with discrete problems — by a succession of individuals addressing specific problems, often without relative priorities or proper recognition of the interactions. As the population ages the proportion of patients with multiple or complex health care needs will increase. Each patient needs to be managed by a form of case manager who is able to coordinate a team of multi-/ inter-disciplinary care providers and establish a care plan by consultation and then ensure it is delivered. These managers can be more generalist health care workers because they will not actually be providing service delivery, just managing it. (sub. 22, p. 1)

Australian Nursing Federation (Vic Branch):

> There has been scant regard or research given to actual models of health care which may be suitable and sustainable in the future. Much of the debate is hospital centric, with an illness focus. Consumer focused primary health and health promotion models of care also need to be factored into the equation. (sub. 133, p. 3)

James Cook University Faculty of Medicine, Health and Molecular Sciences:

> The ageing population, the burden of chronic disease, professional workforce shortages, changing demographics and aspirations of graduates, development of information and communication technology and emergence of new health disciplines — all mean that new ways of thinking about the organisation of health workforce labour and health service delivery structures need to be explored. (sub. 106, p. 11)

General Practice Education and Training:

> Much medical education occurs in acute care settings but increasingly the system must focus on chronic conditions managed by … multidisciplinary teams in community settings. (sub. 129, p. 28)

Royal Australian College of General Practitioners:

> Research has demonstrated that [point of care testing] is accurate, practical and a community-appropriate way of monitoring chronic conditions including diabetes. … The use of [point of care testing] is likely to enable a reduction in repeat appointments currently required to provide results and make changes to treatment. Empirical evidence also suggests that it may result in more efficient workforce utilisation through reduced need to refer testing to other service providers and the administration involved in this process. (sub. 143, pp. 12, 13)

The health behaviours of the population are driving some of these changes. In NSW in 2004, of the population aged 16 years and over, 23 per cent of males and 19 per cent of females were current smokers. For this age group overall, 48 per cent were classified as overweight or obese, only 52 per cent reported adequate levels of physical activity, 13 per cent were at high risk from drinking alcohol and the level of protection from the sun (hats and sunscreens) amongst secondary school students was declining.

These trends have increased attention on the potential to influence demand through a shift to preventive rather than curative medicine — not just for the perceived health benefits but also because it is seen as a means to reduce future workforce requirements. In this context, AHMAC noted that:

> Improving health [though investment in disease prevention] has the potential to reduce demand for health services and hence reduce the need for more highly skilled health professionals. (sub. 166, p. 29)

AHMAC suggested a number of possible approaches to develop improved public health and support individuals in managing their own health including:

- Increased investment in early intervention and prevention activities to avoid the development of illnesses and 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. (sub. 166, p. 30)

Technological advances

As new drugs, treatments and medical procedures are developed, and existing treatments with higher quality are offered, medical practitioners and consumers will seek to take advantage of the perceived benefits (see box 2.3).

Some particular technological changes are likely to be cost reducing, rather than increasing. However, the Commission has estimated in its related study into the *Impacts of Advances in Medical Technology in Australia* (PC 2005d) that, over the decade to 2002-03, technological change has resulted in annual per capita real growth in expenditure averaging about 1.9 percentage points per year — excluding the linked income effect (see below). If anything, it could be expected that this rate will increase into the future.

Box 2.3 **Technology and health expenditure**

The use of new medical technologies has been a major driver of growth in health expenditure. Over the period 1992-93 to 2002-03, over one-third of the annual growth in Australia's real health care expenditure was attributable to technological advances. Such pressures are expected to continue, or even accelerate.

Decisions to use particular technologies are usually driven by practitioners, in consultation with their patients, and are influenced by the various incentives and constraints imposed by the health system. The major factors influencing provider decisions to use newer technologies include:

- awareness of technological advances and their potential benefits;
- assessment of clinical need;
- financial and other incentives provided to practitioners and institutions, for example, by reimbursement arrangements and liability laws;
- budget and other constraints, such as regulations and guidelines, imposed by governments and institutions, including hospitals; and
- the skills and availability of health professionals.

Whether particular advances in medical technology increase or decrease spending on health care depends on the impact on unit treatment costs, the level of service use and their impact on spending on other services. To date, technology appears to have played a key role in driving spending growth in two key areas — hospital care and pharmaceuticals. For hospital care, the average cost of treatment has risen, partly due to growth in spending on increasingly expensive technologies such as prostheses. And while new pharmaceuticals have improved treatment options, they have also expanded those options, as well as increasing the average cost of PBS-listed drugs.

Of course, increases in expenditure have brought benefits — there have been measurable improvements in various indicators of health and mortality in recent years. However, it is difficult to apportion these to health spending or particular technologies with any degree of precision.

Source: PC (2005d).

Technological advances have a range of effects on the demand for health workers and their skill requirements. For example, the surgical fitting of increasingly complex prostheses requires an understanding of engineering concepts. Advances in remote monitoring technologies enable, and stimulate demand for, care in the home. Some technologies also reduce the need for hospitalisation, surgery or extended residential care. Others create new cohorts of patients to be treated, extend treatment periods, or require new types of workers to deliver them. In the extreme, some technologies, such as robotics, have the potential to substitute for conventional health workers. Thus, the impact of technological change on aggregate demand for health workers is extremely difficult to predict. What is clear, however,

is that different models of care and new workforce practices will be required to accommodate the wider range of treatment possibilities and approaches ensuing from these technological advances.

In a different context, developments in information technology have opened up opportunities to improve efficiency through E-Health. Greater use of interlinked clinical data through the use of electronic health records, allowing improved access to patient information, would support a more seamless provision of care — such as from primary care to emergency acute care. Such records could also facilitate better coordination and cooperation in a range of other health workforce contexts, offering potential cost savings and benefits to consumers, health service providers and the health system in general. The benefits could be especially significant for patients with chronic conditions, who have a long-term medical history and/or need to see several different health providers. In this respect, as noted, it is anticipated that the incidence of chronic disease will increase as the population ages.

Higher incomes and expectations

As incomes rise, communities and individuals alike are usually willing to spend more on maintaining and improving their health. Particularly at an individual level, the size of this effect is linked to the development and dispersion of new technology (PC 2005d). That is, new technology provides the wherewithal for translating increased willingness to consume health care services into actual spending decisions. Even so, the Commission has recently estimated that per capita real growth in health expenditure due to income growth (excluding the technology link) over the decade to 2002-03 averaged some 1.5 percentage points a year (PC 2005d).

Income linked expenditure growth is expected to continue into the future. Further, with better education and the availability of much more relevant information (for example, through the internet), health care consumers are becoming more discerning, with higher expectations about the services they require. This, too, will tend to increase per capita expenditure. That said, income growth also affords, in large part, the means to fund greater willingness to spend on health care services and the technological advances that this stimulates.

An ageing population

The fourth factor impacting on the per capita demand for health services is ageing. As the average age of the Australian population rises, per capita demand for health services will rise, as older people typically need more health services than young people (see box 2.4). Currently, across health services as a whole, expenditure on

the over 65s is around 4 times more per person than that on those under 65, and rises to 6 to 9 times more for those over 85 (PC 2005b).

The Commission has estimated that over the decade to 2002-03, population ageing increased real per capita health expenditure by some 0.6 percentage points per annum on average (PC 2005b). However, population ageing in Australia is still at an early stage. It is expected that, driven by long-term declines in fertility and increased longevity, one-quarter of Australians will be aged 65 years or more by 2045, around double the present proportion. Although there is a degree of debate between commentators in the field, and there are interacting effects of trends in disability and disease prevalence (see box 2.4), the Commission's view is that ageing is likely to put considerable pressure on the future rate of health expenditure growth.

Workforce supply factors are also important

The extent to which health service needs can be met, and consequently the level of health expenditure, is affected not only by trends in demand, but also by supply side factors. Health workforce supply is influenced by both developments in the broader labour market and health specific issues including the level of workforce re-entry, retention rates, overseas recruitment and how effectively the existing workforce is deployed.

Broader labour market issues

For the labour market as a whole, the ageing population will be a major influence on future workforce supply. Labour participation falls significantly after the age of 55 — many in this age group reduce their hours or move out of the labour force altogether. Thus, as the population ages in future, aggregate labour participation rates will decline, all other things being equal. Recent Commission projections suggest that, in 2044-45, the labour force participation rate will be 7 per cent lower, and average hours worked per person 10 per cent lower, than in the absence of population ageing (PC 2005b).

Thus, effective labour supply (the total number of hours actually worked each year) will grow more slowly than it would have in the absence of ageing. For example, given a continuation of existing participation trends, labour supply growth is projected to be slower than population growth from 2011-12 (PC 2005b).

Box 2.4 **Ageing and health expenditure**

Over the period 1991-92 to 2001-02, population ageing accounted for an estimated 13 per cent of the growth in real health care expenditure (PC 2005b, p. 47). However, in future, ageing is expected to play an increasing role in driving expenditure growth, both in its own right and as it interacts with other pressures:

- As technology improves, more medical procedures can be performed safely on elderly people, and society's expectation is currently that the elderly will receive such treatment.
- Research and technological developments tend to focus on where the disease burden is greatest (and where commercial payoffs will be highest) — commonly illnesses associated with ageing.

That said, there is not a complete consensus on the *extent* to which population ageing will increase future health care needs. Some commentators argue that the effect of ageing will continue to be swamped by the effects of income growth and technology, that people will be healthier in the future thereby offsetting the impacts of ageing, and/or that most costs are associated with the last years of life, so that living longer will not involve significantly higher health costs.

Nevertheless, after considering the available evidence, a recent report by the Commission on the implications of ageing concluded that:

- demand and technology are acting to increase per capita expenditure more for older age groups, suggesting that the rising share of older people in the future will compound the underlying growth in health expenditure arising from income growth and technology;
- foreseeable trends in disease prevalence and disability seem unlikely to alleviate the fiscal pressure associated with ageing; and
- available data supports the view that costs rise with age rather than arising predominantly at the end of life.

Ageing of the population will also result in increased demand for aged care, in both residential and community settings. This sector currently employs around 30 per cent of the overall health workforce.

Source: PC (2005b).

These influences within the broader labour market will stimulate both short-term and long-term responses. Upward pressure on real wages is likely to emerge, stimulating changes in the participation rate as some people are encouraged to work longer or re-enter the workforce. In the longer term, changes in real wages will also trigger the movement of workers between sectors, generate substitution between labour and other inputs, and focus attention on the scope for changes in education and training regimes to expedite workforce preparation.

Given the labour-intensive nature of many health services, and the more limited scope to substitute other inputs for labour — although this may change somewhat as medical technology develops — it is likely that real wage pressures in the health area will be stronger than in many other parts of the economy. Redistribution of workers from other sectors, and retraining or re-entry of health workers, will only partly offset this. And as many other countries also experience shortages of workers, it may become more difficult to source appropriately trained professionals from overseas. Thus, wage-related cost pressures will be significant.

This of itself is likely to stimulate efforts to develop new models of care that economise on the use of the supply of increasingly valuable and costly health workers. However, wage costs aside, the difficulty of securing sufficient numbers of workers to sustain current service delivery models is likely to require significant adjustments in parts of the workforce. As the South Australia Government succinctly stated: 'fine tuning at the margins will not be sufficient to effect the necessary structural changes to address the problem' (sub. 82, p. 21).

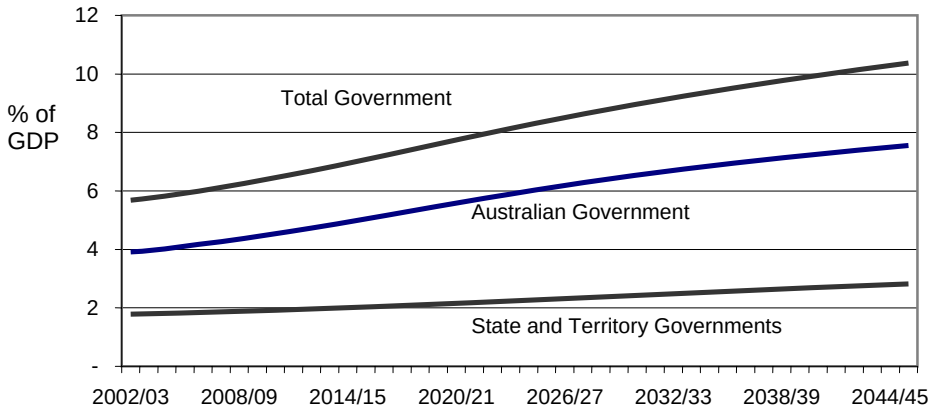
Such pressures are also likely to focus policy attention on retaining existing health workers for longer; attracting some workers who have left the workforce or who are working in other sectors back into the health area; and improving the effectiveness of recruitment of overseas trained health workers. In the latter case, for example, it was put to the Commission by Professor Wayne Gibbon that Australia could even look at establishing health education and training facilities in developing countries where labour will be more plentiful (sub. 48, p. 5).

Enhancing productivity

With health services demand likely to continue to grow strongly over the next decade and beyond, and the costs of employing health workers likely to rise, policy changes will be required to prevent future per capita expenditure on health workforce services and health care more generally from escalating too rapidly. Indeed, the Commission has recently projected that total health care expenditure could account for at least 16 per cent of GDP by 2044-45. As governments between them currently fund two-thirds of all health costs, their fiscal burden would be at least 10 per cent of GDP (see figure 2.1).

Many have questioned the fiscal sustainability of such growth in spending. Thus, to help contain future expenditure growth, it is important that service delivery becomes more efficient and effective. As the major input to service delivery, there is a similar imperative to make the most productive use of the available skills and competencies of the current health workforce, while maintaining appropriate levels of quality and safety.

Figure 2.1 **Projected (own-source) government expenditure on health care as a proportion of GDP 2002-03 to 2044-45**



a Projected using a non-demographic growth rate of 0.6 percentage points above the projected growth in GDP per capita.

Source: PC (2005b, p. 168).

The broad productivity imperative was widely recognised in submissions, and is also central to the National Health Workforce Strategic Framework which provides an agreed foundation for the long term development of the workforce across the entirety of the health system (see chapter 3).

However, good data on the productivity of Australia's health workforce and of the health system more generally is lacking. Thus, as an input to both this study and its wider work program, the Commission has examined what would be involved in developing robust measures of productivity in the health sector and what data and information would be required to support such measurement (see chapter 13 and appendix C).

2.4 What inhibits workforce change?

In keeping with the rest of the health care system, Australia's health workforce arrangements are both extraordinarily complex and highly interdependent. As the Commission has found, understanding how the various components of the arrangements fit together, and what policies and programs apply in each area is a major challenge in itself. This, in turn, renders policy formulation more difficult and increases the incentive to approach policy development on a compartmentalised basis. But in developing effective reform proposals, it is important that each and all of the various cogs which comprise the totality of health workforce arrangements move in reinforcing directions.

In addition, when it comes to the actual design and implementation of reform proposals, it is necessary to identify and overcome a variety of systemic impediments to the development of sustainable and responsive workforce arrangements. The Commission has grouped these impediments into the following categories.

Fragmented roles, responsibilities and regulatory arrangements

The health workforce is planned, educated, deployed, funded and regulated by a myriad of different public and private entities. This can be advantageous in a number of respects. For example, it provides for the development and application of specialised knowledge in specific areas.

But the number of entities involved, and especially the division of responsibility for the various parts of the health workforce system between and within governments, results in conflicting objectives, inefficiencies and cost and blame shifting. All of this detracts from developing a consensus on how to improve workforce productivity. As noted by the New South Wales Government:

> Currently the Australian health care sector is characterised by a series of serious role conflicts ... These role conflicts necessarily influence workforce supply and distribution and coupled with government disconnects can result in serious shortages. (sub. 178, p. 4)

And in the words of the Australian Private Hospitals Association:

> Realistically, until an adequate resolution of this fragmentation [of roles and responsibilities] can be found, sustainable, long-term solutions to shortcomings in the health workforce are unlikely to be developed, let alone agreed. (sub. 109, p. 4)

Importantly, in the communiqué issued after its June 2005 meeting, CoAG noted that 'governments recognised that the health system can be improved by clarifying roles and responsibilities, and by reducing duplication and gaps in services' (CoAG 2005).

Inadequate coordination between governments, planners, educators and service providers

Effective coordination could potentially ameliorate some of the problems arising from the fragmentation of roles and responsibilities between the many bodies involved in health care. This point was highlighted by AHMAC which said:

> Better integration and coordination … between the two levels of government … 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. (sub. 166, p. i)

Similarly, the Committee of Deans of Australian Medical Schools noted that:

> … a national coordination mechanism for the continuum of medical education is essential so that flexible, viable and innovative new models can be explored and, if feasible and successful, funded. (sub. 49, p. 3)

However, an array of input to this study indicates that coordination and collaboration has been deficient in a number of key areas and has been a major contributor to existing problems. Specific shortcomings that have been raised include:

- ineffective coordination between governments at the planning phase — leading, for example, to difficulties in accessing data from individual jurisdictions and subsequent restrictions on the range of information available to individual service providers when undertaking their own strategic planning exercises;
- failure to support the development of a minimum health workforce data set and common terminology, and failure to integrate clinical data sets;
- failure to adequately link projections of the numbers of health workers likely to be required in future, and the needs of employers, with the number and occupational distribution of education and training places;
- failure to ensure that the potential number of clinical training places is likely to match student outflows from the university and VET sectors; and
- limited coordination of reform initiatives between jurisdictions, inadequate sharing of evaluation outcomes and little effort devoted to identifying best practice strategies.

Inflexible regulatory practices

Regulation has an important role to play in the health sector in ensuring appropriate clinical standards and promoting safety and quality objectives. However, as is evident in the discussion in a number of the later chapters, some aspects of the current arrangements are unduly rigid and thus may actually impede the development of a more efficient and effective health workforce. For example, by focusing narrowly on existing professions, many registration arrangements (see chapter 7) reduce the flexibility of the workforce to develop new competencies and scopes of work in response to the changing health care needs of the community. In this respect, the New South Wales Government said:

> Existing regulatory practices have created a health workforce that is overly rigid and has limited capacity to adapt to what is a complex, changing environment with ever evolving service delivery needs. (sub. 178, p. 4)

Similarly, the Queensland Government noted:

> ... the jurisdictional and siloed approach to regulation undermines the capacity for the development or expansion of roles that might best, flexibly provide the health care of the future. (sub. 171, p. 9).

Current arrangements for the accreditation of education and training programs (see chapter 6) similarly serve to reinforce traditional professional roles and boundaries and impede workplace innovation and job redesign. In addition, the multitude of accreditation agencies has resulted in a lack of consistency across those agencies in the requirements they impose on educational institutions and trainers. This has contributed to increased complexity in health workforce arrangements, as well as imposing added compliance costs on these institutions and trainers.

Perverse funding and payments incentives

Current funding and payment arrangements for the services provided by the health workforce primarily direct public subsidies toward medical professionals. These arrangements can distort consumption patterns and, on occasion, lead to the wasteful use of health care resources. Inappropriate relativities in rebates for particular types of subsidised services can also distort decisions regarding career choice within the medical profession. In turn, this can exacerbate workforce shortages in certain areas and make it harder for the public hospital sector to recruit certain types of doctors.

Entrenched custom and practice

Custom and practice are important drivers of behaviour in the health workforce, as they are in various other workforces. Often, of course, the experience underpinning such custom and practice serves patients well. However, it can also stifle necessary and justifiable innovation and change in workplace practices and the evolution of job design and education and training arrangements. Among other things this can, in turn:

- impede transferability of skills across professional boundaries;
- prevent appropriate recognition of prior learning;
- constrain the move to a more competency-based education and training system; and

- discourage the further development of multidisciplinary care approaches.

In the words of the Northern Territory Government:

> Workplace culture underpins [the] delineation of roles that impedes the development of interdisciplinary education, training and practice and the development of new models of care. (sub. PP182, p. 21)

Cultural attitudes within the health workforce also entrench notions of 'high status' and 'low status' work areas. This can reinforce the difficulties faced by such service areas as mental health, disability care and aged care, in attracting and retaining sufficient numbers of appropriately trained staff (see chapter 11).

Problems associated with entrenched custom and practice in the health sector are most commonly attributed to the conduct of professional associations and other interest groups. Relative to some other sectors, these bodies necessarily play a major role in policy formulation and implementation in the health area. This has raised concerns that the entry rules and conduct codes administered by some professional bodies, while primarily directed at maintaining quality and safety standards, can involve an element of income and workload protection.

Quality and safety issues have been prominent in debates regarding the appropriateness of a range of potential workforce-related policy initiatives — changes to scopes of practice being a notable example. This highlights the need for careful evaluation of the costs and benefits of particular reform options to ensure that change is not blocked by unsubstantiated claims. Recognising that the dimensions of quality and safety vary according to the context that care is delivered, the Commission wishes to emphasise that throughout its deliberations, the working presumption has been that any proposed changes to health workforce arrangements should only be supported where they maintain, or preferably *enhance*, the quality and safety of care provided in any particular context. This premise was echoed by a number of participants including the National Rural Health Alliance (sub. PP295, p. 2) which noted its support for health reform as long as it did not jeopardise certain 'non-negotiable' principles including that reform improve or at least not reduce patient safety and the quality of services in rural and remote areas.

Significantly, effective transparency and accountability mechanisms and structures that would help to minimise the scope for unwarranted 'patch protection' seem to have been lacking within parts of the health workforce sector. The Australian Competition and Consumer Commission highlighted this issue in its determination on the training, accreditation and assessment practices of the Royal Australasian College of Surgeons (ACCC 2003).

Moreover, the problems with entrenched custom and practice are not restricted to the actions of health workers and their representative bodies. Inflexible management practices also pervade workplace arrangements, with similarly deleterious impacts on productivity and job satisfaction. In terms of the efficiency consequences, the Australian Medical Association (Victoria) commented:

> The Royal Australasian College of Surgeons identifies the possibility that nonworkforce solutions such as theatre availability, bed availability and patients being ready for care could increase surgical efficiency in the public hospital system by at least 10 per cent, without the need for additional funds and by twenty to twenty-five percent if there was funding to better utilise operating theatres over holiday periods. (sub. PP220, p. 12)

In summary, a number of systemic barriers and impediments have prevented Australia's health workforce from achieving its full potential and from providing Australians with accessible, high quality and safe health services in the most efficient, effective and financially sustainable manner. If not addressed, these systemic blockers are likely to become increasingly costly as the workforce strives to meet the significant challenges ahead.

3 Objectives and strategies

Key points

- To fully address some of the systemic impediments to better health workforce outcomes, changes to the broader health and education and training systems would be required. However, even within the more limited purview of this study, there is still scope for considerable improvement.
- The key objective of workforce reform should be to enhance community access to high quality, safe, efficient, effective and financially sustainable health services.
- This should be achieved through facilitating the development of health workforce arrangements that:
  - maximise the efficiency and effectiveness of the available health workforce at any point in time and help to reduce its maldistribution; and
  - are able to respond in a timely and effective manner to changing needs and pressures.
- The National Health Workforce Strategic Framework provides a sound foundation for the pursuit of better outcomes. CoAG endorsement of the framework would help to engender commitment from the education, finance and central policy coordination areas of governments.
- One necessary response to current workforce shortages and growing future demand for health care services will be to increase the number of education and training places for health workers.
- As well, strategies to improve health workforce recruitment, retention and re-entry outcomes will provide a timely and potentially cost-effective contribution to easing supply shortages.
- Strategies aimed at promoting wellness and managing demand need to be enhanced.
- Measures to increase the efficiency and effectiveness of the available workforce will also be critical and are the focus of this study. Such improvements can be achieved by:
  - the removal of impediments to more responsive workforce arrangements; and
  - more active approaches that seek to define and pursue explicit pathways for desired change in those arrangements.

As noted in chapter 1, health workforce policy is only one component of the wider health care system. There have been numerous recent calls for a review of the totality of the system, including by the Commission in its report on National

Competition Policy (PC 2005e). Indeed, this current study is paralleling a review for CoAG by Senior Officials of some wider health issues, including: improving the integration of the health care system; addressing problems at the interface between the health and aged care and disability systems; increasing the health system's focus on prevention and health promotion; and accelerating work on a national electronic health records system.

Some reforms to the wider health care system — and especially to the way health care is financed and the quantum of that funding — would have major impacts on workforce demand and supply, including through facilitating more health workers and improving job satisfaction (and, as a consequence, assisting with workforce retention and re-entry). They would also widen the available menu of options for improving workforce productivity and, in some cases, enhance the impact of changes that could be implemented within the current parameters of the health care system.

Subsequent chapters draw attention to some of these wider reform issues. But the Commission has been mindful that this is not an investigation into the health care system as a whole, or even into health care financing, let alone into general education and training policies. This necessarily constrains what might be achieved in regard to workforce reform within the context of the present study.

However, as the detailed and thoughtful submissions to this review have pointed out, there are also considerable workforce efficiency and effectiveness gains to be made within the constraints of the current health care system and the public expenditure limits placed on it by governments and the community.

3.1 Objectives for an efficient and effective workforce

As part of the broader health care system, health workforce arrangements are in some senses a means to an end. Hence, options to remove or ameliorate institutional, regulatory and financial impediments to better workforce arrangements must ultimately be assessed on the basis of their contribution to the achievement of broader health care goals. The Commission considers that the objective of the reforms that emerge from this study should be to enhance community access to high quality, safe, efficient, effective and financially sustainable health services. This should be achieved through facilitating the development of health workforce arrangements that:

- maximise the efficiency and effectiveness of the available health workforce at any point in time and help to reduce its maldistribution; and

- are able to respond in a timely and effective manner to changing needs and pressures.

Working toward such an objective should increase the prospect that reformed workforce arrangements for the whole of the health sector would, within any given expenditure constraint, deliver an appropriate number of health workers with the right skills mix. These arrangements should also deliver them when and where required, in terms both of care settings and geographic distribution.

The appropriateness and success of health workforce changes and reforms could be assessed against a number of performance indicators, including measures of:

- quality and safety;
- the nature and extent of evolution in job design and responsibilities;
- the costs and times taken to educate and train health workers;
- the ability of those completing health workforce training to utilise their competencies to participate fully in changing workplace environments;
- how well models of care and service delivery adapt to the changing burden of disease; and
- improvements in the productivity of health workers (see appendix C);

A menu of potential indicators — both input and output based — is provided by the broader National Health Performance Framework developed by the Steering Committee Reporting on Government Service Provision (see box 3.1).

Foundation — the National Health Workforce Strategic Framework

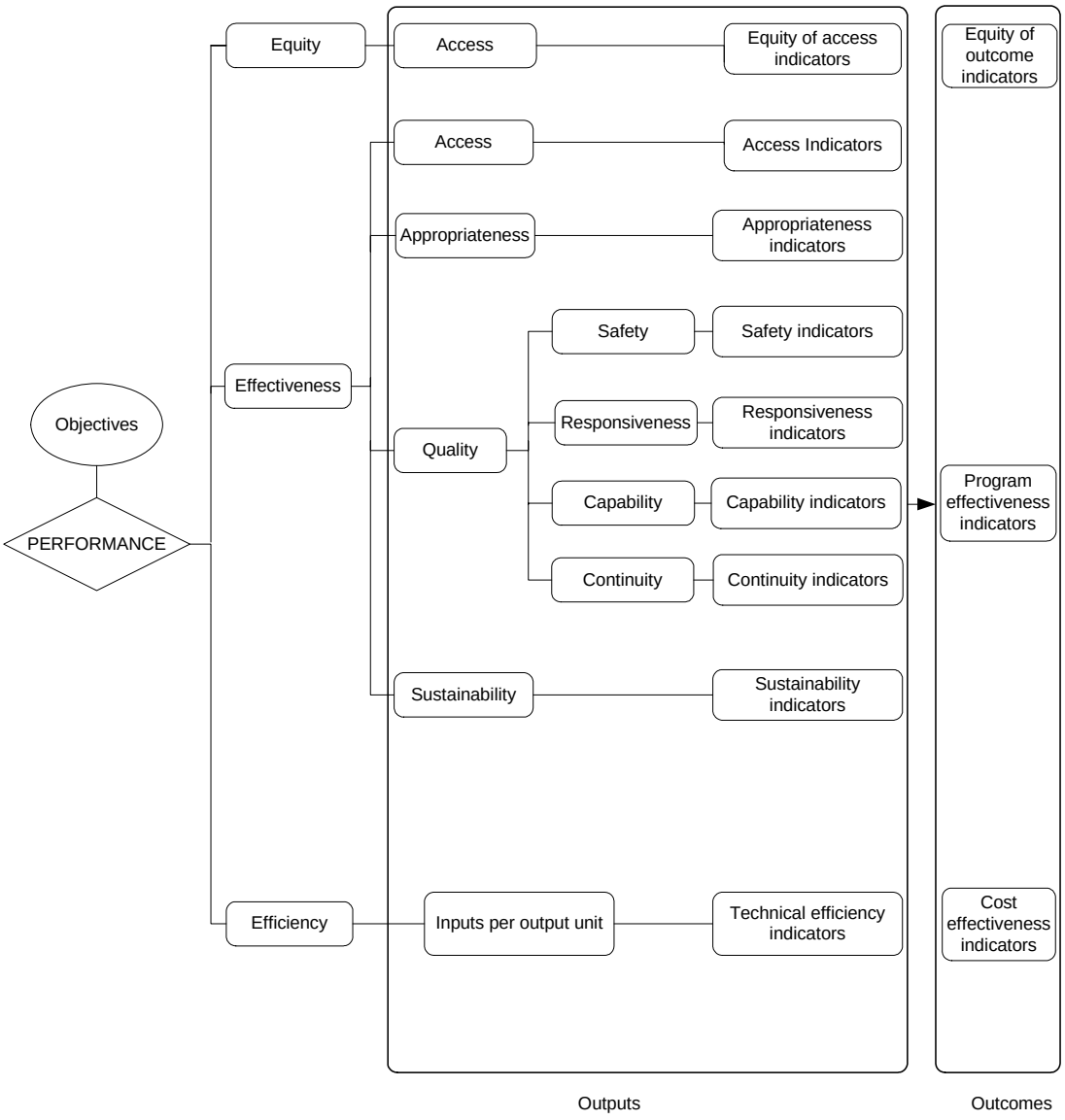
In 2004, key stakeholders in the health care sector agreed to the National Health Workforce Strategic Framework (NHWSF) and it was subsequently endorsed by all Health Ministers. As outlined in box 3.2, the NHWSF sets out a range of principles and objectives for the whole of the health workforce and broad strategies for achieving those objectives. It also incorporates related frameworks for Indigenous and rural and remote health workforces and links to other areas such as the National Mental Health Plan 2003–2008 (Australian Health Ministers 2003).

More recently, the NHWSF has been complemented by the National Aged Care Workforce Strategy (NACWS) — developed by the Ministerial Aged Care Workforce Committee comprising representatives from a cross-section of aged care interests. The NACWS is intended to provide a framework ‘for the aged care sector to plan and develop best practice workplace models that will help deliver high quality care for older Australians’ (CoAG 2005, p. iii).

There was some scepticism about the value of such a framework in its current form. For example, the Australian Private Hospitals Association said:

> … while the Framework was formed from a consultative process and it does identify common principles, the Framework does not adequately point to the ways in which these principles can be implemented to achieve genuine reform. (sub. 109, p. 5)

Box 3.1 **National Health Performance Framework**



Source: SCRGSP (2005b).

Box 3.2 The National Health Workforce Strategic Framework

The NHWSF is intended to guide national health workforce policy and planning over a ten year time frame. It was developed in consultation with governments, consumers, carers, Indigenous groups, professional organisations, health service providers and the education and training sectors. It incorporates related frameworks covering the Aboriginal and Torres Strait Islander health workforce and the health workforce in rural, regional and remote areas, and also links with the National Mental Health Plan (2003) and with the work of the Australian Council for Safety and Quality in Health Care.

The framework embodies seven core principles designed to provide 'a simple set of rules, guidelines and aims which allow all stakeholders to apply them to their own circumstances with a minimum of prescription'. The principles are:

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. It is recognised that this will require:
   - cohesion among stakeholders including governments, consumers, carers, public and private service providers, professional organisations, and the education, training, regulatory, industrial and research sectors;
   - stakeholder commitment to the vision, principles and strategies outlined in this framework;
   - a nationally consistent approach;
   - best use of resources to respond to the strategies proposed in this framework; and
   - a monitoring, evaluation and reporting process.

(continued)

Box 3.2 **continued**

The framework also outlines a range of potential strategies for pursuing these principles — though the listing is not intended to be exhaustive, or directly linked to an 'audit' of current initiatives. Indeed, the explicit intention is for the framework to evolve over time:

> … new community expectations and changing economies and environments will mean that the health needs of the Australian people, and the workforce required to meet those needs, will almost certainly change over time beyond this framework. Accordingly, the framework should be seen as an evolutionary document that will require regular updating and reassessment.

Source: AHMC (2004b).

Others said that there had been inadequate consultation in its development. For example, the Faculty of Medicine, Nursing and Health Sciences at Monash University observed:

> The Faculty supports the framework, but wishes to point out that the visibility of this framework amongst education providers is low. The framework has not been widely disseminated or discussed in the higher education sector. We believe this is primarily due to the very minor representation of the higher education sector in the discussion group that formulated, espoused and launched the framework. (sub. PP229, p. 1)

However, most participants who commented specifically on the NHWSF saw it as a positive step in bringing health workforce stakeholders together; getting high level agreement on what needs to be done; encouraging a longer term focus rather than short term crisis management; and establishing a useful reference point for specific reform directions.

The Commission concurs with these latter views and sees the NHWSF as providing a foundation for the range of specific initiatives that will be required to deliver more responsive and sustainable workforce arrangements across the whole of the health sector. With one exception, its core principles — which emphasise the importance of collaboration amongst stakeholders; the role of an evidence-based approach to policy formulation; the need to monitor, evaluate and report on progress; and the need to recognise links to the broader health care system — appear appropriate.

At the institutional and procedural level, there are some avenues by which the effectiveness of the NHWSF could be increased.

Though the framework has been signed off by Health Ministers, it does not have the explicit endorsement of their counterparts in education and training, or from Ministers responsible for finance or central policy coordination. This may limit the value of the framework as a reform reference point, at least where coordination between these different areas of government is important to achieving better health outcomes.

In the Position Paper, the Commission canvassed the value in having the NHWSF endorsed by CoAG, so as to embrace the education, finance and central policy coordination areas of government. This suggestion was endorsed by a number of participants. The Queensland Government, for example, noted its support for the NHWSF 'to be elevated to CoAG to obtain high-level and whole-of-government agreement on principles' (sub. PP325, p. 7).

Similarly, the NSW Nurses' Association stated that:

> … endorsement of the National Health Workforce Strategic Framework by CoAG would be a positive step toward coordinated and effective long-term workforce planning. (sub. PP237, p. 4)

RECOMMENDATION 3.1

In its upcoming assessment of ways to improve integration within the health care system, CoAG should endorse the National Health Workforce Strategic Framework in order to enhance cohesion between the various areas and levels of government involved in health workforce policy.

The Commission does have a concern with the particular reference in Principle 1 to achieving 'national self sufficiency'. In its view, provided there is compliance with ethical protocols, it is appropriate for Australia to draw on suitably qualified, overseas trained, professionals to supplement the locally trained workforce, and to recognise that its own health workers will migrate to other countries, either temporarily as part of their broader development, or permanently. Importantly, access to internationally trained health workers provides a valuable avenue for skills transmission and through this productivity gains. As the Australian Medical Association said:

> There are considerable mutual benefits from international experience in skills transfer. Australian trainees benefit from overseas training and work experience to round out their skills and education. Similarly, overseas trained doctors benefit from being exposed to clinical training and work in Australia. (sub. PP315, p. 5)

Accordingly, in the Position Paper the Commission proposed that the first principle in the NHWSF should be couched in terms of the need for Australia to produce sufficient numbers of health workers such that there is not an unsustainable reliance on health workers trained in other countries.

While there was considerable support for this proposed change of emphasis, a larger number of participants expressed reservations. The joint response from the State and Territory Health CEOs synthesised the views of these participants in saying the change left 'open to interpretation the extent to which local supply should meet local demand and what an unsustainable reliance on overseas trained health workers

is'. They went on to suggest that 'collectively they should aim to produce [a] sufficient number of health workers net of migration inflow and outflows' (sub. PP332, pp. 7–8).

In the Commission's view, however, there is no greater clarity provided by this formulation than by the change proposed in the Position Paper. However, while it continues to see merit in amending the principle, any change would require agreement among a large number of stakeholders. Accordingly, the Commission considers that in parallel with explicitly endorsing the NHWSF (see below), CoAG should examine whether the current formulation of the self-sufficiency principle is unduly restrictive in the context of the international nature of the health workforce and if so, how it should be interpreted. This approach was supported by the Western Australian Department of Health which said:

> It is recommended that COAG, through its senior officials, obtain agreement on wording to better reflect the imperative to grow local capacity at the same time as interacting in a global market for health professionals. (sub. PP333, p. 2)

The Commission notes, in this regard, that the NHWSF is intended to be an evolutionary document, providing scope to modify any objectives or strategies that prove to be inherently inappropriate, or that are overtaken by changing circumstances.

RECOMMENDATION 3.2

CoAG should consider whether the current wording of the self-sufficiency principle in the National Health Workforce Strategic Framework is unduly restrictive in the context of the international nature of the health workforce and if so, how it should be interpreted.

While there is provision for the evaluation of progress made against the framework's objectives, it appears that responsibility for such monitoring is intended to lie primarily with entities involved in developing and implementing the framework. Thus, the Australian Health Workforce Officials Committee (AHWOC) will report annually to the Australian Health Ministers' Advisory Council and Australian Health Ministers.

Notwithstanding the expertise that AHWOC will bring to the evaluation process, experience elsewhere points to the value of independent monitoring in ensuring that deficiencies that emerge in reform programs are given proper airing, and in minimising the potential for particular interest groups to undermine the reform process. Further, as it is proposed that CoAG should consider endorsing the framework, it would be appropriate for Senior Officials to drive the reviews and co-ordinate the responses of various areas of governments to the outcomes of those reviews.

In endorsing the draft proposal in the Position Paper for independent review of the framework's implementation progress, many participants noted that this will be critical to providing the impetus for change and disciplining the consideration of any amendments. Indeed, several suggested that the review process should extend to monitoring the impacts of the Commission's recommendations should they be adopted. The Western Australian Department of Health, for example, said:

> The regular reviews of progress should include consideration of … the effectiveness of new agencies established as a result of the Commission's proposals. (sub. PP333, p. 2)

The Commission agrees that such an extension to its original proposal would provide an appropriate means of assessing the impact of institutional changes emerging from this study.

RECOMMENDATION 3.3

CoAG, through its Senior Officials, should commission regular reviews of progress in implementing the National Health Workforce Strategic Framework and the impact of policy changes made as a result of the Commission's recommendations. Such reviews should be independent, transparent and their results made publicly available.

3.2 Strategies for achieving improved health workforce outcomes

As noted in chapter 2, in an environment where governments heavily subsidise health care consumption, estimating the underlying demand for health care services — and by extension the number of health workers that will be needed to meet that demand — is complex and problematic. Nonetheless, in the context of current delivery models and governments' willingness to subsidise consumption of health care, it is evident that there are shortages across many parts of the health workforce.

Further, the Commission notes that there is no single solution to these shortages and the various other problems in current health workforce arrangements documented in chapter 2. Rather, a multifaceted approach will be required. This will include: initiatives to boost supply through more education and training and strategies to improve retention and re-entry; strategies to moderate demand such as through a shift toward preventive medicine; and initiatives which maximise the effectiveness and productivity of the available pool of health workers.

Short term responses

In the short term, the two main avenues (aside from even greater reliance on overseas trained health professionals) for addressing shortages will be to educate and train more health workers (where this can be done relatively quickly) and to improve retention and re-entry rates (recognising that the latter are also relevant over the longer term).

Training more health workers

As discussed in chapter 5, a number of participants called for additional funds to be channelled into providing more education and training places to alleviate shortages across all the main health workforce areas: nursing, medical and allied health.

There have, however, been significant increases in expenditure on university (and vocational education) places over the last few years. Moreover, recent statements by the Minister for Education, Science and Training indicate that extra funding will be provided to further boost the number of nursing and allied places through to the end of the decade. These initiatives should go a considerable way toward easing current workforce shortages — assuming that there is sufficient availability of clinical training places to meet the additional demand for such training. More broadly, as discussed elsewhere, this is not a study into the adequacy of either health or education budgets and hence the Commission has not pursued this particular reform direction in any detail.

Retention and re-entry

As noted in chapter 2, retention problems are evident across a range of health professions and, in large part, reflect dissatisfaction with health sector employment. Issues surrounding retention are complex and influenced by a multitude of factors; some of which are not within the scope of governments to control. The ageing of the health workforce, availability of broader career opportunities, increasing demands placed on the health care system by the community and rapid changes in health care technology and associated requirements for educational preparation are but some examples.

The Commission also notes that many of the underlying causes of movement into and out of the health sector (such as the often demanding nature of the work) are common to occupations in other parts of the economy. Indeed, there is evidence suggesting that job satisfaction levels in the health area are not that much worse than in other occupations and that in some parts of the health workforce (for example, medicine) turnover rates are quite low. In addition, as in other parts of the

economy, not everyone who chooses to train in a specific occupation will practise in that occupation.

Participants nevertheless identified a range of specific factors that adversely affect job satisfaction including: a lack of career path and inadequate recognition of skills; inadequate remuneration; limitations on use of skills, scope of practice and capacity for innovation; unsupportive organisational and workplace culture; inadequate access to training and professional development, mentoring and support; inflexible working arrangements; unmanageable workloads; poor status of working in the health area; stress and burnout; and heavy physical and psychological demands.

As noted by the Health Professions Council of Australia:

> It is clear that for many professions, high attrition rates are related to poor career paths and inadequate pay. In order to achieve better remuneration and career prospects, many experienced allied health professionals are choosing to move out of clinical areas into such fields as management and education, resulting in shortages of clinical practitioners. (sub. PP267, p. 6)

Similarly, in commenting on the reasons behind the current nursing shortage in Australia, the Australian Nursing Federation pointed to:

> … the availability of broader career opportunities for women; increasing rates of movement between careers during a working life; poor working conditions; low rates of pay compared to other careers, and the near absence of effective retention policies … (sub. 137, p. 13)

State and Territory Governments have in fact implemented a range of initiatives to improve retention and re-engagement. The South Australian Government, for example, commented that 'major efforts have been made in regard to the recruitment and retention of the medical workforce, particularly nurses and rural doctors' (sub. 82, p. 40). Similarly, the New South Wales Government stated that this was a priority area in that jurisdiction (sub. 178, p. 16).

Governments also pointed to the considerable success of many of these initiatives. Some examples in the specific area of nursing are described in box 3.3. One such development has been the adoption of measures to manage nursing workloads such as reasonable workload clauses in public sector awards and mandatory nurse-patient ratios (though the case for the latter is not universally accepted).

Nonetheless, participants called for a range of additional financial incentives to be provided by the Australian Government to improve retention and encourage re-entry. For example, the Victorian Government (in advocating health-specific changes to fringe benefits tax and superannuation policy) said:

Box 3.3 Nurse retention and re-entry campaigns

Policies to address retention and re-entry problems have been implemented by all State and Territory Governments. Some examples include:

Victoria

In September 2000, the Victorian Government introduced a state-wide campaign with a key feature being the provision of funding to public health facilities for re-entry, refresher and supervised practice programs to encourage nurses to return to the workforce. Elements of the campaign included: award rates of pay while undertaking re-entry/refresher courses; advertising and promoting nursing as a career choice; the Victorian Nurse Back Injury Prevention Program — regarded as a significant factor in staff retention — and midwifery up-skilling for over 400 rural and remote midwives. According to the Victorian Government, these initiatives have proven to be an effective means of increasing nursing workforce supply — with over 2300 nurses being recruited back into the public health care system. It also commented that 'available data for a range of health professions currently in demand in health services suggest there are non-working pools that could potentially be attracted through similar campaigns'.

New South Wales

The New South Wales Government has implemented a range of specific recruitment and retention initiatives including: a re-entry program providing paid training for enrolled and registered nurses out of the workforce for a number of years; funding to train an additional 300 enrolled nurses; a nurse scholarship program targeting areas of workforce shortage; study leave funding to enable positions to be 'backfilled' while nurses are undertaking tuition; professional and clinical skill development programs; and improvements in working conditions through higher remuneration. According to the New South Wales Government, these strategies are 'generating good results' with over 5000 nurses either being recruited or returning to the NSW public health workforce between January 2002 and July 2005 — a 15 per cent increase.

South Australia

The Department of Health's Nursing and Midwifery Recruitment and Retention Strategic Directions Plan 2002–2005, provides a strategic approach to supporting recruitment and retention of SA nurses and midwives. The Plan focuses on more flexible and family friendly workplaces, awards for excellence, vocational and postgraduate training, specific Indigenous and rural projects, as well as the opportunity for workplace review and reform. Refresher and re-entry programs are provided for nurses and midwives who wish to return to the workforce, as well as up-skill and refresh their knowledge. The programs are free of charge and supported by student scholarships.

Queensland

The Queensland Government has announced the provision of a refresher program to 200 nurses in specialty areas and other incentives to attract former nurses back to the profession.

Sources: Victorian Government (sub. 155), NSW Government (sub. 178), SA Government (sub. 82), Queensland Government (2005).

> Incentives to encourage skilled staff to re-enter the health workforce will be increasingly important. In addition to incentives offered by states and territories (such as subsidies to complete retraining), there is a need to consider how Commonwealth employment incentives could be best structured to complement such initiatives. Retaining staff will also be essential to achieving workforce sustainability, and once again, may necessitate a range of state and commonwealth supports, including remuneration incentives whilst training and increased access to child care for staff returning to work after family leave. (sub. 155, p. 25)

Such proposals would of course represent a shift in responsibility for health workforce funding from State and Territory Governments to the Australian Government. And as noted above, this is not a study into the adequacy of health budgets. Accordingly, in the Commission's view, such proposals are more appropriately considered in a collective forum by those responsible for health services funding. In that context, the Commission notes the parallel CoAG Senior Officials exercise is canvassing issues including the supply, flexibility and responsiveness of the health workforce. In responding to the report by its Senior Officials, CoAG could also assess whether national approaches to retention and re-entry are required.

Initiatives to improve efficiency, effectiveness and responsiveness

However, in the Commission's view, measures aimed at boosting the supply of health workers will not by themselves be sufficient to provide a sustainable solution to Australia's health delivery needs. In particular, they will not address inefficient and inflexible workplace arrangements that reduce the productivity of the available workforce.

Hence, in addition to strategies to moderate demand and thereby the need for more health workers, initiatives which improve the efficiency, effectiveness and responsiveness of the health workforce system will be critical to achieving the sustainability goal. In the words of the Queensland Health Systems Review:

> Longer term innovative ways of delivering health services are needed to provide health care sustainability. Simply providing more doctors, more nurses, more beds and more money is unlikely to be sustainable. (QHSR 2005, p. xii).

Similarly, in commenting on avenues to improve workforce outcomes in general practice, the submission from the Australian Divisions of General Practice noted:

> The solution is not just a 'numbers game' or about higher rebates – different modes of working within the primary care setting are needed. While these are important aspects

> of the primary health care system, they are not solutions to contemporary health workforce issues in their own right or in isolation. (sub. 135, p. 2)

Demand management strategies

A number of participants pointed to the potential for demand management strategies to improve health outcomes and thereby reduce the pressure on the health workforce. The Australian Health Ministers' Advisory Council, for example, said:

> 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. (sub. 166, p. i)

A range of specific initiatives has been canvassed in this area including additional resources being made available for health education and health promotion, investment in early intervention and prevention activities and support for self-management by patients. But while investment in such initiatives may well be worthwhile, again there would be funding implications — either through the redistribution of existing health budgets, or through increasing the size of those budgets. Thus, like additional support for education and training places or for retention and re-entry initiatives, the Commission considers that demand management options would be most appropriately considered by CoAG in response to the report of the Senior Officials.

Removing barriers and impediments

The Commission considers that this study can add value by addressing barriers and impediments in the current institutional and procedural frameworks that create perverse incentives, or otherwise detract from the efficient and effective delivery of workforce services across the whole of the health workforce.

Though on occasion the removal of barriers and impediments may result in the cessation of particular arrangements, it is more likely to lead to the modification or streamlining of existing arrangements, where they continue to have legitimate objectives. For example, while professional registration arrangements will continue to provide assurances to the community in terms of quality and safety, they could be amended, in conjunction with changes to accreditation, to facilitate wider scopes of practice and job redesign (see chapter 7).

To a large extent, this approach would enhance workforce responsiveness in accordance with the limited 'market forces' that exist within the current framework. That is, adjustment would be driven by the incentives facing the various stakeholders — the mechanism relied upon in most markets to deliver the best

possible outcomes. As such, the approach would avoid some of the risks inherent in a more directed approach where policy makers override existing market forces and impose their own judgments as to what constitutes appropriate workforce arrangements (see below). It would also allow the workforce to develop and adapt in 'familiar territory' and build on the considerable change that has occurred to health workforce arrangements in recent years.

A more active approach

Equally, there are limits to what such an 'incentives-based' approach could achieve:

- As noted, many of the incentives are driven by the constitution of the broader health and education and training systems, which are not under review in this study — fee-for-service medicine being a case in point.
- The approach would not provide explicit levers to address entrenched custom and practice, or to deliver the coordination required to ensure complementary change in the different parts of the health workforce apparatus.
- And under this approach, there is no process by which the complexities and tradeoffs often involved in major job redesign can be fully evaluated.

In such situations, an active approach which both identifies the desired end point of reform and mechanisms for achieving those desired outcomes, is likely to have advantages over a non-directive and incremental 'incentive-based' approach. As well as providing a vehicle for cutting through entrenched custom and practice, it would also facilitate the effective coordination of the reform process. As noted, especially for significant workforce changes, complementary policy actions are often required at several points in the system, usually involving different levels of government. And perhaps most importantly, an active approach could be helpful in promoting greater emphasis in policy making and evaluation on how to get best value from the whole of the health workforce, rather than from particular groups of health workers.

The Commission acknowledges that such an approach is not without risks. As experience in a range of other areas illustrates, directive judgments made by policy makers do not always prove to be correct, imposing sometimes significant costs on the community and impeding rather than facilitating adjustment.

However, in the Commission's view, with sensible implementation and effective governance arrangements, such risks need not be excessive. Accordingly, and in the light of the limitations in some situations of relying solely on improved incentives, it has proposed more active reform approaches in a number of key areas.

4 Workforce innovation

Key points

- There has been considerable change and innovation in health workforce deployment across Australia in recent years.
  - This has included improvements in workplace efficiency and the growing use of inter-disciplinary and multidisciplinary approaches to patient care.
- However, the evidence suggests that various opportunities for more significant workforce innovation, including broadening scopes of practice and more major job redesign, have not been progressed, or even properly evaluated.
  - Evaluation of the case for nurse practitioners, for example, has been ad hoc, jurisdictionally based and drawn out.
- Adjustments to institutional, regulatory and funding arrangements, as discussed in succeeding chapters of this report, will encourage some ongoing workforce innovation.
  - On their own, however, they are unlikely to be sufficient to guarantee that major opportunities for innovation will be considered on a national, systematic and timetabled basis.
- A national advisory agency should be established, to identify, evaluate and facilitate nationally significant workforce innovations:
  - Its framework would be based on quality, safety and cost effectiveness. It would assess and report publicly on implications for the workforce directly and for such matters as education and training; accreditation and registration; and funding.
  - Its governance arrangements would be based on health, education, financial and consumer knowledge and experience, structured to reflect the public interest generally rather than represent the interests of particular stakeholders.
  - The agency would complement local initiatives, focusing on innovations that may have national significance, including those that involve cross-profession collaboration.

A key message from the preceding chapters is that increases in the level of demand for health services as technology develops, the population ages and community expectations increase, are likely to lead to major health expenditure pressures over the next few decades. As well, the nature of health services demand is changing significantly. And current workforce shortages and other problems must be addressed.

An improvement in the efficiency and effectiveness of health workforce arrangements is one important response. This will involve such changes as better workplace practices, enhanced coordination between professionals and the introduction of broader scopes of practice. Each, however, may require action across a range of policy areas, for example: education and training; accreditation and registration; and funding and payment arrangements; as discussed in the following chapters.

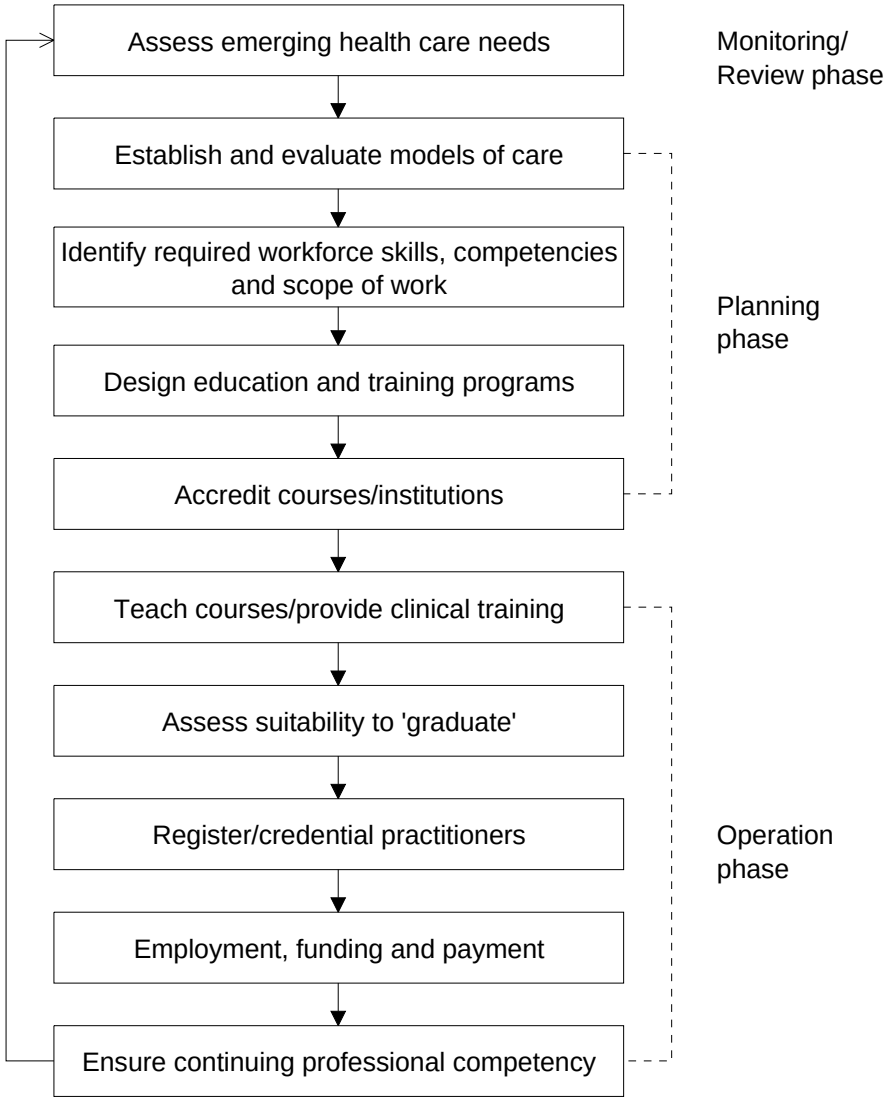
This chapter commences with an overview of relevant institutional and regulatory arrangements and recent developments in workforce deployment in Australia and overseas. Then, based on the Commission's judgment that the changes canvassed in the following chapters are unlikely on their own to be sufficient to guarantee the consideration of 'major' opportunities for workforce innovation and improvement, the chapter discusses the role for a health workforce improvement agency.

4.1 The institutional and regulatory framework affecting workforce deployment

Conceptually, workforce deployment is influenced by several linked sequential processes (figure 4.1). These include: monitoring and review, where changing and emerging health care needs are assessed, together with the implications for service delivery and education and training arrangements; a planning phase involving the design of models of care and education and training courses, and the accreditation of curricula and institutional arrangements; and an operation phase which includes the delivery of education and training, registration, employment, funding, payment, care giving and continuing professional development. All of these processes can have a very significant influence on how and by whom health services are provided.

A number of health sector institutions and regulatory bodies are involved at various stages of job design and deployment. Some play a role across a number of processes — for example, accrediting bodies may also be involved in testing overseas trained practitioners for registration purposes and in curriculum design. Further, there are differences across professions as to which entities undertake which roles — for example, accreditation is carried out by professional associations for some professions, by registration boards for others and, in some cases, by specialist accreditation agencies. And as well as there being health-specific institutions and regulatory arrangements, and health services funding and payment arrangements, there are also broader arrangements that impact on health workforce deployment, such as policies relating to the public subsidy and regulation of education and the generally applicable industrial relations system.

Figure 4.1 **Processes influencing workforce deployment**



Some of the most prominent entities that control or impact on workforce deployment and scopes of practice include: governments; bodies with delegated powers (including registration boards and some accreditation agencies); employers; educators and trainers; professional associations; industrial associations; and health insurers (box 4.1). State and Territory Governments play a particularly important role — so that even where national approaches are warranted, the ability to 'make things happen' often lies with those jurisdictional governments.

4.2 Recent developments in Australia and overseas

Australia

Within these broad institutional and regulatory arrangements, there has been

considerable change in workforce deployment practices in Australia over recent years, across a number of areas. New or extended roles for workers in particular job settings have been adopted and there has been growing use of inter-disciplinary and multidisciplinary team-based approaches to care. Box 4.2 gives some examples.

Box 4.1 **Roles in workforce deployment**

Governments

Even though the Australian Government provides a significant share of funding, the State and Territory Governments carry ultimate responsibility for many matters affecting the workforce, including quality and safety. Governments also have an influence through the broader industrial relations system.

Registration and accreditation bodies

Most health practitioners are required to be registered to protect public health and safety. Registration boards often assess practitioners against relevant standards and qualifications approved by accreditation agencies. They also ensure continuing professional competency.

Educators/trainers

Universities, VET and other education and training institutions, professional associations, health service providers and individual clinicians deliver education and clinical training to health workforce professionals. They develop course structures, curricula and training programs, often subject to approval from the relevant accreditation agencies, and examine the competence of students and trainees.

Employers and industrial associations

Workplace practices, rules and regulations play a role in shaping workforce deployment through, for example: workplace-specific processes for credentialing and defining the scope of clinical practice for various practitioners; rules governing whether and how frequently practitioners may practise within the establishment; and through their influence on industrial relations agreements.

Professional associations

Professional associations influence deployment through their formal and informal input into accreditation, registration, credentialing, and education and training, including continuing professional development. Entry rules and conduct codes developed or administered by such bodies also influence what is possible in the workplace.

Insurers

The nature and extent of coverage provided by both medical indemnity insurers and private health insurers affects the settings, provision, and nature of care.

In general, however, most workforce changes have involved either initiatives in particular job situations or greater use of team based approaches, with only limited role-based innovation on a wider basis. Further, the process for evaluating major innovation options — and facilitating their adoption when found to be worthwhile — is deficient. In the case of nurse practitioners, for example, consideration has been ad hoc, jurisdictionally based, drawn out and not accepted by all relevant stakeholders (box 4.3).

Box 4.2 **Examples of workforce changes in Australia**

Workplace improvement

- At the Flinders Medical Centre, a study of the patient journey to highlight duplication, delays and potential errors, led to improvements in patient care, increased productivity and a reduction in staff turnover (sub. 82, p. 39).
- In a number of Queensland hospitals, physiotherapy departments in conjunction with orthopaedic surgery departments have commenced a 'fit for surgery' project, which aims to reduce cancellations for elective surgery through ensuring fitness preoperatively (sub. 171, p. 12).

Formalised teamwork and multidisciplinary approaches

- In Victoria, Barwon Health has developed a Community and Mental Health Program based on a multidisciplinary, care management model. Its Community Mental Health Teams, for example, comprise a psychiatrist, a psychiatric registrar, nurses (with psychiatric registration or endorsement by the Nurses Board of Victoria) and at least one social worker, psychologist and/or occupational therapist. Barwon Health considers the teams a success and is transferring the model to other services.
- In NSW, integrated primary health care services are being developed, where groups of GPs, community health workers and other clinicians will provide 'accessible and appropriate care' in the community, with the aim of preventing unnecessary admissions or readmissions to acute care (sub. 20, pp. 11–12). In addition, as part of the Sustainable Access Program, hospital-level innovations are being trialled. Solutions to patient flow problems identified by staff at John Hunter Hospital, for example, included multidisciplinary care meetings to improve coordination of patient care between units (ARCHI 2004).
- Two rounds of coordinated care trials have been funded by the Australian Government, with the aim of reducing hospitalisation of people with chronic or complex needs by managing and coordinating their care (see box 10.8 in chapter 10). Individual care plans spanning primary, acute and allied health services, and the pooling of funding from existing government programs, are key features of the trials.

(Continued next page)

Box 4.2 (continued)

New or extended roles and practitioner substitution

- There has been an expansion in nursing roles. For example, Queensland employs Rural and Isolated Practice Endorsed Nurses and Sexual and Reproductive Health Endorsed Nurses, while South Australia is trialling a nurse colonoscopist role.
- In some jurisdictions, midwives may undertake 'enhanced roles', which allow them to order and interpret routine laboratory tests during pregnancy, labour and delivery, as well as administer pharmaceuticals.
- The Northern Territory has developed competencies for Aboriginal Environmental Health Workers — community based health personnel who will undertake key environmental health duties (sub. PP182, p. 23).
- According to the Council of Remote Area Nurses of Australia, in remote primary care clinics, nurses and Aboriginal Health Workers substitute:

  … a range of GP and allied health services in the absence of ambulances, chemists or pharmacies, radiology services, dentists, social workers, and drug and alcohol services. (sub. 134, p. 6)

While the Commission offers no judgments about the merits of particular possible changes — and notes that many have detractors as well as supporters — the case study of podiatric surgeons (box 4.4) also shows the lack of an agreed formal assessment process under which the benefits and costs of the more significant innovation opportunities can be evaluated.

The UK and USA

In many cases, other countries appear to have moved significantly faster and more proactively than Australia in workforce innovation. The specific institutional and regulatory arrangements of these countries appear to have a more strategic and systematic approach to such innovation than does Australia.

For example, the United Kingdom has trialled a large number of new roles in recent years, across the spectrum of health professionals. As it was considered that expanding the workforce would not, by itself, be sufficient to deliver the desired improvement in patient service, the National Health Service (NHS) Modernisation Agency set up a Changing Workforce Programme (CWP). This created 13 pilot sites to focus on testing, developing and implementing role redesign.[1] The pilots

[1] The CWP closed at the end of March 2005, but aspects of its work are continuing through other programs, such as the National Practitioner Programme (NPP) and the Career Framework for

were assessed in early 2003; overall, it was found that role redesign and changes in the scope of practice had made a difference and led to service improvements — reductions in waiting times, more personalised care, better management of workloads, increased job satisfaction, development of specialist skills, reduced

Box 4.3 **Nurse practitioners in Australia**

Nurse practitioners are nurses with advanced educational preparation who can function autonomously and collaboratively in an expanded clinical role. They may prescribe medications, initiate diagnostic investigations and refer patients, but only in accordance with clinical guidelines while practising in defined positions. From initial investigation of the concept in the early 1990s, there are still only a handful of authorised nurse practitioners operating in Australia, with NSW having the most (54 currently employed with a further 26 in transitional arrangements — Queensland Health 2005).

Many doctors and pharmacists have been reluctant to accept the introduction of nurse practitioners, expressing concern over a number of issues, including with prescribing. Recently, the AMA has stated that patients are being 'short-changed' when offered care by a nurse practitioner instead of a GP:

> When GPs examine a particular ailment, they are assessing the whole person. … [Nurse practitioners] don't have the diagnostic ability to analyse patient history and look at symptoms with regard to total systems in the body. Nor can they work out management plans for an individual that take into account the whole person. (Glasson 2005)

There are also regulatory and funding barriers to the wider practice of nurse practitioners, for example:

> … as there is limited opportunity for nurse practitioners to operate under the Medicare Benefits Scheme, it is difficult for such roles to exist, when clients who use a nurse practitioner are required to pay full fees. (South Australian Government, sub. 82, p. 32)

And in seeking to introduce nurse practitioners, each jurisdiction has moved at a different pace, with seemingly uncoordinated processes of review and different trial procedures. While jurisdictions have had to work through their own legislative barriers to change, such as Poisons Acts and so on, it appears that opportunities for greater inter-jurisdictional learning, coordination and cooperation have been missed.

The experience with nurse practitioners also illustrates that such major change can be very difficult to progress in the face of opposition from key workforce groups. The Australian Nursing Federation commented:

> One of the major obstacles to the utilisation of nurse practitioners in Australia is the opposition of medical practitioners; opposition which has its roots in their desire for control over the activities that nurse practitioners undertake (such as prescribing medicines, initiating diagnostic investigations), which they see as their exclusive domain. (sub. 137, p. 6)

Health. The Modernisation Agency was dissolved and superseded in July 2005 by the NHS Institute for Innovation and Improvement.

vacancies and turnover, better attitudes to change and the creation of more attractive jobs (NHS 2003, p. 5). A more recent example of health workforce change in the UK is the announcement in November 2005 that independent prescribing rights for qualified nurse prescribers and pharmacist prescribers will soon be extended to 'any licensed medicine for any medical condition — with the exception of Controlled Drugs' (UK Department of Health 2005).

Box 4.4 **Podiatric surgeons**

Most foot surgery in Australia is carried out by orthopaedic surgeons specialising in foot and ankle surgery. However, some podiatric practitioners also offer surgical services — the profession emerged in Australia in 1978 and there are currently 25 podiatric surgeons, with a similar number of trainees. Countries such as the US and UK utilise podiatric surgeons to a much greater extent — for example, 80 per cent of all foot surgery in the US is performed by podiatrists.

Podiatric surgeons have argued that there is scope for them to undertake a greater amount of foot surgery, at lower cost and with the same or better outcomes than surgery provided by orthopaedic surgeons. They have claimed that greater usage of podiatric surgeons has the potential to increase the productivity of both podiatric surgeons and orthopaedic surgeons, as each professional group would provide services more in line with their skills and training. The Australasian College of Podiatric Surgeons also argued that regional areas could benefit — 'there are podiatric surgeons available to provide a service but the barriers … prevent their workforce participation' (sub. 131, p. 9).

However, as well as opposition from orthopaedic surgeons, there appear to be various regulatory and funding barriers to greater workforce substitution in foot surgery:

> As a small emerging profession [podiatric surgery] is struggling in an environment which has systemic and regulatory constraints maintained by governments, private health insurers and the model under which the current health care system operates. (Australasian College of Podiatric Surgeons, sub. 131, p. 5)

The College went on to provide a list of specific barriers which included:

- state regulations which exclude podiatric surgeon from the definition of medical practitioner;
- lack of access to surgical rights in public hospitals;
- unwillingness of private health insurers to provide rebates for services provided by podiatric surgeons;
- lack of rebates to medical practitioners (eg anaesthetists, pathologists and radiologists) who provide services to patients of podiatric surgeons; and
- no uniform or national access to prescribing privileges for the independent management of patients' pharmacological needs (sub. 131, p. 3).

The United States also has a wider range of professional roles than Australia, many introduced decades ago in response to demand and supply pressures. For example, the first physician assistants graduated in 1967 — they now number more than 50 000 and, in 2003, treated around 192 million patients, under physician supervision, but often without their immediate involvement (AAPA 2004, p. 12). They are able to conduct physical examinations, diagnose and treat illnesses, order tests, counsel on preventive health care, assist in surgery and, in virtually all States, can write prescriptions (Department of Health and Ageing, sub. 159, p. 18). And certified registered nurse anaesthetists began practising prior to 1900, now carrying around 65 per cent of the anaesthetic workload, often independently (Professor Wayne Gibbon, sub. 48, att. 2, p. 1).

Of course, some overseas models may be more appropriate for Australia than others. The Commission notes, for example, that the Australian and New Zealand College of Anaesthetists considered the model being developed in Canada, where anaesthesia assistants work under the supervision of specialist anaesthetists, is 'much more appropriate' than other models 'whether from the USA, UK, Europe or developing countries' (sub. PP 236, p. 2).

Importantly, major workforce innovations in other countries have often been explicitly facilitated by changes to other policies — for example, while the advanced practice nurse role in the United States evolved in response to shortages of physicians and advocacy by the nursing profession, it was notably supported and encouraged with federal funding and legislative changes (Buchan and Calman 2005, p. 37).

4.3 An active approach to workforce innovation

Succeeding chapters of this report discuss a range of barriers and impediments to better health workforce deployment arising from arrangements in such areas as education and training, accreditation and registration, and funding and payment mechanisms. Changes proposed in those chapters should encourage better utilisation of the workforce. However, in the environment described above, the Commission considers it is unlikely that such changes will be sufficient to facilitate more major job innovation.

It has been acknowledged that it is imperative for Australia to make better use of its health workforce. In this context, Principle 5 of the National Health Workforce Strategic Framework recognises that the realignment of existing workforce roles and the creation of new roles may be necessary to make optimal use of workforce skills and ensure best health outcomes (see box 3.2 in chapter 3).

Some participants supported role change in some situations, but not in others (box 4.5). The Australian Doctors' Fund argued that many of the technical divisions in medical practice have developed so as to clearly delineate roles and responsibilities in the interest of patient safety:

> The doctor/patient relationship is the cornerstone of quality medical practice. Creating roles that blur the division between a medical practitioner and a non medical practitioner will promote uncertainty and lower the confidence of the Australian public in the medical profession. (sub. PP192, p. 1)

A number of nursing organisations such as the Nurses Board of Western Australia (sub. 141) and the Australian Nursing Federation (Victorian Branch) (sub. 133) were concerned that unskilled workers could be introduced to undertake roles that are currently undertaken by registered health professionals such as nurses. They considered this would lower safety standards and public confidence in the health system (NSW Nurses' Association, sub. 139). But, in contrast, these organisations generally supported the development of the nurse practitioner role.

In the Commission's view, such comments illustrate the importance of providing for detailed case by case assessments of specific innovation opportunities. Indeed, major changes to existing scopes of practice and roles can be complex, with implications for not only the health workforce but also for health service providers, education and training arrangements, accreditation and registration agencies, governments in their capacities as health funders, private insurers and so on. Changes in one area can have flow-on effects in others — for example, enhancing the ability of nurses to substitute for doctors in some roles could exacerbate an existing nursing shortage. Difficult judgments are often required in relation to the weightings that should be accorded to the range of conflicting objectives that can arise in such situations. And uncoordinated or ad hoc approaches to existing roles and scopes of practice may well delay nationally based reform and be counterproductive, especially if they focus on the immediate problems or ignore inter-jurisdictional issues.

These considerations suggest that there would be merit in establishing a formal institutional arrangement — a health workforce improvement agency — to assess the contribution that such changes could make to improving the efficiency and effectiveness of service delivery if applied more generally, within a framework of maintaining or enhancing the safety and quality of care. Such an agency would identify, from the richness of innovation both locally in Australia and overseas, those areas of major job evolution/substitution and redesign that have potential national significance and could be of net benefit to the community.

Box 4.5 **Participants' comments on assessing job redesign**

Queensland Nurses' Union (sub. 80, p. 17):

> Appropriate consultative arrangements involving all key stakeholders must be established and proposed changes to skill mix and role boundaries must be based on evidence and any changes subject to rigorous monitoring and evaluation processes. … the primary objective is to ensure timely access to safe, high quality, evidence based and appropriate health services for the community.

Professor Wayne Gibbon (sub. 48, p. 5):

> Significant workforce reform is required to change existing service delivery models and roles within the workforce. … the health provider community should plan such reform in a well considered way, design the changes that are required and educate for them …

The Victorian Government (sub. 155, p. 38) proposed the establishment of a 'National Health Workforce Planning Council' which would have a number of roles, including to:

> … develop planning methodologies that support innovative workforce models and work redesign.

Western Australian Government (sub. 179, p. 26):

> Identifying those changes to workforce roles and skills sets that are beneficial while maintaining standards of health service delivery is the challenge ahead. … Approaches will need to address the current entrenched compartmentalisation of the health workforce into occupational groups which is reinforced by current regulation, accreditation, training and industrial relations frameworks.

South Australian Government (sub. 82, p. 43):

> National leadership on the direction of workforce reform and the need to have breakthrough solutions that may fundamentally change the way current health professions are structured and trained is necessary if progress is to be made. It is essential that this be linked to the development of new service models.

Tasmanian Government (sub. PP180, p. 16):

> [Create] a national body to undertake whole-of-health workforce planning with a long range outlook [with a range of functions including] assessment of innovation which may enhance productivity through changes to roles, models of care, processes and technology.

ACT Government (sub. 177, p. 1):

> [there should be] a national focus on workforce and workplace redesign with the goal of realigning competencies with improved job roles. A focused, targeted examination of health professional workers, such as allied health professionals, might provide the initial evidence for piloting expanded scopes of practice that includes more complex clinical skills.

CDAMS (sub. 49, p. 2):

> To address the problems of healthcare workforce shortage and maldistribution, there is a need for appropriate short and long term planning underpinned by well validated evidence and real understanding of the community's needs which requires a coordinated and cooperative approach and a long term vision which transcends electoral cycles.

AMA (sub. 119, p. 4):

> Many of the proposals for substitution would have a marginal impact on the availability of medical practitioners and create very significant quality and safety issues at first consideration. It is up to the proponents of these schemes to make the case that they can be introduced without detriment to quality and safety.

The work of such an agency would not be directed specifically at solving shortages of particular skills, or merely at reducing expenditure through improved efficiency of service delivery. Rather, its focus would be on actively and transparently evaluating job innovation opportunities and the appropriate scopes of practice in an unbiased and objective manner. Its success in this role is likely to be much greater if it receives support and cooperation from governments, employers, professional and industrial associations, and other key stakeholders.

4.4 Establishing a health workforce improvement agency

In its Position Paper, the Commission proposed the establishment of an Australian health workforce improvement agency, along the lines discussed above. In response, there was widespread in-principle support for that draft proposal from a range of participants including State and Territory Governments, the Department of Health and Ageing, the AMA, nursing groups and bodies representing the allied health professions. (Some examples of views are included in box 4.6.)

However, there were a number of caveats presented, generally relating to the proposed agency's functions, approach, governance and likely effectiveness. These comments have reinforced the Commission's view that getting the detail right in such areas will be crucial to the agency's success in facilitating significant workforce reform. Accordingly, the Commission has set out below its views on some of the central issues.

Independence

It would be possible to add the functions outlined below to the responsibilities of existing agencies or committees, such as AHMAC, or to those of the other new bodies proposed by the Commission (see later chapters).

Indeed, a number of participants, including the Society of Hospital Pharmacists (sub. PP207), the Confederation of Postgraduate Medical Education Councils (sub. PP298) and the Australasian Podiatry Council (sub. PP281), called for a single agency to combine the functions of the health workforce improvement agency and the proposed health education and training council (see chapter 5). The APA (sub. PP271) and the Health Professions Council of Australia (sub. PP267) considered that this agency should also be responsible for numerical workforce planning, in effect the approach favoured by some other participants including the Victorian Government in its initial submission.

Box 4.6 **Examples of participants' comments on a health workforce improvement agency**

The Department of Health and Ageing commented there would be:

> … advantages in the proposals to establish new advisory structures, reporting directly to Health Ministers, on initiatives to promote health workforce innovation ... (sub. PP293, p. 5)

The State and Territory Health CEOs:

> … support the proposed establishment of a national health workforce improvement agency … (sub. PP332, p. 9)

The Tasmanian Government agreed:

> … that a dedicated approach is required to achieve better outcomes in relation to health workforce innovation. … careful consideration will need to be given to resourcing, change management processes and the governance arrangements associated with the agency. (sub. PP 339, p. 5)

The Victorian Government:

> … supports the proposed establishment of a national health workforce improvement agency, but believes that the functions proposed for an advisory health workforce education and training council … should be combined with those currently proposed for this agency. (sub. PP297, p. 2)

The College of Nursing said:

> The establishment of one advisory agency is vital if we are to identify models and practices which meet appropriate health outcomes, facilitate job redesign and enable innovative opportunities. Without a united approach, individual groups will continue to work in isolation with vested interest as the core of decision making rather than a more global view of the best workforce for society. (sub. PP292, p. 1)

The Australian Medical Association (AMA) in its support said:

> The AMA supports the recommendation for an advisory health workforce improvement agency and strongly advocates medical profession involvement in such a body. (sub. PP315, p. 6)

The Australian Physiotherapy Association (APA) also agreed:

> … there is a need for a body focusing on workforce improvement and innovation and that … agency should be advisory in nature. (sub. PP 271, p. 10)

However, not all participants were supportive. The Victorian Branch of the Australian Nurses Federation (ANF) said:

> ANF (Vic Branch) does not believe that the establishment of a further advisory agency at the Federal level would further the development of workforce innovation. We believe that existing mechanisms for consultation and advice could perhaps be enhanced and facilitated rather than yet another body established. (sub. PP287, p. 1)

However, in the Commission's view, the workforce improvement agency should be established as a stand alone entity:

- Its functions and the expertise required of its board members (see below) would be different from existing bodies, as well as from the other new bodies proposed

by the Commission. In particular, the agency would be required to undertake extensive evaluation and assessment of innovations against a broad range of criteria, including patient quality and safety, broader health effectiveness, education, and economic/financial criteria. Combining these functions with other roles could cause a loss of focus and thereby reduce the effectiveness of the assessment process.

- As the prime evaluator and facilitator of nationally significant health workforce reform, the agency's credibility and effectiveness will rely fundamentally on its independence, transparency and whole-of-community perspective — thus it is important that it be seen to be independent of existing arrangements, workforce interests and professional groups.

While setting up a new agency will increase administrative overheads and could give a perception of greater bureaucracy, the Commission considers that there would be nonetheless significant net benefits from that approach.

The Commission envisages that the agency would be national, agreed to by all jurisdictions through the Australian Health Ministers' Conference, and established by the Australian Government.

Advisory body

Some participants considered that the agency should be given the power to carry through its findings about job substitution and redesign into operation — in effect, implementation powers. For example, in responding to the Position Paper, Speech Pathology Australia stated its view that:

> Unfortunately, a major limitation of the proposed agency would be its inability to impose/enforce its recommendations. Whilst this agency would be linked to other key health workforce agencies, without the power or capacity to force implementation of its recommendations, any ability to achieve workforce innovation or change may prove difficult. Consideration should be given to providing this agency with powers of implementation ... (sub. PP260, pp. 3–4)

However, even if this was feasible, it would extend the agency's functions significantly beyond those envisaged by the Commission. It would result in a degree of overlap with other bodies, including the accreditation and registration agencies, education and training institutions, as well as the jurisdictional health departments. The Commission considers that it is particularly important that there is a clear and uncompromised remit for those bodies tasked with regulatory functions.

More fundamentally, 'automatic' implementation would detract from the sovereignty of jurisdictions in managing their health and wider budgets (also see the

discussion in chapter 9 about the advisory nature of workforce numbers projections).

Thus, in the Commission's strong view, the new agency should be advisory in nature. Specifically, it should report publicly and make recommendations to AHMC (though in practice AHMAC would be providing relevant briefings to AHMC).

Consideration was given to recommending that the head of the improvement agency should also be a member of AHMAC, to further its effectiveness in driving beneficial workforce innovation. On balance, however, the Commission judges that this could be seen to compromise its independence.

The agency would, however, need to develop sound relationships with, and where appropriate provide advice to, other existing and proposed agencies — including the health and education council (chapter 5), accreditation and registration agencies (chapters 6 and 7), and the MBS review committee (chapter 8), as well as the Australian Commission on Safety and Quality in Health Care (Health Ministers 2005) and the Australian Research Council (ARC). Its published reports would assist those agencies in their work.

Finally, the agency will only be successful if it is seen to have authority in terms of the quality of its work and the soundness of its conclusions. Accordingly the agency should be provided with adequate funding and resources. The efficiency of its operations and its effectiveness in facilitating workforce change should be reviewed after an appropriate time — the Commission suggests five years.

Functions and approach

The agency's terms of reference would concentrate on evaluating major job evolution/substitution and redesign opportunities that have the potential to improve the efficiency and effectiveness of service delivery if applied more generally, within a framework of maintaining or enhancing the safety and quality of care.

The agency would assess situations where existing scopes of practice could be broadened and where changing the legal responsibility for the patient's welfare is contemplated. It would assess the benefits of better multidisciplinary approaches to care, as well as the efficiencies from better utilisation of the existing workforce and health facilities. It would give full consideration to the implications for the workforce itself, and to the interests of their professions.

A benefit–cost multidisciplinary approach would underpin the agency's assessments. Its reports would identify the broader institutional and regulatory implications for the health and education systems, including accreditation and

registration, as well as the financial implications. Where considered desirable, the agency could cooperate in targeted pilot studies.

In all cases, the focus would be on changes which could be applied widely across many workplaces. It would complement the wide range of local innovations that are being developed in individual workplaces or initiated collaboratively between professions. Chapter 13 sets out an example of how the agency would operate within the new regime proposed by the Commission.

Where appropriate, the agency's coverage would extend to the unpaid health workforce and to the aged care workforce. However, given the scope of this inquiry (chapter 1), the Commission has not examined the merits of establishing a separate improvement agency for the aged care workforce specifically, as requested by Resthaven (sub. PP186). In this respect, Aged and Community Services Australia (sub. PP230) called for the agency to be relevant to the aged care sector and not only focus on the acute sector.

As discussed in chapters 10 and 11, the agency should be explicitly required to take account of issues relating to rural and remote Australia and to groups with special needs in its work.

Agenda

Particular evaluative tasks could be referred by stakeholder groups through AHMC or initiated by the agency itself, drawing on local Australian innovations or overseas experience. Opportunities for change will already have been trialled in particular settings — this would continue to be encouraged. The agency should establish, through broad consultation, an annual work program so that major job opportunities can be analysed on a systematic and timetabled basis. The work program should be published on the agency's web site.

During the course of this study, participants have canvassed a wide range of specific job innovation opportunities, with still further possibilities evident from the experience of other countries. Some of these are more appropriately examined in the context of individual workplaces or jurisdictional health systems. However, several appear to be possibilities for broader consideration on a national basis by the proposed agency.

These include:

- expansion in the scopes of practice for midwifery, Aboriginal Health Workers and for various allied professions including physiotherapy, podiatry,

occupational therapy, radiography, sonography, pathological laboratory scientists, and pharmacy;

- revisions to skill mix in emergency departments and the appropriate use of the maternity workforce;
- the division of work in nursing, some allied health professions and pharmacy between the variously qualified professionals, for example between registered and enrolled nurses, and between physiotherapists and assistants in physiotherapy;
- more major job redesign such as the development of physician assistants, surgical care practitioners, rural health practitioners, nurse anaesthetists, medical assistants and paramedic practitioners; and
- the workforce needs of the aged care sector.

The Commission is not in a position to put forward a view on which of these, or any other, innovations should form the basis for the agency's initial investigations. Ideally, the agency would start with those possibilities likely to bring the greatest net benefit to the community on a national basis. Often, however, that may not be readily determined until after investigations are undertaken.

Governance

As many participants recognised, good governance will be crucial to the success of the agency in facilitating appropriate job innovation.

The Victorian Government said:

> The independence of the agency, and an effective governance structure, supported with adequate resources will be essential … (sub. PP297, p. 4)

Similarly, the Royal College of Nursing commented:

> Central to the effectiveness of an agency such as this is its governance. (sub. PP266, p. 3)

And the Queensland Government noted:

> It would be crucial that governance arrangements ensure that the 'public interest' is the agency's first concern and that it does not replicate or embed vested interests that exist in current arrangements. (sub. PP325, p. 8)

A first requirement will be for the agency's board to be comprised of members who collectively would bring with them the necessary health, education, finance and consumer knowledge and experience required.

Second, board members will need to give the highest priority to upholding the independence, transparency and whole-of-community values of the agency. In the Commission's strong view, although the names of potential members could be put forward by health departments, employers, universities and professional associations, they must be appointed as individuals for their own expertise, for a set term of 3 to 5 years (which could be renewed), and not as representatives of those sponsoring bodies. Further good governance practices are outlined in chapter 13.

RECOMMENDATION 4.1

The Australian Health Ministers' Conference should establish an advisory health workforce improvement agency to evaluate and, where appropriate, facilitate major health workforce innovation possibilities on a national, systematic and timetabled basis.

- ***Board membership should provide the necessary health, education, finance and consumer knowledge and experience, structured to reflect the public interest generally rather than represent the interests of particular stakeholders.***
- ***The agency should report publicly and make recommendations to the Australian Health Ministers' Conference as to appropriate workforce reforms and their implications, including for other health workforce arrangements.***
- ***The agency should, as appropriate, provide advice to other national agencies or bodies recommended in this report.***
- ***The agency's efficiency and effectiveness should be reviewed after five years.***

5 Health workforce education and training

Key points

- Responsibility for policy direction, funding and delivery of education and training for Australia's health workforce is shared across a broad range of players.
  - The system is complex, poorly coordinated, and insufficiently responsive to changing needs and circumstances.
- Ensuring that there is sufficient funding for education and training places will be one part of a multi-faceted response to current workforce shortages and growing future demands for health care.
- Changes to institutional, regulatory and funding mechanisms are also necessary to:
  - deliver better education and training outcomes from available funding; and
  - ensure efficient and timely adjustment of education and training arrangements to the changing requirements of those receiving and delivering health care services.
- To improve coordination between the education and training and health delivery sectors, the Australian Government should consider developing a health education agreement with State and Territory Governments for the allocation of places for university-based education of health professionals within each jurisdiction.
- To facilitate a more coherent approach to skills development, a health workforce education and training council should be established to provide independent and transparent advice on:
  - opportunities to improve health workforce education and training approaches (including for vocational and clinical training); and
  - their implications for courses and curricula and accreditation requirements.
- To put clinical training on a sustainable long term footing, a high level independent taskforce should be established to improve the information base and recommend changes to facilitate more transparent and contestable training arrangements, including through:
  - a more appropriate allocation of clinical training costs according to the benefits accruing to the various parties;
  - greater reliance on explicit payments for training services, within a system that will continue to rely on considerable pro bono service provision; and
  - removing regulatory or other barriers that impede the development of contestable delivery or otherwise impede efficient and effective clinical training outcomes.

5.1 Objectives of education and training

In a broad sense, the objective of health workforce education and training is to underpin the efficient and effective delivery of health services by providing the appropriate number and mix of health workers, equipped with the right skills and competencies. With skill needs continually evolving as a result of advances in technology, changes in the burden of disease and demographic shifts, it is particularly important that the health workforce education and training system is responsive to the changing demands put upon it.

Health workforce education and training outcomes are of course heavily influenced by the configuration of the broader health care and education systems. Settings in these broader systems impact on both the demand for, and supply of, health care workers and the services available to educate and train them.

And, requirements for health workforce education and training are necessarily aligned to the permitted scopes of practice for qualified practitioners in the various occupational groups. This again serves to highlight the need for the reform process to recognise linkages across the system so as to ensure that all of the cogs in the health workforce apparatus are moving in concert.

5.2 How does the current system work?

Responsibility for policy direction, funding and delivery of education and training for Australia's health workforce is shared across a broad range of players including two tiers of government, universities, vocational education and training providers, specialist colleges and professional associations, accreditation agencies and health service delivery bodies. The result is a complex system in which coordination problems abound, and which many claim is not sufficiently responsive to changing health care needs, or to opportunities to provide workforce services in new and more effective ways.

The complexity of the system, and the delineation of responsibility across levels of government, have also posed considerable challenges for the Commission in seeking to identify policy options that would deliver better outcomes in the future. As the later discussion in this chapter illustrates, in some areas, there are a number of reform possibilities, each with strengths and weaknesses. Hence, the choice of approach entails a degree of judgment.

University-based education

Education of most health workers is university-based, including for medical practitioners, registered nurses, dentists, pharmacists and all of the main allied health occupations.

The Australian Government has primary responsibility for policy and funding of the university sector (and for the accompanying HECS and student loan arrangements). It provides (differential) funding support for an agreed number of places in set discipline clusters, primarily on the basis of dialogue between the vice-chancellor of each university and the Minister for Education, Science and Training. However, for medicine, new places are jointly determined by the Minister for Education, Science and Training and the Minister for Health and Ageing.

In the past, universities have had considerable scope to subsequently vary the actual number of places in most health care courses (depending on demand and the cost of course provision), and even to unilaterally close or suspend entry to courses (eg podiatry), including in areas of workforce shortage. However, the Minister for Education has decided to introduce a clause in funding agreements which will require consultation before specialised and nationally significant courses are closed. This clause covers specialised heath courses in areas experiencing a national skills shortage. Also, under the new funding framework, adjustments can be made to a university's funding if the total actual number of places delivered by that institution varies beyond parameters set out in legislation and guidelines.

Students in places supported by the Australian Government pay fees (HECS) which vary according to course type. Universities can also enrol full fee-paying domestic and international students within certain limits.

Degree program design, content and length are determined by universities in consultation with the relevant professional associations/colleges and accreditation agencies such as the Australian Medical Council; the Australian Nursing and Midwifery Council; State and Territory Nursing Boards; the Australian Dental Council and peak allied health bodies. Undergraduate degree length is 3 years for nursing, 4 to 5 years for allied health courses and 4 to 6 years for medicine. However, entry to many health care professions is also possible through shorter postgraduate courses for those students with an accredited undergraduate degree.

VET

Though having a somewhat lesser overall role in health workforce education and training than the universities, the VET sector is the setting for the preparation of several important workforce groups, including enrolled nurses, various 'assistants' to more qualified professionals, some Aboriginal health workers and personal care workers.

These VET courses are funded by a mix of government funding and student fees. Two-thirds of governments' contribution comes from the States and Territories, with the balance provided by the Australian Government through specific purpose payments to the jurisdictions.

Until now, States and Territories have been primarily responsible for planning the numbers of publicly supported VET places, although the Australian Government has exerted influence through its coordination and funding role. That planning process has had regard to the needs of industry and an assessment of state priorities and economic development needs. However, under new arrangements, commencing from 1 July 2005, national training priorities and targets, including in relation to specific skill needs, will be given greater weight.

The specific training packages for health workers, providing nationally endorsed competency standards, qualifications and assessment guidelines, are progressed through the Community Services and Health Industry Skills Council, in consultation with State/Territory health departments, jurisdictional nursing bodies, training authorities, and the Department of Employment, Science and Training (DEST). Course duration is 12 to 18 months on a full-time equivalent basis. In addition, on-the-job or practical training is provided through traineeship and apprenticeship schemes which are subsidised by the Australian Government.

Clinical training

Undergraduate clinical training

Undergraduate clinical training in medicine and nursing usually involves placements in public hospitals. Much of the clinical training component of allied health courses also involves public hospital placements, though some is provided in private hospitals and in private practices. In public hospitals, trainers are either salaried employees or Visiting Medical Officers providing their time on a pro bono basis — though some States and Territories indicated that a training component is

included in remuneration arrangements. In other settings, delivery of training is typically pro bono.

Public hospitals may receive some payment from universities for the use of their facilities for clinical training purposes. Indeed, there is an explicit clinical training component in the Government's contribution to medical and nursing course costs. Also, provision has been made for additional funding of $54 million for clinical training provided to nurses (DEST personal communication). However, for allied health courses, there is no separately identified clinical training component in government funding. Hence, universities must meet the cost of any payments to public hospitals (or other training providers) from general funding sources.

Postgraduate clinical training

While there are postgraduate clinical training requirements in some nursing and allied health areas (see appendix B), such training is usually of limited duration. Much of this training is paid for by the practitioner concerned.

Specialist medical postgraduate training is of much longer duration — sometimes up to 10 years.

- The first step involves an intern year in an accredited public teaching hospital. Successful completion allows for registration to practise, but not access to the MBS. This is followed by a residency year, also in a public hospital.
- Those seeking to specialise seek entry to a specialist training college program approved or accredited by the relevant professional college. In the case of those seeking to become general practitioners, they enter the Australian General Practice Training Program, which is administered by GPET (General Practice Education and Training). This training is delivered by regional training providers (RTPs) and provided largely by College Fellows, mainly in community-based GP practices. In the case of those seeking to specialise in other areas, the bulk of the training involved is provided in public teaching hospitals, again largely by College Fellows on a pro bono basis. However, as discussed below, the private sector is playing a greater role than in the past.

The Australian General Practice Training Program is explicitly funded by the Australian Government, with funds allocated to RTPs through a 'constrained' competitive tender process (see below). In addition to payments for practising GPs to provide education and supervision to trainees, a pro bono component may sometimes be involved. Trainees also pay fees to the Royal Australian College of General Practitioners (RACGP) for that supervision and to sit the college examination.

The cost of postgraduate training in other medical specialties is similarly shared between several parties. In addition to supervision provided by College Fellows:

- State and Territory Governments meet infrastructure costs for the training conducted in their hospital facilities, as well as the labour component of training delivered by salaried hospital staff and, depending on contractual arrangements, some of the cost of supervision provided by College Fellows.
- The States and Territories also meet the salary and infrastructure costs of some unaccredited training positions in particular specialties. (However, lack of accreditation means that such training does not lead to college membership — a requirement to access MBS funding.)
- Trainees make a contribution through payments to the relevant colleges, including to meet the administrative costs for the colleges of oversighting training programs and assessing trainees.
- Private hospitals are providing and funding a small but growing amount of training to postgraduate medical students. In areas like dermatology, pathology and rheumatology, the private sector also provides training outside of the hospital setting (with some of these training places supported by subsidies from the Australian Government). The private hospital sector has also long played a role in postgraduate nurse training.

A breakdown of the costs associated with post-graduate clinical training for surgery is provided in box 5.1, though this is one of the few instances where such information is available (see below) and even here it is not particularly precise.

5.3 How well is the system performing?

By any measure, there has been considerable change in health workforce education and training in Australia since the early 1990s. Examples include:

- major modifications within the university-based component to curriculum design, course content and teaching methods (including common course modules allowing for inter-disciplinary education and problem-based learning);
- expansion in the range of course options in allied health sciences;
- the introduction of graduate entry programs that have increased the options available to potential trainees and facilitated some streamlining of courses to reflect relevant undergraduate training in other areas;
- better grounding in clinical sciences for registered nurses through the move from hospital-based preparation to a degree course; and

Box 5.1 **An example of the cost of clinical training**

Surgical Training

The establishment of training positions in public hospitals requires funding for both the salary of the trainee plus on-costs and for meeting the relevant College's accreditation criteria. This funding is generally drawn from general budget allocations to public hospitals (or area health services).

In submissions to the ACCC's authorisation process for the Royal Australasian College of Surgeons (RACS) training program in 2003, estimates for total trainee salary costs ranged between $100 000 and $120 000 (Western Australian and Queensland Government estimates respectively). Total trainee costs including additional infrastructure, equipment, nursing and allied health could amount to some $1 million to $2 million, depending on the sub-specialty (Queensland Government estimate).

In addition, the RACS submitted that their members provided pro bono services for the supervision of trainees valued at $216 million each year (around $144 000 per trainee). However, a number of submissions to the ACCC review commented that such services were not actually provided on a pro bono basis. NSW Health, for example, said:

> … it should be noted that contracts for VMOs working at teaching hospitals usually include the provisions of teaching and training of post-graduate medical officers as part of the professional services provided by the VMO. (ACCC 2003, p. 159)

Several participants to this study made a similar observation. Professor Peter Brooks, for example, said:

> Much of this pro bono training is done by College Fellows who have full time positions in universities or hospitals or are engaged in training while receiving payment from the State health system as VMO's. (sub. PP194, p. 2)

In its assessment of the public benefit provided by the RACS training, the ACCC was unable, on the information available, to precisely estimate the proportion of pro bono training provided by College Fellows. However, it concluded that the value of these activities was, *at a minimum*, in the order of $20 million to $25 million each year ($13 300 to $16 700 per trainee).

In addition, trainees themselves pay fees to the RACS for clinical supervision and examinations, amounting to some $31 000 per trainee over the life of the training program. The College received in the order of $5.5 million in trainee fee payments in 2002.

- an increased focus on structured, competency-based learning in the VET sector, with greater collaboration among stakeholders.

Indeed, according to some commentators, such changes are evidence of considerable dynamism in the current arrangements (see, for example, Brooks, Doherty and Donald 2001 and Dowton et al. 2005).

However, as the following discussion illustrates, most participants in this study considered that the outcomes delivered by the current health workforce education and training regime are still far from ideal. And looking to the future, there was widespread concern that if inefficiencies, rigidities and coordination problems in the current regime are not addressed, effective and timely adjustment to the changing needs of health care providers and care recipients is unlikely.

Major performance gaps identified by participants

Insufficient places

In the light of existing workforce shortages, most participants commenting on education and training issues saw the major problem as being insufficient education and training places, especially in the university system. Such concerns were raised in relation to all of the main workforce areas: nursing, medical, dental and allied health. For example, the Australian Nursing Federation (Victorian Branch) commented that:

> Unless the Commonwealth Government expands University places for nursing undergraduates, the future supply of registered division one nurses for our major teaching hospitals and specialty fields of nursing across the state will be damaged irreparably. (sub. 133, p. 8)

The Health Professions Council of Australia said that:

> Australia needs more allied health professionals. However, decisions on how many students to enrol at universities are not based on need but on commercial concerns. (sub. 70, p. 9)

The Australian Council of Deans of Health Sciences (sub. 67, p. 3) commented that while there are workforce shortages across the full spectrum of health professions, 'the level of investment to address problems of undersupply and maldistribution of allied health professions [has] been relatively modest to date.'

And commenting specifically on the situation in dentistry, the Australian Dental Association said:

> The most significant factor that exists in the dental workforce is the lack of dentists and the resultant inability for many Australians to access dental care. This is not due to any inefficiency in the dental labour force but is the result of years of government neglect in not responding to demands for additional dental places to be allocated to Universities. (sub. PP310, p. 9)

Such concerns remain despite the considerable expansion in health related university (and vocational education) places over the last few years. According to

DEST, available university places increased by 15 per cent between 2001 and 2004 (although the demand for places rose by close to double that figure). DEST also noted that recent decisions to inject extra funding into health-related higher education will see an additional 4800 nursing places and 3600 allied health places (including dentistry and physiotherapy) provided by 2008 and a 30 per cent increase in medical places by 2009. In addition, AHWAC projections show current nursing shortages remaining broadly stable in the period to 2010 without any further initiatives to increase undergraduate nursing places (see appendix B).

As discussed further below, there were also widespread concerns about shortfalls in clinical training places, especially in some key medical and allied health areas. Those shortfalls were expected to worsen in coming years due, in large part, to the expansion in health-related higher education places noted above.

In contrast, relatively few concerns were raised about numbers of health places in the VET sector. This may partly reflect the somewhat lesser overall role of the sector in the preparation of health workers. However, as elaborated on in box 5.5, because State and Territory Governments provide much of the funding for VET training, and are the main employer of health workers trained in the system, they have a considerable incentive to ensure that numbers of places are sufficient to meet demand.

However, this does not mean that opportunities to improve workforce supply through VET are always available. As noted by the Tasmanian Government (in the context of its small and dispersed population base):

> … the ability of local [vocational] education and training providers to sustain viable services is made problematic by low numbers overall, particularly if attempting to provide services in a decentralised fashion or with a significant component of "in the workplace" training. It can be quite difficult to negotiate sufficient workplace training opportunities for the number of participants required for a viable course … (sub. PP180, p. 13)

The quality and relevance of the education and training provided

Despite significant and ongoing change in health workforce preparation, State and Territory Governments in particular contended that education and training courses have not kept pace with developments in health care needs and changing care models. The ACT Government, for example, said that it:

> … is increasingly recruiting health workers who require further education, upskilling and training to reach the skill level required to meet the job requirements and the growing needs of certain population groups, for example the aged. This is most evident in nursing and medicine … [It] reflects a lack of alignment between course content and current job roles … (sub. 177, pp. 8–9)

In arguing for the development of a nationally agreed set of basic medical procedures, the Postgraduate Medical Council of New South Wales said that:

> There is currently a great deal of variability in the ability of students and [international medical graduates] to perform basic procedures on day 1 of their internship/year of supervised training. This is sometimes a reflection of the competence of the individual, but can also be the result of different curricula approaches of different Universities. (sub. 153, p. 2)

And in the specific area of nursing, the Commission was advised in discussions that nurses often require additional training (the so-called graduate year) after completing their university education to make them 'job-ready'.

The extent of concern regarding the suitability of graduates in the medical area, in particular, recently prompted the Minister for Education, Science and Training to commission a study into undergraduate medical education (DEST 2005). Among other things, the study is aimed at ensuring that '… young doctors completing their undergraduate medical degrees have the right skills, knowledge and attitudes to become successful interns in our health systems and to have a solid basis for continued professional learning and research.' The steering committee established to progress the study is due to report in 2006.

The duration of education and training

Several participants said that the often lengthy duration of health workforce education and training — especially in the medical area — reduces the capacity of the system to respond to shortages in a timely fashion and complicates broader workforce planning. Some further contended that, in many areas, the absence of streamlined retraining pathways, or appropriate recognition of prior learning, exacerbates the difficulties of accommodating demands for additional workers or replacing those who exit the workforce (see below).

The potential to reduce the duration of education programs through changes in these areas was highlighted by DEST:

> Credit transfer and recognition of prior learning can both operate effectively to reduce the length of time it takes to acquire or upgrade qualifications. This not only means students can join the workforce more quickly but also frees up places for others to learn. It can also reduce unnecessary and duplicated learning thereby reducing the cost of training, helping to increase participation in education and training, and removing a potential barrier to people wishing to refresh or upgrade skills. (sub. PP181, p. 12)

However, while there was general acceptance of the need for appropriate recognition of prior learning in course structures and retraining programs, there was less consensus on the scope to substantially speed up current timeframes.

Some believed that accelerated entry to the workplace could be achieved without compromising quality standards by, for example:

- moving to a 'skills escalator' model of education and training as is occurring in some other countries, possibly embodying shorter 'generic' health degrees (see box 5.2);
- allowing medical students to begin to specialise in their undergraduate years;
- training some doctors in narrow specialist fields and limiting the scope of practice to these areas; and/or
- introducing competency-based (as opposed to time-based) clinical training.

However, other participants contended that significant advances in medical knowledge and technology argue in favour of increased rather than reduced course length, and militate against moves to create a more generalist health workforce through generic health degrees. In this latter regard, the Australian and New Zealand College of Anaesthetists said:

> Although the medical Colleges are sometimes accused of being educational 'silos', and that there should be more commonality in training, the great advances in knowledge and technology in medicine in the last 40 years or so have required specialisation for their safe application. A doctor entering years of postgraduate vocational training to specialise as a cardiac surgeon cannot afford much of that time to keep up with the generic knowledge and skills required of a junior doctor, a general practitioner, or an anaesthetist, and emerge a competent cardiac surgeon. (sub. 38, pp. 3–4)

Similarly, the Australasian Podiatry Council noted that:

> The strategy of reducing discipline specific health training … has great potential to dilute quality health care and adversely affect community wellbeing. (sub. PP281, p. 4)

Others questioned the usefulness of the skills escalator model on the basis of issues involved in its practical application. For example, James Cook University Faculty of Medicine, Health and Molecular Sciences commented:

> … there is recognition of the problems with real-world educational design and efficiency inherent in this clinical training model as well as a better appreciation of the layers of red-tape that such arrangements bring (in multiple outcome assessments, recognition of current competence mechanisms, employer and community education etc). (sub. PP303, pp. 4–5)

And while supporting moves to reduce the length of clinical training, and pointing to some possible options for doing so in the surgery area, the Royal Australasian College of Surgeons (sub. 83, p. 5) nonetheless cautioned that there is a risk this could reduce the standard of surgical services.

Box 5.2 **Alternative models of health workforce preparation**

Multi skilled health workers

A frequently cited option for accelerating entry to the workforce and enhancing workforce flexibility, is the preparation of multi skilled health workers through the development of a common degree program. Under this model, a relatively short generic health degree would provide a common preparation in foundation sciences (eg physiology, anatomy, human behaviour) and a core skill set based on achieving specific competencies in assessing basic human physical function. This basic core skill set would then provide a platform for *earlier* specialised training in more specific areas.

Skills escalators

Under the 'traditional' model of health workforce preparation, trainees must fully complete applicable education and training programs before being able to practise. In contrast, under a so-called 'skills escalator' model, trainees would be able to:

- exit their education and training program on attainment of pre-determined skills and be certified to practise according to the skill level attained; and
- re-enter the program in order to progress to higher levels (with appropriate recognition of prior learning).

This model is being introduced in the United Kingdom under the NHS Modernisation Strategy.

There are already elements of this approach in the Australian system. For example, there are opportunities to enter some health professions via postgraduate as well as undergraduate courses. And, as noted earlier, medical practitioners who have completed their intern year can practise prior to entering specialist training.

Proponents claim that its wider application, based around common learning modules and possibly short generic health degrees (see above), would enable earlier participation in the workforce, as well as facilitating: greater integration across health professions; structured assimilation of overseas health workers; entry from non-health occupational fields; and greater scope for delegation of tasks in the workplace.

However, the merits of such an approach are not universally accepted (see text).

Source: Based on Duckett (2005a).

Inadequate pathways between VET and higher education

A number of participants — State and Territory governments in particular — contended that existing articulation arrangements between the VET and university sectors are inadequate and that improvements in this area could ease workforce supply problems by facilitating career development. The Western Australian Government, for example, said:

> Cross-sectoral linkages between schools, the VET and higher education sectors need to be improved. Career path structures that are supported by skill development programs that enable the smooth transition from non-degree qualified vocations to the professions have significant potential to alleviate some of the labour market supply problems that plague Health. (sub. 179, p. 22)

By way of example, it claimed that a VET qualification in enrolled nursing (often combined with some workforce experience) is not given adequate recognition by universities when enrolled nurses seek to progress their careers by entering into an undergraduate registered nurse program.

The Commission notes that there has been some recent general reform in this area. As noted by the New South Wales Government:

> The Joint Committee on Higher Education (JCHE) working party has developed principles of good practice for disseminating information on, and implementing, credit transfer and articulation. The JCHE has recommended that the Ministerial Council on Education, Employment, Training and Youth Affairs (MCEETYA) adopt these principles. The JCHE is also recommending a national mapping exercise be conducted of current practices in credit transfer and articulation; and the establishment of a data working party to improve national performance in this area. (sub. 178, p. 23)

However, the New South Wales Government went on to say that the success of future initiatives in this area will be reliant on the Australian Government making available university places for articulating TAFE students.

> Better opportunities for vertically integrated career paths across the vocational education system, health and higher education are essential to increase the supply of educationally prepared health workforce for the future. (sub. 178, p. 23)

Lack of access to clinical training

Alongside calls to increase the number of health-related education and training places, the need to provide matching clinical training opportunities was widely seen as critical. In this respect, current clinical training arrangements were generally viewed as having failed to deliver sufficient training places for either undergraduate students or postgraduate trainees. Particular concerns were expressed in relation to allied health and some of the medical specialties — though they were by no means limited to these areas. Indeed, at a broad level, the Australian Council of Deans of Health Sciences suggested that:

> … access to quality clinical teaching placements is likely to emerge as the major rate-limiting factor in an effort to ramp up professional training programs. (sub. 67, p. 5)

Yet while there are shortages in many areas, there are also unfilled postgraduate training places in some medical specialities, especially outside the major cities.

Inadequate support from both the Australian Government (in its role as the main provider of funds for university education) and State/Territory Governments (in their role as providers of training facilities and opportunities in the public hospital system) was commonly cited as a major contributor to the lack of places in many areas (see box 5.3). However, participants also pointed to a range of other contributors, including:

- a failure to properly consider the clinical training implications of policy initiatives to boost the number of university places in the health area;
- the tradeoff for public teaching hospitals between service delivery and support for training, especially in an environment where overall resources are stretched, and where there is often no explicit budget allocation for training;
- changes in the casemix of public teaching hospitals which, as noted earlier, have been the main setting for much clinical training. In particular, with the shift of more elective and other non-urgent surgery to the private hospital sector, the focus of teaching hospitals is increasingly on treating more complex acute conditions. This has in turn reduced the breadth of clinical training possibilities in the public system; and
- impediments to the conduct of more clinical training in private hospitals and other private facilities — including the lack of explicit funding to pay for the use of facilities, and possible medical indemnity concerns.

Some participants also considered that continued heavy reliance on pro bono provision of training services by private practitioners was not sustainable over the longer term. In this regard, the chairman of the Committee of Presidents of Medical Colleges recently remarked:

> Currently, pro bono work is an enormous contribution by senior fellows in all colleges; but is it sustainable? In general, people who contribute substantial time to college functions, such as examinations, education and training supervision, do so by their own choice but I am not confident this will continue for much longer. (Child 2005, p. 48);

Similarly, the Western Australian Government said in its submission:

> There is currently a growing reluctance within the health professions to continue to take on the burden of supervised clinical practice. A more equitable system of providing students with the opportunity to develop technical skills is required. (sub. 179, p. 23)

However, this view was disputed by other participants including the Australian Medical Association which said it '… does not accept that the current system is unsustainable.' (sub. PP315, p. 8).

Box 5.3 **Participants' comments on access to clinical training**

Difficulties in accessing clinical training were raised in relation to most areas of the health workforce. While these difficulties were seen as resulting from several factors (see text), as the following comments from participants illustrate, lack of funding for placements was generally put at, or close to, the top of the list.

Medicine

> Owing to a lack of government funding of training facilities, training opportunities for obtaining operative and consulting skills are limited at all levels in obstetrics and gynaecology; to increase our annual intake beyond the current limit would seriously impact on the quality of training and supervision. (Royal Australian and New Zealand College of Obstetricians and Gynaecologists, sub. 112, p. 8)

> There are plenty of surgical posts that could be accredited as specialist training positions if funding were available. The source of that funding is outside of the RACS' control and rests with the Australian and State and Territory governments. (Royal Australasian College of Surgeons, sub. 148, p. 6)

And the Australasian College of Dermatologists (sub. 104, p. 5) similarly said that it consistently had difficulty in obtaining funding for new training positions.

Allied Health

> There is a huge amount of pressure placed on public hospital physiotherapy departments to provide undergraduates with the experience they need to be job ready. The system largely functions on the goodwill of clinicians and is unsustainable. (Australian Physiotherapy Association, sub. 65, p. 12)

Nursing

> Schools of nursing currently struggle to ensure an adequate supply of quality clinical placements to offer students the required clinical hours to adequately prepare them for registration. The current system is untenable where schools of nursing are at the mercy of the health system who have no mandate or inducement to offer the placements. Competition between schools of nursing for the placements perpetuates this problem. (Council of Deans of Nursing and Midwifery, sub. 63, p. 4)

Course funding relativities

Several participants commented on government funding relativities across university-based health courses, with a particular concern being that these relativities are biased against the provision of allied health courses. Synthesising these concerns, the Australian Council of Deans of Health Sciences argued that:

> … funding levels do not provide sufficient income to universities to adequately support the smaller, more specialised health disciplines such as podiatry and prosthetics, that, despite the relatively small numbers of professionals needed in comparison to medicine and nursing, are still critical to the national ability to provide a comprehensive level of health services. (sub. 67, p. 7)

More specifically, the Australasian Podiatry Council said:

> Under the current Commonwealth Grant Scheme, universities receive just under half the amount of annual per-student funding for the education of a podiatrist, than for a student in dentistry or medicine. Yet, the cost of course delivery is comparable, particularly with regard to the integrated clinical component of training. (sub. 88, appendix 1, p. 3)

There was also commentary on the impacts of HECS fees on participation in health workforce training (see box 5.4), and on problems associated with the current arrangements for accrediting education and training programs in the health area. Accreditation issues are considered separately in the next chapter.

5.4 How could the system be improved?

In considering options to address these types of performance gaps, it is important to keep in mind the substantial change in education and training arrangements for the health workforce that has already occurred and the significant recent increases in funding for places. Moreover, the demands on university and VET systems from the health care area must be considered in the context of those from a whole range of other areas.

Further increases in funding for health-related higher education places will be an important part of the policy package for addressing increased demand for health workers in the future. Indeed, while it will be some time before the benefits of recent measures to increase places are realised, the additional health workers delivered by those extra places will then be available to provide services for many years to come.

However, there are limits on the capacity of governments to fund additional education and training places for health workers and also limits on downstream clinical training capacity. Hence, policy attention must also be given to ways of improving the efficiency and effectiveness of the arrangements for preparing the future health workforce.

Consistent with its approach elsewhere in the report, the Commission has focused its attention on changes to institutional and regulatory arrangements and to funding mechanisms that could enhance the efficiency and effectiveness of health workforce education and training and thereby:

- deliver better value from the funding available for the education and training of health workers; and

Box 5.4 **HECS fees and participation in education and training**

Several participants contended that HECS fees for health workforce courses are excessive and that the resulting debts — especially for longer courses — discourage student participation.

However, as in other disciplines, income forgone rather than HECS debt will generally represent the major cost of undertaking university-based health workforce training. As such, HECS charges are likely to have a lesser impact on overall participation levels or course choices within the health area than, say, funding arrangements under the MBS (see chapter 8).

Moreover, in the Commission's view, a contribution towards the cost of tertiary education is appropriate given the increase in earnings capacity that generally ensues. Accordingly, the Commission has not pursued this issue further.

- promote efficient and timely adjustment in health workforce education and training arrangements to the changing needs of those receiving and delivering health care services.

What are the key systemic impediments that must be overcome?

Deficient coordination mechanisms

In achieving better education and training outcomes, a pressing need is to improve coordination both within the education and training area, and between this area and the other key components of the health workforce regime. Synthesising the current deficiencies in coordination processes, AHMAC reported that:

> [State] 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. (sub. 166, p. 31)

Similarly, the Northern Territory Government noted that:

> … the ability of the health sector to influence the outcomes in the educational sector remains a critical issue for developing the quantity and capacity of the local health workforce. (sub. PP182, p. 26)

Coordination failures are evident at several key points. The one that has attracted most attention in this study is the interface between DEST and State and Territory health authorities in regard to funding for university-based health workforce education and training. Thus, the South Australian Government remarked:

> There is no formal mechanism that engages the relevant stakeholders of DEST, the Commonwealth Department of Health and Ageing and AHMAC in the way that university places are planned and funded to better meet changing workforce supply requirements. (sub. 82, p. 34)

Similarly, the New South Wales Government observed that while protocols to provide for bilateral consultations had been established via the *Agreement between Commonwealth and States in relation to Higher Education 1991*:

> … this consultation and coordination process is no longer working. It is vital that this is remedied. (sub. 20, p. 2)

Notably, there appear to be fewer such coordination problems in the VET sector (see box 5.5), where the States and Territories provide much of the funding for places and are the major employers of health workers trained in the system. But even here, some problems still arise.

A number of participants highlighted the inherent tensions between the aims of the university sector compared with those in health delivery (with several arguing this was the result of incentives created by the current university funding model.) Citing its Department of Education Services, the Western Australian Government noted:

> For us the primary issue is that there is a major discontinuity between the role universities believe they have, which is to provide a broad general education informed by a research ethos on the one hand, and the needs of a health service which generally requires highly skilled employment-ready graduates on the other hand. Any attempt to improve the current situation needs to be prepared for this difference in perceived roles. (sub. 179, p. 13)

Also, as alluded to above, lack of effective coordination between different components within the health workforce education and training system is causing problems. Articulation of qualifications between the VET and university sectors is one such problem area. But the greatest difficulties arise in relation to clinical training. Some of the consequences were highlighted by the Committee of Deans of Australian Medical Schools (CDAMS) who said that:

> The lack of consultation and planning relating to the creation of new medical school places and new schools has produced chaotic effects in the health care sector, and has threatened to undermine many effective long-term relationships between individual medical schools and their partner health units and practitioners. … Creation of new medical schools must take account of the availability of clinical placements and not continually create the need for reactive responses to political whim. (sub. 49, p. 10)

Box 5.5 **Comparing the performance of the VET and university regimes**

Some of the institutional features of the university and VET regimes have particular implications for outcomes in the health workforce area:

- VET preparation in health has parallels with a 'purchaser-provider' model. That is, State and Territory Governments, which currently fund the bulk of the training services, are also (through their health departments) the predominant employer of health graduates from that system.
- In the university sector, on the other hand, funding and policy direction are provided by one level of government to prepare health workers who will often spend at least the early part of their careers working in public hospitals for another level of government.

The VET sector is also characterised by more formalised institutional linkages to facilitate both national and state level collaborative approaches to policy and priority setting, and greater industry/employer involvement in course design and content — as exemplified by the Community Services and Health Industry Skills Council.

State Governments have argued that these characteristics of the VET system provide for effective alignment of course mix and content with their needs as employers of health workers. The contrast was drawn with the outcomes of the university system, with AHMAC arguing that those responsible for delivering services have:

> … little influence over the places in tertiary health courses, the type, content and length of the courses, where and by which institutions the courses are offered, course closures, the funding provided to institutions to deliver health courses etc. There is often considered to be a misalignment between service and client needs and the skills, knowledge and attributes imparted through existing training models and curriculum. (sub. 10, p. 7)

Indeed, in a subsequent contribution to the study (sub. 166, p. 23), AHMAC said that there could be scope to make greater use of the VET system in addressing current and future health workforce shortages, noting amongst other things that:

- delivery could be targeted to those already in the workforce;
- VET is incremental in approach, which means that people can build their skills over time to match changing roles; and
- VET courses could be more readily marketed to older workers, people returning to work, or those wishing to change career while remaining in the workforce.

These views were echoed in some State Government submissions.

However, some of the apparent advantages of the VET system in the health area seemingly have as much to do with the internalisation of the training and service delivery functions within the one level of government, as to the constitution of the system per se. Moreover, there were a range of problems in the VET system which were brought to the Commission's attention including: jurisdictional differences in course type, duration and quality which impede national consistency and impact on the mobility of graduates across jurisdictions; and overlaps and inconsistencies between training packages which lead to inefficiencies in training delivery.

Similarly, the Northern Territory Government commented:

> While the health system welcomes any increase in undergraduate places, there is minimal consultation with jurisdictions about the capacity for supervision or management of those additional students. This approach is clearly ad hoc and, with the increasing pressure placed on a workforce in shortage, this system is not sustainable. (sub. PP182, p. 27)

Custom and practice blockers

Many mooted changes to the nature of education and training for health workers raise complex issues and trade-offs. The appropriate balance between generalist and specialist education and training, and the scope to reduce the duration of courses, are but two areas where there is considerable debate on the direction in which the regime should be moving.

Much of this debate is based on differences of opinion about the intrinsic merits of alternative approaches. But as in other aspects of health workforce arrangements, debate is sometimes coloured by a desire to preserve existing responsibilities, or to maintain or increase influence. And in some areas, longstanding practice is a barrier to the exploration of better ways of educating and training the future health workforce. For example, efforts to facilitate greater private sector involvement in the postgraduate clinical training of medical specialists have seemingly been impeded by the lack of transparency in the funding of that training and the consequent inability to increase contestability in the supply of training services.

Against the backdrop of deficient coordination mechanisms and the inertia of custom and practice, the Commission has looked at options directed at:

- increasing input from health care providers in the allocation of funding for university-based health workforce education and training;
- providing a vehicle for independent and transparent assessment of 'directional' change in health workforce education and training; and
- providing for a more sustainable clinical training regime over the longer term.

Changing responsibility for the allocation of university places

Responsibility for determining the overall quantum of Australian Government financial support available for university-based education and training of health workers resides with the Federal Education Minister and DEST. While there is a degree of consultation with health departments and other key stakeholders, requirements in the health care area must be considered in conjunction with the

needs of all of the other sectors reliant on the university system to provide core workforce skills.

However, it does not necessarily follow that responsibility for allocating available funding for health care courses across disciplines, or indeed universities, must remain solely with DEST. That is, while DEST continues to set the overall funding quantum, the health area of government could assume control of, or play a greater role in, the allocation of places including through:

- the Australian Government's Department of Health and Ageing (DoHA) — as canvassed by Duckett (2005b);
- a body comprising representatives from all of the State and Territory health departments (as proposed by the Victorian Government — sub. 155, p. 45);
- a body made up of representatives from the health areas of both levels of government;
- specific provisions to bring health sector education and training outcomes within the Australian Health Care Agreements negotiated between the Australian Government and each State and Territory Government (as also canvassed by Duckett — sub. PP197, pp. 4–5); or
- the development of a separate stand-alone agreement for university-based health education and training between the Australian and State and Territory Governments.

What are the potential benefits?

A division of funding-related responsibilities — which has been employed in some other countries (for example, diploma level nurse training in the United Kingdom) — or a formalised 'high level' negotiation between the health and education areas of two levels of government, would have two main benefits.

- By taking advantage of the extensive linkages between health service providers and the health areas of government, either of these approaches would provide for a better informed allocation process.
- More importantly, such approaches would give the areas of government responsible for funding and for delivering a significant level of health care services, greater scope to influence the type of health workers produced by universities. This could further increase the prospect that the mix of health course places is the best that can be achieved from available funding.

That said, the likely magnitude of these benefits is less clear. In particular, there has been little hard evidence submitted to the Commission to indicate that the mix of

university-based health care places emerging from current arrangements is greatly distorted — virtually all of the argument has centred on the creation of additional places, rather than the need to train more of some workers and fewer of others.

Also, any such change would not come without some costs. These include the potential subjugation of the broader role of university-based education to short term service delivery needs (see below).

More broadly, the question arises as to why such an approach, if soundly based, should not apply in other areas outside of health.

The Commission's view

Notwithstanding uncertainty about the magnitude of the current mix problems and the existence of some costs, the Commission considers that the approach of giving the health area greater input into decisions about the allocation of funds available for university-based health workforce education, has considerable attractions. Apart from the in-principle benefits, the present arrangements are generating considerable disquiet, with the ongoing debate consuming valuable policy resources.

Moreover, the Commission is not convinced that efforts to build better linkages between the health area and DEST alone — as canvassed by AHMAC (sub. 166, pp. 35–36) — would prove successful. This approach has been tried in the past and, on the evidence before the Commission, continues to fail. An alternative mechanism is therefore required. Nonetheless, greater cooperation between DEST and DoHA would be a desirable complement to any such alternative.

In the Position Paper, the Commission proposed that DoHA be made responsible for the allocation of funds on the basis that:

- It would provide for single rather than collective control. Especially in the current environment of some significant workforce shortages, debate about the distribution of available funding across universities could become intractable in a multi-jurisdictional forum.
- As a portfolio shift in responsibility within the Australian Government, it would reduce the risk that DEST's loss of primary responsibility for determining how funds were spent, would lead to less favourable treatment of health-related education and training in the distribution of overall university funding.
- DoHA is already involved in the allocation process for medical places. As such, an extension of its role would be a less dramatic and potentially more workable shift in responsibilities than the alternative proposal for a multi-jurisdictional approach involving the States and Territories.

In responding to the Position Paper, some participants agreed with this assessment. For example, while noting that the proposed change would not overcome issues relating to insufficient places, the Australian Nursing and Midwifery Council said:

> Identification by the Commission of the need for a shift in responsibility for funding allocation for the education and training of heath workers to the Department of Health and Ageing is welcomed by the ANMC as a possible means of streamlining funding within the health sector. ANMC therefore supports this proposal, subject to appropriate quarantining of funds to meet the shortfalls in nursing and midwifery places in the university sector and nursing places in the VET sector. (sub. PP225, p. 3)

However, most participants opposed the suggestion, or were sceptical that it would lead to any material improvement. Several suggested it could also have significant costs, primarily because it could shift the focus of the education system too heavily toward service delivery. In this context, the School of Physiotherapy at the University of Melbourne noted:

> Universities are clearly more than workforce training institutions – a central role of universities is to undertake research to provide evidence for the most cost effective and efficient health practices and to imbue graduates with the capacity to continue to learn and incorporate new developments into their own practice. Therefore a model that focuses on 'training' of the health workforce may not produce an effective adaptable health workforce. (sub. PP312, p. 3)

Similarly, the Australian Medical Council (sub. PP306, p. 2) warned that the shift could be '... detrimental to the longer term flexibility of the workforce and its capacity to adapt to new circumstances, technologies and challenges.'

A range of other concerns were also raised, including that the proposed approach would disadvantage those health professions (for example, psychology, dietetics and physiotherapy) where graduates do not work exclusively in the health area, and that it would increase the administrative complexity for universities by requiring them to negotiate with two different federal agencies for health and non-health places. On this point, the Australian Vice Chancellors Committee said it saw no '… efficiency gain to be made in splitting funding responsibilities across a number of bodies.' (sub. PP354, p. 1). In addition, the Committee of Deans of Australian Medical Colleges considered that the proposed change would create significant tensions within universities. It said:

> … such a shift would run the risk of creating deep educational and organisational rifts between medical/health schools and faculties and other faculties in the universities. (sub. PP337, p. 4)

In the light of these comments, the Commission accepts that there would be a range of risks and costs involved in shifting responsibility for the allocation function from DEST to DoHA which could well outweigh the potential benefits. That said, given the considerable dissatisfaction with the current arrangements, the Commission

continues to see merit in developing a mechanism which gives the health sector a greater say in the allocation process.

One such mechanism was put forward by Professor Stephen Duckett who advocated the:

> … incorporation of funding of health professional education within the 2008–2013 Australian Health Care Agreement. (sub. PP197, p. 4)

Under this arrangement, the States and Territories would be given a notional allocation of Commonwealth supported places for health professional education and then have the ability to negotiate with universities about the curriculum, distribution of places across the various professions and across universities and the development of new programs. In turn, universities would expect that each respective jurisdiction would assume responsibility for ensuring the availability of clinical placements. In addition, DoHA would play a coordinating role to align jurisdictional outcomes with national health workforce requirements.

Features of this bilateral model are similar to the model suggested by the Victorian Government in its initial submission. It said:

> A potential model could see the quantum of funds based on identified jurisdictional education and training needs made available for States/Territories to determine the health education places to be purchased from universities and VET providers and allocate clinical placements to support delivery. This would be subject to periodic renegotiations on a three to five year cycle, taking into account broader service growth and relative growth against other sectors. Negotiations with education and training providers would similarly occur periodically to provide a level of funding certainty and in a manner enabling each State and Territory consistency with their broader education policies. (sub. 155, p. 45)

It went on to list the broad operational guidelines that such an agreement would operate within:

> The agreement between the Commonwealth and each jurisdiction would clearly outline the purposes for which the funds were being utilised and the accountability and reporting requirements that jurisdictions and funded institutions would need to fulfil. It would provide a vehicle through which national training priorities could be preserved, State and Territory requirements be articulated, baseline training numbers could be negotiated and substitution between VET and higher education providers could be facilitated. (sub. 155, p. 45)

In the Commission's view, however, incorporating the allocation of university places into the Australian Health Care Agreements would be a problematic approach, especially given the historically adversarial nature of the negotiation process and the various service delivery issues that must also be addressed through them. Indeed, in the light of these service delivery considerations, there would be a

risk that longer term education and training needs could be subjugated by short term delivery imperatives — especially given the Agreements are increasingly taking the form of a single 'fungible' block of funding.

In a similar vein, in rejecting this approach the Joint State and Territory Health CEO's response to the Position Paper contended that:

> The acute care focus of the [Australian Health Care] Agreement does not reflect the breadth of health workforce education and training and acute care financing is not well aligned to education and training considerations. (sub. PP332, p. 12)

Given such drawbacks, an alternative approach which may warrant consideration involves the development of a stand-alone agreement covering the allocation of available funding for university-based education and training of health workers. This would potentially give the States and Territories a greater say in allocation decisions.

The Commission recognises that there is some risk that this would result in an undue focus on the education and training requirements for just one group of health workers — those employed by State and Territory governments (and in public hospitals in particular) — and lead to the same sorts of problems identified in relation to the proposal to shift responsibility for allocation of funding from DEST to DoHA.

However, such concerns should not be overplayed. Importantly, the Commission does not envisage final responsibility for the allocation of funding being transferred to the States and Territories. Rather, the arrangement would involve a commitment by the Australian Government to provide an agreed number of university places in individual health disciplines to each jurisdiction. Accordingly, DEST would continue to play a role in the allocation process at the jurisdictional level and thereby bring a broader health workforce perspective to bear. DEST would also remain responsible for negotiating with individual universities for the delivery of these places. And the agreement-making process should not preclude greater cooperation between DEST and DoHA, with the latter having a role to play in engendering broader health workforce considerations to allocation decisions.

The Commission further notes that while not being responsible for funding the bulk of health care services provided outside the public hospital system, the States and Territories still have strong incentives to ensure that their citizens have access to adequate health workforce services in the broad. In this respect, the Commission was frequently told in discussions that sound linkages exist between the health departments in each State and Territory and those responsible for service delivery in settings outside the public hospital sector — including private hospitals and aged care operators. Moreover, under this sort of arrangement it would be possible for

smaller jurisdictions, which are unable to offer the range of undergraduate health courses required by their health systems, to seek agreement for those places to be provided through higher education institutions in other jurisdictions.

At the very least, the Commission considers that a separate stand-alone allocation agreement is likely to have fewer drawbacks than the other approaches discussed above. This approach would explicitly quarantine the funding available for health-related university education and training and serve to more closely align the needs of service providers with the outputs of the higher education sector. It could also be used as a mechanism to improve the coordination of clinical training placements in public hospitals — recognising that the delivery of that training in a broader range of settings is an important longer term goal (see below). Accordingly, the Commission is of the view that further investigation of this approach is warranted.

In regard to its actual operation, the Commission considers that the duration of the agreement would need to be sufficient to provide a degree of certainty to the stakeholders involved with respect to the number of places to be provided, but not be so long as to limit flexibility in adapting to changes in circumstances. In the Commission's view, an agreement length of about three years would appear to represent an appropriate middle ground.

RECOMMENDATION 5.1

The Australian Government should consider developing an agreement with State and Territory Governments for the allocation of places for university-based education and training of health professionals within each jurisdiction. However, under such an agreement — which should be of at least three years duration — the Department of Education, Science and Training (in consultation with the Department of Health and Ageing) would remain responsible for determining the total quantum of funding for university-based health education and training and for negotiations with individual universities on the distribution of those places.

Establishing health colleges

A quite different way of helping to promote a better mix of university-based health workforce education and training — at least from the perspective of the States and Territories — was put forward by Professor Wayne Gibbon from the Centre for Ambulatory Care Research (sub. 48, pp. 25–26). It would involve the creation of State health colleges (effectively in competition with the universities) which could design, develop and teach new programs, or purchase and teach pre-existing accredited programs.

According to Gibbon, this approach would allow the States and Territories to tailor course mix and content to their workforce requirements, shorten the lead times needed to make changes in curricula and student numbers, and reduce the cost of developing new degree courses and training programs.

As Gibbon noted, recent amendments to higher education legislation which permit non-university providers to offer courses if the Minister for Education in each State/Territory accredits those courses, have removed any outright barriers to the creation of such colleges. Hence, it would be open to individual States and Territories to pursue this approach were they to judge it to be worthwhile and were willing to commit funding. (Current legislative arrangements do not provide for course contributions from the Australian Government for non-university providers.)

Facilitating change in health workforce education and training models

As noted earlier, there continues to be considerable debate about a range of issues pertaining to education and training models, the configuration of health workforce courses, and course curricula. The issues are often complex, there are inevitably tradeoffs involved, vested interest concerns intrude on the debate, and longstanding practice sometimes inhibits policy innovation.

From time to time, various independent assessments of these issues have been undertaken to assist those with policy or implementation responsibilities in this area. For example, DEST is currently coordinating a study of medical education in Australia which aims to provide a body of evidence and ideas from which medical schools will be able to draw in formulating curricula.

However, there has also been recent discussion of institutional initiatives to cut through blockers to 'directional' change in health workforce education and training. In particular, there have been various proposals to create a national 'Health Education and Training Council' to provide for independent analysis of directional change issues and associated policy and other initiatives. For example:

- The National Health Workforce Strategic Framework identified such a council as a possible means to more effectively engage the health and education and training sectors.
- The most recent Medical Education Conference (2005) advocated the approach as a way to both promote collaboration between stakeholders, and to provide evidence-based policy solutions to identified problems in health education.
- Several participants in this study have similarly proposed council-style initiatives — in some cases combining an advisory role with course accreditation

and other statutory functions. (See for example, the Victorian Government (sub. 155, pp. 49–50) and the ACT Government (sub. 177, p. 8).)

In addition, the recent Queensland Health Systems Review recommended a similar (though state-based) arrangement be created, with a central training and education coordinating body responsible for all health professional groups (QHSR 2005, p. xlix).

The Commission agrees that a national and systematic dialogue on health education and training matters would have several benefits:

- It would be a forum to draw together the views and expertise of the various stakeholders and to secure agreement on how worthwhile new directions in education and training of health workers (including vocational and clinical training) would be best implemented.
- With appropriate governance structures, including a balanced membership, it could act as an 'honest broker' on divisive issues and those where existing interests might unduly influence outcomes under a more informal and less transparent process.
- It would facilitate consideration of education and training issues on an integrated rather than profession-by-profession basis. Amongst other things, this could provide greater scope to identify common education and training requirements across particular professions, and consequent opportunities to further develop inter/multi-disciplinary training approaches.

And given that such a council would be formalising and consolidating current discussion of these issues, the Commission does not give weight to concerns that this would represent just another layer of bureaucracy.

As with the health workforce improvement agency, a wide range of issues would have to be considered in the process of establishing an education and training council and its functional scope. Although detailed terms of reference and administration and funding arrangements would be matters for resolution between the relevant parties, the Commission envisages that:

- The council's assessments should cover all forms of health workforce education and training, including vocational and clinical training. Accordingly, it would subsume the current *advisory* role of the VET sector's Community Services and Health Industry Skills Council (CSHISC), or of its successor under the new VET arrangements. However, the CSHISC's course development and related functions would not be affected.
- The new advisory council should have an established work program so that proposed changes can be assessed on a systematic and timetabled basis.

Assessments would include: evaluating the relevance of existing curricula to service delivery skill requirements; the feasibility of fast-tracking elements of professional education; avenues to ensure sufficient levels of practical experience are incorporated into education programs; new approaches to the delivery of clinical training; ways to better utilise interdisciplinary and competency-based education and training models; and opportunities for better articulation between the VET and university sectors to facilitate career development and re-entry opportunities. The council would draw on overseas experience and research in conducting these assessments.

- The council should be purely advisory and operate on a stand-alone basis. Thus, it should have no formal role in the accreditation of health-related education and training courses. And though the Commission considers that a single national accreditation body should be introduced (see chapter 6), combining that role with the advisory role outlined above could give rise to conflict of interest issues, and thereby undermine the effectiveness of both arrangements.
- However, the council should have formal linkages (at the secretariat level as a minimum) with the accreditation agency, as well as with the proposed health workforce improvement agency (see chapter 4). In particular, it should be a source of advice to the accreditation agency on the implications for courses, curricula and clinical training requirements of job design proposals emanating from the workforce improvement agency. As such, it would be a mechanism for helping to ensure that all the cogs in the health workforce apparatus are meshing together properly.

Against a background of wide-ranging support for the concept of an advisory education and training council, a number of respondents to the Position Paper suggested that it should be amalgamated with the proposed Health Workforce Improvement Agency. ACT Health, for example, commented that a combined agency:

> … would allow for a more efficient use of resources and has the benefits of facilitating an integrated approach to workforce innovation (the competencies for new/redesigned roles would be more closely aligned to education and training requirements) and establishing articulated pathways from the VET sector to tertiary education. (sub. PP336, p. 3)

The Health Professions Council of Australia (HPCA) shared this view on the basis that 'Separate bodies encourage internal competition and 'silo' building and complicate communications with stakeholders.' (sub. PP267, p. 3).

And in similarly supporting a combined body, the Confederation of Postgraduate Medical Education Councils of Australia said that:

> The establishment of an advisory health workforce improvement agency and a separate advisory health workforce education and training council … would run the risk of perpetuating the malalignment between workforce planning, education and training. (sub. PP298, p. 2)

While the Commission sees some merit in these arguments, on balance, it does not consider that such an amalgamation would be desirable. This view is based on the different functional roles the Commission sees the two agencies fulfilling. The proposed Council, on the one hand, is envisaged to be an 'ideas forum' where new directions in education and training could be raised and debated. The workforce improvement agency, on the other hand, would have a more formal remit to systematically evaluate workplace change and job redesign opportunities. Moreover, the Commission considers that appropriate governance arrangements (see below), and effective linkages between the two agencies, would at least partly address the concerns raised by those participants seeking formal amalgamation.

Indeed, like the workforce improvement agency, the effectiveness of the council will depend critically on its composition and accompanying governance mechanisms. Without effective arrangements in this regard, the council could well become an impediment to, rather than a facilitator of, desirable change.

Governance issues were similarly the focus of many responses to the Position Paper. The joint submission from the State and Territory Health CEO's, for example, endorsed the Commission's stated requirements for due process. A number of participants, however, conditioned their support for the council (either as a separate or combined body) on the basis of direct representation for individual professional groups (see, for example, Centre for Psychiatric Nursing Research and Practice (sub. PP342, p. 7); Australian Council of Physiotherapy Regulating Authorities (sub. PP252, p. 11); Speech Pathology Australia (sub. PP260, p. 5); and The College of Nursing (sub. PP292, p. 1)).

But, acceding to such requests would almost certainly create a dysfunctional institutional model. In the words of the Queensland Government:

> There is a risk that each sectional interest will seek to be represented on the proposed new agencies, bodies and councils and result in oversight by unwieldy committees immobilised by representatives interests. (sub. PP 325, p. 6)

Similarly, the New South Wales Government commented that:

> Governance of any agency should not allow individual professions to capture the education agenda and should also ensure that professional organisations and specialty colleges can be engaged in a way that supports innovation over natural professional protectionism. (sub. PP352, p. 14)

In the light of these observations, the Commission considers that the key governance requirements for the proposed new council are:

- a small board which provides for input from education, employer and professional interests, structured to reflect the public interest rather than the interests of particular stakeholders;
- an independent chairperson; and
- provision to report directly to the AHMC so as to increase the likelihood that its analysis and advice are properly considered by policy makers.

With such governance requirements met, an advisory health workforce education and training council would be of considerable assistance in facilitating further change and innovation in the preparation of Australia's future health workers.

RECOMMENDATION 5.2

The Australian Health Ministers' Conference should establish an advisory health workforce education and training council to provide independent and transparent assessments of:

- ***opportunities to improve health workforce education and training approaches (including for vocational and clinical training); and***
- ***their implications for such matters as courses and curricula and accreditation requirements.***

The council should have a small board which provides for input from education, employer and professional interests, structured to reflect the public interest rather than the interests of particular stakeholders. It should report directly to the Australian Health Ministers' Conference.

A more sustainable clinical training regime

While several participants characterised the current state of play on clinical training as one of crisis, in the Commission's view, the pressures are neither uniform nor such as to suggest that the system will become totally dysfunctional in the near future.

- Though access to both undergraduate and postgraduate clinical training is becoming increasingly difficult in some key areas, in others there is reasonable balance between demand and supply, or even unfilled training places (eg, geriatric medicine, psychiatry, renal medicine, GPs).
- Notwithstanding increasing service delivery pressures, a large amount of clinical training continues to be provided to students, often on a pro bono basis.

- Reflecting its increasing importance in the provision of hospital services, the private sector is undertaking somewhat more clinical training than in the past.

Also, some of the current problems have stemmed from recent increases in undergraduate places. While indicative of lack of coordination within the education and training system, to some extent they are cyclical problems that will be resolved over time. Moreover, various responses to the undergraduate 'bulge', including by State and Territory Governments, are likely to ameliorate the consequences in the short to medium term. Notably, across Australia, the number of clinical training places for medical specialists increased by 14 per cent between 2000 and 2003 (see appendix B).

Equally, however, there are clearly systemic problems in current clinical training arrangements:

- There is a dearth of accurate, consolidated information on such things as available clinical training capacity (professional and site) and the numbers of undergraduate and graduate students seeking clinical placements.
- Funding for clinical training comes from a variety of disparate sources and is not always separately identified. This lack of transparency makes it more difficult to mobilise training resources in a coordinated way.
- The lack of explicit payment for many clinical training services — whether to the entities providing the infrastructure or to those providing the training — makes such training vulnerable to competing service delivery needs. It also inhibits the emergence of alternative competent training providers. Indeed, clinical training for General Practitioners under the GPET arrangements (see box 5.6) is the only area where funding and training delivery occurs largely within an explicit, transparent and contestable framework (although even here there is some pro bono supervision by College Fellows and a service delivery function performed by trainees as part of the training process).

The last of these characteristics of the current arrangements is proving to be a particular impediment to greater clinical training in the private sector. In the absence of a dedicated funding pool, there has been an ongoing debate (see below) about who should pay for training in private hospitals. Thus, while private hospitals are providing an increasing share of hospital services, growth in their training activities appears not to have been sufficient to offset reduced training capacity and activity in the public system.

Against this backdrop, and in what is intended to be a forward looking study, the Commission has therefore assessed what is required to help ensure that over the *medium to longer term* the clinical training regime is able to:

- offer adequate clinical training capacity at any point in time;
- respond in a timely manner as those needs change; and
- deliver training in the most cost-effective way — including, as appropriate, by competing providers.

To achieve this, effective coordination between the health delivery and education and training sectors is essential. Most simply, this might involve implementing a 'booking' system to match training places with student placement requirements. More broadly, institutional initiatives to increase the input of health care providers to the allocation of funding for university-based health workforce training (see above), could be particularly helpful in minimising mismatches between undergraduate intakes and available clinical training capacity.

The proposed workforce improvement agency could also play a role by drawing the attention of governments to the clinical training ramifications of job redesign. So too could the proposed health workforce education and training council in advising on the implications of new approaches to the provision of clinical training — especially those which could take pressure off the system by delivering training more efficiently.

But the Commission also sees the need for a better information base and some changes of emphasis within the broad clinical training framework.

Some of these requirements may well be encompassed by the current Medical Specialist Training Steering Committee (MSTSC) exercise aimed at putting specific proposals to AHMAC in the first half of 2006 (DoHA, sub. 159, p. 52). Amongst other things, this committee will be exploring issues relevant to the benefits and costs associated with diversification of training away from public teaching hospitals, and the implications for service delivery in those hospitals. It will also be reviewing training programs in the medical area to better align curricula with training settings. Indeed, the South Australian Government argued that the MSTSC's recommendations may have application to other health professions and that therefore broader clinical training reforms should await the outcomes of its deliberations (sub. PP343, p. 5).

However, in the Commission's view, past experience suggests that 'medically driven' health workforce reform may not always fully reflect the needs of other health professions. Accordingly, it sees the MSTSC exercise as being an important input to the broader reform process mapped out below, rather than the driver of that process.

A better information base

There is a clear need for those with policy responsibility in this area to have more accurate and comprehensive data on how the clinical training regime (and in particular specialist medical training) is actually working. It is telling that the policy areas of governments do not have a complete picture across the health workforce of who is providing clinical training, where it is being provided, and how its cost is distributed across the various players.

There is widespread recognition of the need for improvements in the information base. Apart from initiatives that may emerge from the MSTSC exercise, there is already some work in train at the State level. For example, the New South Wales Government noted that to support the development of mechanisms to coordinate and manage clinical placements:

> Work is progressing on priority actions identified including mapping current clinical placement arrangements, defining the purpose of clinical placements across all disciplines and review outcomes, collecting data on expected future demand for clinical placements, simplifying the number of clinical placements, identifying best practice models of clinical placements and clarifying governance models. (sub. 178, p. 30)

The RMIT University referred to a similar exercise in Victoria noting:

> The Victorian Government is currently conducting an audit of state-based clinical training that will address many of the concerns raised by the Commission and potentially provide a platform for further discussion. (sub. PP308, p. 5)

However, by themselves, such initiatives are unlikely to be sufficient. The initiatives though important are piecemeal, rather than occurring within an overarching framework reflecting national goals and priorities. It is far from clear that there will be sharing of the information collected at the jurisdictional level so as to facilitate the creation of a consolidated national data base. And, as noted above, the work of the MSTSC is focussed on specialist medical professions rather than the workforce as a whole.

Hence, the Commission sees the need for a coordinated and 'whole-of-workforce', national approach to improving the clinical training information base.

The Commission recognises that meeting the information requirements outlined above will be no easy task — especially determining precisely how costs and contributions to those costs are distributed (see section 5.2). The extent to which negotiated remuneration for Visiting Medical Officers working in public hospitals includes an implicit allowance for the provision of pro bono training services, is just one of the issues that arises in this context. Separately identifying the training component within total operational grants paid to teaching hospitals presents

another dilemma. However, the lack of such information is hampering efforts to develop transparent funding structures better able to provide for longer term clinical training needs.

Explicit payment for clinical training services

In the Commission's view, greater use of explicit payments to those providing infrastructure support for clinical training, and for the training services themselves, is likely to be necessary if the system is to remain sustainable over the longer term. Importantly, a dedicated revenue stream for both training providers and the institutions in which training is conducted would reduce the vulnerability of clinical training to competing demands on those resources.

Explicit funding could also be particularly helpful in encouraging the private sector to take on a larger clinical training role. In this regard, the Australian Private Hospitals Association commented:

> If Australia is to have a well-rounded health workforce, there is a pressing need to ensure that medical, nursing and allied health practitioners receive training in both the private and public hospital sectors. In order for this to occur, a coherent and equitable model of delivering and funding such training must be developed and implemented. (sub. 109, p. 2)

Also, explicit payment would provide a means to make funding for clinical training more contestable (see below) — with the ensuing competition in the provision of training services helping to enhance the efficiency of service delivery, and facilitating the emergence of new training approaches. The Commission notes that, as well as underpinning the arrangements for the training of GPs in Australia (see box 5.6), initiatives to make funding explicit and transparent have been part of clinical training reforms in countries such as the UK and New Zealand.

However, there is clearly some resistance to moving in this direction. Notwithstanding its concerns about the longer term sustainability of pro bono training provision, the Committee of Presidents of Medical Colleges (sub. 47, p. 1) said that there is little 'enthusiasm' for greater reliance on explicit payment models within the colleges. Also, the Victorian Government (sub. 155, p. 43) expressed concern that if an explicit payment model led to higher charges for trainees, existing financial incentives for those completing training to practise in the private system would be reinforced.

Box 5.6 **The GPET clinical training model**

General Practice Education and Training (GPET) was established by the Australian Government in 2001 to develop, oversee and provide funding for postgraduate training for medical graduates seeking entry to general practice. Previously, training was provided exclusively by the Royal Australian College of General Practice (RACGP).

There are presently around 1800 trainees undertaking a three year course, the Australian General Practice Training Program, which leads to RACGP fellowship. The Australian Government contributes around $60 million a year to the program. In addition, trainees pay fees to the RACGP for supervision and assessment. And there is also some pro bono service provision by College Fellows.

The program is delivered through 22 regional training providers (RTPs) across Australia, which are chosen through a tender process. (Successful tenderers have typically been partnerships between local GP 'coalitions of interest'). Supervision of trainees is provided by practising GPs, contracted by the RTPs.

RTP boards variously comprise representatives from medical colleges, universities, divisions of general practice, community organisations, consumers and other relevant bodies. Devolution of program delivery to the regional level is intended to provide scope to recognise diversity in needs and priorities in the training program, including in regard to preparation for work in rural and remote areas.

Though providing an example of an alternative to the predominant way of providing clinical training in Australia, these arrangements have not been problem free. A particular concern is that training necessarily continues to be organised according to RACGP standards and requirements. While the college (sub. PP329, p. 6) said that it employs very inclusive approaches with a range of stakeholders with the aim of being 'responsive to changing community and professional needs', GPET suggested that RACGP control of the process has sometimes impeded consideration of issues relevant to determining appropriate competencies:

> Tensions may arise when professional organisations define training requirements, determine the qualifications for practice, determine entry to the profession and define the scope of practice. It seems inherent that a regulatory system controlled by professional interests will emphasise role delineation. This impedes the incorporation of a broader range of expert input into defining professional competence. (sub. 129, p. 6)

Moreover, though there are avenues additional to the GPET program for clinical training to become a GP, these too are controlled by the RACGP. Hence, competition in the delivery of GP training services remains constrained, notwithstanding an element of contestability in the GPET component. As discussed in the text, the Commission considers that one of the primary reasons for making funding for clinical training explicit and contestable is to allow competing new delivery models to emerge.

A review of the cost-effectiveness of GPET is currently in progress.

Source: General Practice Education and Training (sub. 129).

But in the Commission's view, such concerns, of themselves, do not support continuation of an approach dependent on implicit funding and quid pro quos. For example, the issue of explicit payment to those providing training services is entirely separable from the question of how the costs of that training should be distributed across the various parties.

That said, the Commission emphasises that greater reliance on explicit funding and payment for clinical training services would not, and should not, preclude a continuing important role for pro bono training services. Indeed, notwithstanding the previously noted doubts about their sustainability over the longer term, for the foreseeable future, pro bono services will remain a key component of Australia's clinical training regime.

How should costs be distributed?

In the Commission's view, subject to the level of pro bono services that practitioners are willing to provide, the costs of clinical training should be met from three main sources.

- There should be a contribution from the education budget in lieu of the wider public benefits of having ready access to a well trained and clinically competent health workforce.
- Trainees should meet a part of the costs in recognition of the increase in earning capacity that typically results from the higher level qualifications and competencies delivered by such training.
- And where provision of training involves a service delivery function — as is often the case in hospitals in particular — the value of those services should be reflected in a contribution from the service provider (and ultimately from the health budget, private insurers and patients).

The significance of these three components, and hence the appropriate cost distribution, will vary across individual clinical training services. In particular, the service delivery and private benefit components will typically be higher for post-graduate training than for more basic clinical training embodied in undergraduate courses.

Elements of this cost and funding distribution underpin current clinical training arrangements. For example, undergraduate clinical training is funded by a combination of higher education subsidies and HECS charges. And a significant part of the cost of post graduate medical training is funded from service delivery budgets, with that funding augmented by contributions from trainees (as well as pro bono input).

However, the absence of good information on the distribution of benefits and costs of clinical training and how that training is currently funded (including the overall contribution of pro bono services), makes it very difficult to ascertain whether the current delineation is even broadly appropriate. That said, it is notable that in the case of clinical training for surgeons — one of the few areas where detailed costings have been attempted — trainees currently appear to meet as little as 3 per cent of overall training costs (see box 5.1).

The Commission acknowledges the practical difficulties of precisely determining and allocating costs according to the delineation set out above. Unbundling the service delivery component will be particularly problematic in some circumstances. But, in the absence of such unbundling, the current problems associated with lack of transparency and reliance on implicit funding sources will continue to compromise good clinical training outcomes. Moreover, the development of contestable delivery models (see below) will simply not be possible.

How much should the private sector contribute?

Several submissions to this study advocated a fourth source of funding for clinical training — a contribution from the private hospital sector additional to the direct value of the service delivery component in any training that it undertakes. For example, AHMAC observed that while not every private service is in a position to provide clinical training, all benefit from the availability of trained staff. It went on to note that:

> 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. (sub. 166, p. 33)

However, in the Commission's view, such a levy would not be appropriate. In keeping with the broad costing and funding delineation outlined above, *private and public hospitals alike* should only pay for the service delivery component embodied in clinical training. Indeed, wider application of the approach advocated by AHMAC could ultimately lead to employers meeting a substantial component of overall higher education costs.

It is true that public hospitals will be at an additional disadvantage in competing for staff relative to their private counterparts if they are required to fund more than just the service delivery component of clinical training. This situation could arise, for example, if charges for trainees are too low. But seeking to compensate through 'second best' levies on the private hospital sector will simply defer the necessary step of identifying and properly allocating costs according to the principles outlined above.

Addressing any unintended consequences of higher charges for trainees

As noted earlier, the Victorian Government (sub. PP297, p. 19) expressed concern that if a more efficient and equitable distribution of costs led to higher charges for trainees, it could reinforce the disincentives for practise in the public sector resulting from factors such as generally lower remuneration levels. Accordingly, it went on to propose a 'return for service' model where students would be required to commit to work either within the public sector, or to treat public patients in their private practices for a defined period after qualification. The Victorian Government likened this approach to the bonding arrangements used for medical student places in areas of need and also argued that it would have a more immediate impact on workforce supply and distribution than other costing and funding reforms.

However, while the Commission acknowledges that the concern raised is a real one, it sees considerable problems with the solution proposed.

- As is widely recognised, compulsory bonding arrangements are themselves likely to have a variety of adverse consequences for service delivery and thus for the well-being of patients.
- The causes of recruitment and retention difficulties in the public system are best tackled directly, including through competitive remuneration structures. Like the levy proposal, there is a risk that second best bonding measures could take the pressure off making the more fundamental changes required to deliver a sustainable clinical regime.

Encouraging contestable delivery

The Commission considers that another key requirement for a more efficient and sustainable clinical training regime is to, wherever possible, open up delivery to competition. As experience in a range of other sectors shows, contestability in service delivery can be a powerful tool for promoting more cost-effective provision and, through the emergence of new providers, for encouraging innovation and quality enhancement.

In the particular context of health workforce clinical training, the two components of funding that should notionally be contestable are governments' contribution in lieu of wider public benefits, and charges levied on the trainees themselves. In effect, these funding sources should 'follow the trainee', depending on how and where they elect to acquire their training. Conversely, the service delivery component of clinical training is specific to particular service providers. Hence, in a contestable delivery environment, service providers wishing to supply clinical

training would ‘top-up’ the generally accessible funding pool according to the ‘service’ value to them of trainees.

It is important to recognise that contestability in training delivery would not greatly alter many of the core components of the current clinical training regime. Professional bodies and their members would still have an important role to play in providing input to the proposed national board that would accredit training programs (see chapter 6). And notwithstanding the potential for greater use of clinical simulators (see box 5.7), the delivery of training would still rely heavily on the existing group of trainers.

However, those trainers would be working in a potentially wider range of settings and receiving explicit payment for their services. As noted earlier, a dedicated and contestable funding stream would facilitate more clinical training in the private hospital sector — a particularly important outcome given the continuing drift of a range of practitioners away from the public hospital system. Also, universities have advised of their interest in assuming a greater role in managing the delivery of clinical training services (see box 5.8).

There are, of course, a variety of constraints on both the degree of contestability feasible in this area and on the extent of competition that is likely to emerge. The scope to employ the approach is likely to be particularly problematic in situations where the service delivery component of clinical training is very high and thus where the contestable funding pool — the general government subsidy and contributions from trainees — is commensurately low. Pre-vocational training of interns and resident doctors in public hospitals prior to their entry to specialist programs, would be one area where such constraints loom large.

Further, as the AMA (sub. PP315, p. 8) observed, in many rural and remote areas, there are unlikely to be competing suppliers of clinical training. In other cases, there could be an element of ‘cherry picking’, leaving the public sector responsible for the bulk of ‘less viable’ training activity. (These issues are discussed further in chapter 10 in relation to the delivery of care services in rural and remote areas.) More broadly, the AMA contended that previous experience with managed competition in the Australian health care sector does not auger well for the likely success of contestable funding approaches for clinical training.

Box 5.7 **Simulated clinical training**

Clinical simulators can both substitute for, and complement, clinical training involving patients. Over the last decade, a number of simulation laboratories have been established in Australia on a collaborative basis between medical colleges and universities and, in some cases, State health departments.

Several participants pointed to the intrinsic benefits of simulated training. For example, the Urological Society of Australasia observed:

> A number of surgical skills laboratories are being set up throughout the country which eventually should provide virtual models, cadaver and live animal practice opportunities before supervised surgery on human patients is undertaken and competency to operate independently determined. (sub. 130, p. 4)

The New South Wales Government commented that:

> As an adjunct to clinical learning and consistent with best practice, better use should be made of simulated learning opportunities. There appears to be no clear national approach to development and use of this learning model and the Australian Government should take the lead on this important issue. (sub. 178, p. 30)

And Professor Peter Brooks said that overseas evidence indicates that simulated training delivers better outcomes in some areas:

> … in the training of laparoscopic cholecystectomy techniques, simulator trained residents performed the procedure 30% faster and made six times fewer errors while standard trained subjects were nine times more likely to fail to make progress and five times more likely to injure the gall bladder ... Simulators are now used extensively for training in cardiac endoscopy and interestingly the Federal drug administration in the USA has mandated simulator training for some of the newer cardiac stents. (sub. 13 (attachment), pp. 9–10)

In regard to the contribution of clinical simulators in promoting more efficient workforce outcomes, the South Australian Government said that:

> In QLD, a Skills Laboratory has been developed which can be used for competency testing in relation to the medical workforce. For example, testing of hand eye coordination early in medical training would enable the students to be assessed for their capacity to undertake certain specialisations that require high levels of hand/eye coordination (eg surgery). This could lead to earlier preselection for certain types of specialisation and reduce wastage. (sub. 82, p. 37)

However, others such as the HPCA (sub. 70, p. 10) cautioned that 'Computer-based learning experiences can enhance but not substitute for hands-on training in a hospital or other clinical environment'. It noted that simulators are costly and still require clinicians both to devise and supervise workshops in a laboratory setting, and develop the competencies which form the basis of assessment.

Box 5.8 **What role for universities in clinical training?**

Aside from the management of clinical training for medical students and some other disciplines, the current role of Australian universities in the clinical training of health workers is quite modest, being mainly limited to on-site training in certain allied health areas such as dentistry and podiatry, and involvement in consortia delivering postgraduate training to GPs under the AGPT arrangements. In contrast, universities in countries such as the USA and Canada play a significant role in postgraduate clinical training across the full spectrum of medical specialities. This was also the case in Australia during the first half of the last century.

University interests submitting to this study wished to explore opportunities to increase their current level of involvement in the clinical training area. For example, CDAMS argued:

> As expert educational providers universities could, if properly funded to do so, provide the necessary education and training programs which could then link with and inform the certification processes managed by the Colleges. (sub. 49, p. 14)

However, it went on to say that this would require a process of unbundling of the education component of State-based hospital funding, as happened several years ago in the UK to create the 'Service Increment for Teaching'.

The Committee of Presidents of Medical Colleges (sub. 47, p. 1) expressed some scepticism about this approach, claiming that it has not been widely successful in other countries and that there is little support for it within the Australian medical colleges. Nonetheless, collaborative initiatives between the colleges and the universities are currently being canvassed, which would see universities providing the more academic-related components of clinical training programs such as in basic sciences, communication and ethics modules.

Some have suggested that clinical training could occur within universities outside of the college system. In this regard, during the recent ACCC authorisation process for the Royal Australasian College of Surgeons' (RACS) training program, the Hunter Area Health Service submitted that:

> … an opportunity now exists to establish a new, innovative, high-quality medical graduate training program — to be accredited by the Australian Medical Council and to complement the training program undertaken by the Colleges … For example, a surgical training program could be designed and implemented by the University of Newcastle, in partnership with the College and Hunter Health. Such a program could stand-alone (without the College's involvement, if the College were not prepared to participate) and be independently accredited by the AMC … (ACCC 2003, p. 121)

Hunter Health also contended that the program could be funded on a user pays basis without any need for government funding — though the Commission understands that no progress has been made in implementing the proposal due to funding constraints.

However, in the Commission's view, both GPET and clinical training reform programs in other countries suggest that, in *some* circumstances, contestable funding is both viable and can contribute to more efficient, innovative and

sustainable clinical training services. Hence, what is required is an institutional and funding framework which encourages contestability where appropriate, rather than hinders it. In this regard, the Commission reiterates that appropriate cost allocation and explicit payment mechanisms are crucial.

Changes to regulatory and indemnity insurance arrangements

For there to be greater contestability in the provision of clinical training, some changes in regulatory arrangements may also be required. For example, as discussed earlier, some have suggested that the effectiveness of the Australian General Practice Training Program has been compromised by the continuing control of the RACGP over all of the specific training pathways. It is partly to address these sorts of concerns that the Commission is recommending the introduction of a new independent national accreditation board for all health education and training courses (see chapter 6).

There may also be some issues to be resolved in regard to indemnity insurance for those supervising clinical training in the private sector. While the Medical Indemnity Industry Association of Australia (sub. 62, pp. 5–6) said that access to indemnity insurance should not be a barrier to private sector training, with 'affordable' cover available to both supervising practitioners and trainees, others expressed the view that there are still impediments in this area. However, little supporting detail was provided. Medical indemnity issues are discussed further in chapter 12.

Giving effect to these requirements

Implementing the changes advocated by the Commission will clearly be a challenging task. The issues involved are intrinsically complex — not least how best to support and encourage a continuing element of pro bono training provision, while at the same time moving towards greater reliance on explicit payments and contestable service delivery.

Moreover, the reform directions required cut across a number of discrete policy spheres — including education, health services delivery, funding and central policy coordination. Hence, the Commission considers that CoAG, rather than Australian Health Ministers, should be responsible for driving and oversighting the reform process in this key area.

Indeed, without CoAG involvement, there is a real risk that the sort of coordination problems that have hindered past reform efforts and detracted from training outcomes will continue to frustrate necessary change. CoAG involvement would

also provide an opportunity to assess the case for some consolidation of government funding for clinical training — an approach advocated by some jurisdictions.

RECOMMENDATION 5.3

As a matter of priority, CoAG should establish a high level independent taskforce to:

- ***collect and assemble comprehensive and nationally consolidated data and information on: the demand for clinical training across all health professions; where it is being provided; how much it costs to provide; and how it is being funded; and***
- ***in the light of this information, recommend specific changes to facilitate more transparent, coordinated and contestable clinical training arrangements, including through:***
    - ***— a more appropriate allocation of clinical training costs according to the benefits accruing to the various parties;***
    - ***— greater reliance on explicit payments to those providing infrastructure support or training services, within the context of a system that will continue to rely on, and benefit from, considerable pro bono provision; and***
    - ***— removal of regulatory or other barriers that impede the development of contestable delivery or otherwise impede the efficiency and effectiveness of clinical training outcomes.***

6 Accreditation

Key points

- The process of *accreditation* assesses and evaluates education and training courses and institutions to 'guarantee' standards and consistency of health professional education and training.
  - It is complemented by *registration* which gives professionals the legal right to practise.
- Current accreditation arrangements can inappropriately reinforce traditional professional roles and boundaries, and thus impede job innovation. Inconsistent requirements imposed on educational institutions and trainers by different agencies create further inefficiency.
- A national cross-profession approach to accreditation would preserve the best features of current arrangements while facilitating:
  - more timely and objective consideration and adoption of beneficial cross-profession job evolution and redesign options;
  - interdisciplinary and multidisciplinary education and training and articulation between VET and higher education and training;
  - improvements in the appropriateness and consistency of accreditation in the different professions;
  - uniform national standards on which to base professional registration; and
  - reductions in administrative and compliance costs.
- Governments should establish a single statutory national accreditation board for health workforce education and training.
  - This board should be separate from a national registration board (chapter 7).
  - Initially, at least, the board could delegate responsibility for functions to appropriate existing entities, on terms and conditions set by the board. Such entities would be selected on the basis of their capacity to contribute to the overall objectives of the new accreditation regime.
  - VET should be covered by these new arrangements, although there are grounds for excluding it until the arrangements are operating successfully in other areas.
- The new board would also assume responsibility for accreditation functions in relation to overseas trained health professionals.

Accreditation stands at the interface between what the community and employers need from the health workforce, and the education and training that provides the

workforce with the skills and competencies to meet those needs (see figure 4.1 in chapter 4). Its primary role is to assess and approve education and training courses and facilities so as to provide 'guarantees' of standards and consistency of health professional education and training, when measured against required workforce skills, competencies and scopes of work. When done well, accreditation can facilitate such matters as beneficial job evolution, a more effective distribution of competencies, and interdisciplinary and multidisciplinary approaches, on the one hand, and the necessary educational and training curricula and facilities on the other.

The process of accreditation is complemented by registration — this legally recognises practitioners' qualifications, experience and 'character' as being suitable for practise. Its purpose is to help overcome the information asymmetry between health professionals and their patients, and to provide assurances of quality and safety. As explained by the Joint State and Territory Health CEOs:

> Under [current arrangements], accreditation standards (which often draw upon or refer to profession specific competency and/or professional standards) in effect set qualifications requirements for registration and may also form part of disciplinary processes. Registration boards will issue codes and guidelines that provide advice on issues of interpretation and set expectations around how practitioners will be judged against such standards, where these exist. (sub. PP332, p. 21)

Most registration boards currently have considerable discretion as to the qualifications they recognise and the conditions they impose on registration, including recognition of scopes of work and/or codes of professional conduct. In this respect, much of the initial commentary from participants about accreditation/registration focused more on the registration boards themselves (see box 7.1 in chapter 7), although submissions in response to the Position Paper more extensively canvassed issues ranging across both the accreditation and registration functions.

This current chapter covers accreditation, including an assessment of whether the accreditation and registration functions could usefully be combined, while chapter 7 covers registration issues.

6.1 Existing accreditation arrangements

With the notable exception of nursing (which is working towards a national approach to nursing regulation through the Australian Nursing and Midwifery Council), much of the accreditation task within Australia for university based training and beyond is undertaken on a national basis, sometimes extending to New Zealand. However, it is undertaken by over 20 different bodies and there are

considerable differences in approaches across professions (table 6.1). Some of these bodies have explicit statutory functions, while others may have responsibilities delegated from registering authorities or themselves fulfil a registration role. In some professions, accreditation bodies were established in cooperation with, or as an initiative of, the respective peak professional associations.

Table 6.1 **Examples of accreditation bodies and functions**

Profession	*Agency*	*Scope*
Medical	Australian Medical Council	Undergraduate education (Australia and New Zealand) Specialist medical colleges (by agreement)
	Postgraduate Medical Education Councils (state based)	Intern posts
	Specialist medical professional colleges	Learning plans, training posts, facilities
Nursing	State nursing registration boards	Education and training
Dental	Australian Dental Council	Courses (jointly with New Zealand)
Optometry	Optometry Council	Courses (Australia and New Zealand)
Physiotherapy	Australian Council of Physiotherapy Regulating Authorities	Courses
Podiatry	Australasian Podiatry Council	Courses
Pharmacy	Council of Australian Pharmacy Registering Authorities	Pharmacy providers and courses
Sonography	Australian Sonography Accreditation Registry	Courses (also fills a registration role)

Sources: Various, including AHMAC (sub. 166) and Victorian Government (sub. 155).

The accreditation arrangements for the medical professions are particularly complex and diverse, reflecting in part multitiered education and training arrangements. Thus, they involve not only the Australian Medical Council, but also a number of Postgraduate Medical Education Councils as well as the specialist medical professional colleges. In regard to the latter, some recent work of the Australian Competition and Consumer Commission (ACCC) is relevant:

- In June 2003, the ACCC granted authorisation to the Royal Australasian College of Surgeons for a number of its processes in relation to the training of surgeons and the assessment of overseas trained doctors. This was subject to the College

implementing a number of reforms, broadly relating to transparency, accountability, stakeholder participation and procedural fairness (ACCC 2003).

- Subsequently, the ACCC reviewed, jointly with the Australian Health Workforce Officials Committee, the extent to which those principles were followed by other specialist medical colleges. The recommendations arising out of that July 2005 report (ACCC 2005b) were agreed by Australian Health Ministers (ACCC 2005a).

At the VET level, accreditation often proceeds through the development and approval of competency-based training packages on a national basis. Many of those of relevance to health are progressed through the Community Services and Health Industries Skills Council, a tripartite national body representing relevant governments, employers and unions. This council operates across traditional professional-based boundaries.

Accreditation can take place at a number of levels, including: courses and curriculum; teaching processes; assessment processes; approval of facilities; training plans for individual students and training positions. Accreditation does not usually involve the actual examination or assessment of individual students and trainees. The complexity of accreditation can vary, but major exercises can be broad in scope (for example, assessment of a medical school), lengthy (18 months or more), and require the input of expert resources. Health professionals often contribute to accreditation processes on a pro bono basis.

6.2 Issues and proposals

Initial submissions

As noted above, many initial submissions focused on registration functions rather than those of accreditation. Where there was commentary on accreditation, it usually outlined the role of existing accreditation agencies in relation to the various health professions, without raising any major concerns or problems. Generally, existing accreditation arrangements were seen to be performing a necessary and worthwhile role in an adequate fashion, at least from the viewpoint of individual professions. For example, the Royal Australasian College of Surgeons considered there were ‘no stiffer tests in Australia’ than the accreditation standards of the Australian Medical Council, and hoped that ‘this issue [of accreditation of surgeons] had finally been put to rest’ (sub. 148, p. 5).

However, in their initial submissions, some participants, with a perspective of the operation of accreditation arrangements across the health professions, expressed concern about the efficiency and effectiveness of the regime as a whole. In the view of the Australian Government Department of Health and Ageing:

> The separate, complex and profession-based regulatory provisions currently operating State by State adversely affect health workforce capacity. A nationally consistent approach to regulatory arrangements for health care professionals which is centred on individual competencies would encourage portability, workforce flexibility and help address workforce distribution issues. Agreement has recently been reached on introducing nationally consistent arrangements for the medical profession, but not for any of the other major health professions. (sub. 159, p. 32)

Two broad areas of concern were identified by this group of participants. The first centred on the effect of current accreditation arrangements in reinforcing traditional professional roles and boundaries and thus impeding job innovation. The second was the lack of consistency in the requirements that different accreditation agencies impose on educational institutions and trainers (box 6.1).

The solution to these problems was seen as involving consolidation of the accreditation functions for the various professions within the one national framework, perhaps coupled with national registration as well.

For example, AHMAC considered that the adoption of a cross-profession national model would:

- support the development of a more responsive system by reducing inconsistencies and inefficiencies within current arrangements;
- remove or substantially reduce the complexities associated with multiple accreditation across multiple jurisdictions; and
- through the development of core competencies on a national basis, 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.

Moreover, it considered that the potential of national arrangements to constrain 'innovative solutions to workforce issues locally' could be 'easily overcome by constructing the national accreditation standards, principles and processes to support such innovation' (sub. 166, p. 40).

The Tasmanian Government commented that the development, endorsement and accreditation of new health care roles on a national basis would greatly benefit health care in Tasmania (sub. PP180, p. 15). It called for streamlining of accreditation, by:

Box 6.1 Concerns with accreditation arrangements raised in initial submissions

Reinforcing traditional roles; stifling job development

> [Accreditation bodies] reinforce traditional workforce roles, rather than focusing on evolving service and client needs. The single-discipline focus is opposed to current policy directions that encourage inter-disciplinary approaches, optimal use of workforce skills and workforce adaptability. (Victorian Government, sub. 155, p. 48)

> … 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. (AHMAC, sub. 166, p. 38)

Costs imposed by multiple agencies and/or lack of consistency

> If a coordinated approach to the accreditation of hospitals in relation to education and training was developed this would provide a significant improvement to hospitals and would cut down on a great deal of administration and save time. (Postgraduate Medical Council of NSW, sub. 153, p. 5)

> Currently, a range of professional self-interest groups is responsible for course accreditation. The process is cumbersome, long — up to two years — and is relatively costly. Accreditation standards and the methods of inspection also vary significantly between professions and can be applied inconsistently across jurisdictions. The ACT requires a greater range of health courses but current accreditation processes appear to be an insurmountable obstacle to course growth. (ACT Government, sub. 177, p. 11)

> The process of accreditation is unacceptably variable across different professions and in different States. Using hours as a fundamental yardstick … is inappropriate in a work environment where processes and practices have changed radically in the last 20 years, and which is also fundamentally inhospitable to the trainee. (Monash University, Faculty of Medicine, Nursing and Health Sciences, sub. 89, pp. 6–7)

> As this fragmentation of organisation suggests, some rationalisation in relation to accreditation and certification should be considered. (Committee of Deans of Australian Medical Schools, sub. 49, p. 17)

> 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. (AHMAC, sub. 166, p. 39)

> Making a single national body responsible for: (1) course accreditation in Australia or overseas, including identification of competencies required at various levels across health occupations; and (2) the assessment of skills and qualifications, including recognition of current competence and assessment of internationally trained practitioners. (sub. PP180, p. 18)

The Victorian Government was more specific. It suggested the Australian Government and the States and Territories work together towards the establishment of a National Health Education and Accreditation Council which would be a 'multidisciplinary model for national course accreditation, curriculum leadership and the assessment of international practitioners' (sub. 155, p. 51) — the functions proposed are listed in box 6.2.

Box 6.2 **The Victorian Government's proposed National Accreditation and Education Council**

According to the Victorian Government, a National Health Accreditation and Education Council should be established to:

- Identify competencies required for both entry level and more specialised practice across the health workforce, based on common core competencies.
- Assess and accredit courses for health practitioners seeking to enter (or re-enter) the health workforce.
- Maintain and publish a list of approved courses of study.
- Develop and publish standards and guidelines on the criteria and processes for course accreditation and assessment of international practitioners following consultation with key stakeholders such as educational institutions, professional bodies, consumers and government. This would include mandatory minimum requirements for safe practice assessments prior to entering the workforce.
- Assess courses and determine equivalence of overseas courses for accreditation purposes.
- Assess qualifications of international practitioners and determine additional requirements for purposes of registration in all categories.
- Provide leadership on national reforms and implement policy directions that allow the education and training system to respond to emerging health industry needs.

Source: Sub. 155, p. 51.

Response to the Commission's Position Paper

In its Position Paper, the Commission argued in favour of cross profession national accreditation placed under the responsibility of a single statutory national accreditation agency. The many comments received in response were fairly evenly divided for and against such an approach (box 6.3).

Of particular note is the support of the State and Territory Governments for a national across profession accreditation agency, also reflected in the submission

Box 6.3 **Views for and against consolidated national accreditation**

College of Nursing:

> Separation of accreditation across the health [professions] is just one more thing which contributes to the fragmentation and inflexibility of practices and education and training. (sub. PP292, p. 2)

Chiropractors' Association of Australia:

> … the current profession based accreditation arrangements … have given rise to inconsistencies; reinforce workforce rigidities; discourage the exploration of new professional roles and job redesign; and block the efficient and effective deployment of the health workforce. (sub. PP263, p. 22)

Aboriginal Medical Services Alliance Northern Territory:

> [the proposal] would enhance the multidisciplinary nature of service delivery, especially in primary health care services. Such a body would further assist in the process of achieving national registration process across health disciplines. (sub. PP244, p. 1)

Committee of Deans of Australian Medical Schools:

> [we agree] in principle with the proposed approach … [with the provisos that the AHMAC suggestion of a staged introduction be adopted and] that the excellent achievements of current accreditation processes, particularly those of the Australian Medical Council [be specifically acknowledged and] … be used as a base on which to build the overarching national system. (sub. PP337, p. 7)

Professions Australia:

> … creation of a national accreditation body is [not] necessary to support job redesign and workplace flexibility. (sub. PP346, p. 1)

Australia Medical Association:

> … there can be little doubt that the result … of national consolidation of accreditation will be the homogenisation of the health profession with the consequent disengagement of professional groups in the provision of the expertise required for appropriate standards setting. (sub. PP315, p. 8)

Dental Hygienists:

> The Australia Dental Council … efficiently carries out accreditation … (at no cost to the government) and another level of regulation and bureaucracy is absolutely unnecessary. (sub. PP301, p. 2)

Australian Nursing Federation:

> There are significant professional differences between the professions and it would not be beneficial to develop uniform national standards. (sub. PP291, p. 8)

Australian Physiotherapy Association:

> [we reject] outright the notion that professional standards are best established by anybody other than clinical experts in that discipline. (sub. PP271, p. 13)

Royal Australian and New Zealand College of Psychiatrists:

> … the present system for accreditation of medical colleges by the AMC is currently working well, and … the proposed change risks creating an inferior system. (sub. PP245, p. 2)

from the Joint State and Territory Health CEOs (sub. PP332). Further, the Australian Government's Department of Health and Ageing commented that:

> There is merit in the Commission's recommendation for a staged introduction of a national accreditation system for health workers. This would enable future workforce training and design issues to be considered on a whole of workforce basis rather than in the current professionally compartmentalised framework. (sub. PP293, p. 4)

In the Commission's view, several participants arguing against the draft proposal appear to have misinterpreted its intent, suggesting that it would lead to generic health workers, 'homogenised' health roles, a lowering of accreditation standards, and/or loss of professional interest and expertise in accreditation. For example, in proposing an alternative national accreditation arrangement (box 6.4), the Australian Medical Council commented that it had understood that:

> … the Productivity Commission was proposing to dismantle the existing, internationally recognised accreditation processes and reduce the involvement of the health professions in the accreditation of health workforce education and training on the grounds that 'professional self interested groups' constituted an impediment to job substitution and redesign. (sub. PP306, p. 1)

The Commission shares the concerns of these participants that the quality and safety of health services provision in Australia should not be compromised. Its intention is to build on the expertise inherent in existing accreditation arrangements, while facilitating improvements in a number of ways — as elaborated on in the following section. The Commission sees no merit in the blanket production of generic health workers, homogenised work roles or lowest common denominator approaches, and rejects the notion that introduction of a consolidated national accreditation framework would lead to such outcomes. Further, its proposals would continue to draw on, and indeed enhance, the full range of professional health and education expertise which is currently contributing to quality accreditation.

To give clear guidance to the reform process, the Commission has set out its proposal in more detail, including the proposed governance and operating arrangements — see section 6.4.

6.3 The case for a single national accreditation regime

As noted above, several participants considered that there would be advantages from greater national consolidation of accreditation functions, but considered that this would be best pursued on a profession by profession basis or, alternatively, by way of consolidation within broad groupings such as the medical professions, nursing, dentistry and the allied health professions.

Box 6.4 **The AMC's proposal for national accreditation**

The AMC considered that there is considerable scope for increased efficiency in the current accreditation processes without diminishing the successful elements of those processes. Accordingly, the AMC advised that it would support the establishment of a Coordinated National Accreditation Scheme that included the following elements:

- An over-arching National Accreditation Council to facilitate national accreditation processes and innovation across the health professions and service delivery groups.
- The accreditation processes conducted through the existing professional accreditation bodies under the umbrella of the National Accreditation Council and with appropriate statutory authority.
- Integrated accreditation processes developed to deal with new health workforce delivery models, job redesign or multi-professional groups. (The joint Australian Dental Council/AMC accreditation process for oral and maxillofacial surgery, which is a joint dental/medical qualification could serve as a model for this type of accreditation model.)
- Adequate funding for allied health professions to develop robust and efficient accreditation processes as part of a national accreditation framework.
- An agreement to share expertise.
- Participation of other related accreditation agencies, such as the Australian Council for Health Care Services and the Australian Universities Quality Assurance Agency under the National Accreditation Council, to address the problem of duplication in accreditation processes and explore options for further streamlining. (This interchange is already underway following a recent Professions Australia workshop.)

Source: Sub. PP306, p. 7.

The Commission accepts that there are likely to be benefits from consolidation of accreditation on either of these bases which, in several respects, would build on existing arrangements. Indeed, within professions, a national approach to accreditation is already widespread. Further, although there can be a division of functions across a number of agencies within a profession, there is growing consolidation, as evidenced by the functions that the Australian Medical Council now undertakes for a number of specialist medical colleges.

However, in the Commission's view, drawing all health professions into a consolidated national accreditation framework would bring additional benefits:

- Together with the formation of a national workforce improvement agency (chapter 4) and national registration (chapter 7), it would facilitate a whole of workforce approach to health workforce policy.

- In turn, this would support accreditation of education and training related to new and developing health workforce roles recommended by the proposed improvement agency.
- It would facilitate consideration of such issues as the role for interdisciplinary and multidisciplinary education and training, the appropriateness of common education and training modules across professions, and the merits of competency based and/or skills escalator approaches. Further, the inclusion of VET would facilitate consideration of articulation issues.
- It could promote the improvement of accreditation standards, the adoption of best practice as well as consistency between professions where warranted, while avoiding onerous requirements where not appropriate.
- And there could be administrative and compliance cost savings and efficiencies from greater uniformity in the accreditation requirements imposed on education and training institutions.

Possible costs

Of course, a move to consolidated national accreditation would not be without costs. Apart from some disruption and other transitional costs, several participants contended (see above) that there is some risk that the approach would reduce the professional commitment currently underpinning profession specific arrangements.

The likely size and duration of these costs, however, will depend crucially on the manner in which such a framework is implemented. For example, operating arrangements which draw and build on the existing professional accreditation agencies are more likely to have fewer costs of this nature than a completely new system.

Weighing up

On balance, the Commission considers that significant net benefits are likely to arise from the introduction of a national across profession accreditation framework for health workforce education and training. This is especially the case as the potential costs can be minimised through intelligent design of such a framework, and its associated operational structure.

That all Australian Governments — State, Territory and Federal — support a consolidated national approach gives weight to the Commission's conclusion, as well as confidence that the approach can be effectively translated into practice.

6.4 Implementing a national accreditation board

As recognised by various participants, including the Victorian Government and AHMAC, the move towards a national accreditation system will need to be approached in a considered, measured and inclusive manner. To assist policy makers in their consideration of the many implementation issues, the Commission has set out below its views on some important design and institutional features.

A separate national board

In the Commission's view, a national cross profession consolidated approach to accreditation should be given statutory force. Appropriate legislation will be needed to establish a national board, with a number of options available in this regard, including uniform legislation across jurisdictions, template legislation, and single law. However, the approach chosen would need to guard against the problems that have reduced the effectiveness of mutual recognition in relation to state based registration arrangements (chapter 7).

Some participants considered that one consolidated national arrangement should be established to cover both accreditation and registration functions across professions. For instance, the Joint State and Territory Health CEOs considered that:

> Combining these functions would ensure a more systems based approach to the development and maintenance of professional standards and the range of instruments through which these are given effect (including accreditation standards and disciplinary processes conducted as part of ongoing regulation). Combining the registration and accreditation functions would also ensure that the model would be impartial and independent and could continue to be self-funding through practitioner registration fees. (sub. PP332, p. 22)

However, in the Commission's view, it would be good regulatory practice to separate the setting and verification of standards at the education and training institutional level from the application and maintenance of standards in relation to individual practitioners. Further, the Commission believes it is possible to establish two separate boards — accreditation and registration — on an 'impartial and independent' basis.

Coverage of professions

The national accreditation board should cover, as a minimum, the education and training for all those health workforce professions for which registration is currently compulsory. Thus, the regime would encompass many of the existing mainstream medical, nursing, dentistry and allied health professions.

Further, there will often be justification for including a profession in national accreditation even if compulsory registration of that profession is not warranted, for example, because credentialing and/or self-regulation provides a better alternative to registration. Inclusion in national accreditation of such professions could support such objectives as facilitating cross profession perspectives, and improving education and training through more consistent and appropriate accreditation processes. Case-by-case judgment will need to be exercised, however, particularly as scopes of practice change and evolve, and new roles develop.

Coverage of VET

There was some comment about the inclusion of VET in an all-embracing national accreditation arrangement for the health workforce. Some, for instance, such as Health Reform South Australia (a coalition of non-government organisations) considered that VET should be:

> … considered in tandem with university based training, not at a later time. VET provides a substantial proportion of the workforce for aged care and community care. … VET also provides some good examples of how it has developed training in response to community need and this experience may be valuable when considering redefinition of roles and the competencies required within these roles. (sub. PP276, p. 4)

However, others argued against VET's inclusion on a number of grounds, including: that health training undertaken in that sector is already subject to a national framework that ensures nationally recognised qualifications; and that current VET accreditation processes and 'quality' of accreditation are deficient when considered against the needs of higher education and training.

In the Commission's view, inclusion of VET in a consolidated national health workforce accreditation arrangement would bring a number of benefits:

- it would reinforce an across profession perspective to accreditation;
- it would encourage improvement to the 'quality' of accreditation for VET where that is required;
- within a profession, it would facilitate coordination and development of education and training across the full range of roles — for example, within nursing from assistants in nursing and enrolled nurses to registered nurses and nurse practitioners;
- similarly, it would contribute to better linkages between the health workforce and workers in the aged and community care sectors; and

- it would facilitate the development of appropriate articulation arrangements between VET and higher education and training on a more widespread and coordinated basis.

Even so, there are reasons to consider delaying the incorporation of VET within a new national health accreditation framework. First, the current VET system appears to respond reasonably flexibly to the changing needs of the community and employers, without undue emphasis on a profession-specific approach. Indeed, the system may well provide some object lessons for the new national arrangements for university education and postgraduate training.

Second, the VET system is currently undergoing considerable change as the Australian Government beds down its new arrangements (see chapter 5). As well, the Commission notes that a review of the Health Training Package was scheduled to be finalised by December 2005. This review 'will identify and address new skills mixes and clustering of competencies standards to reflect changing roles and workplace requirements' (Department of Education, Science and Training, sub. PP181, p. 11).

Third, the task of establishing national across profession accreditation for higher education and training, including postgraduate education and training, will be a significant challenge on its own, without complicating the process by also including VET.

On balance, in the Commission's view, VET should be included as soon as feasible, although there are some grounds for excluding it until the new arrangement is operating successfully in other areas.

Functions

The national board would exercise statutory powers across the range of accreditation functions including, as appropriate, accrediting courses, facilities and institutions. It would cover academic teaching as well as clinical and other forms of practical education and training, including postgraduate education and training. Functions such as the selection of students, assessing students and certification would generally remain with education and training providers, although assessment processes would be of legitimate interest to the accreditation board.

As noted, a prime aim of accreditation is to promote effective and consistent standards for health professional education and training, when measured against required workforce skills, competencies and scopes of work. From this viewpoint, it would also be advantageous for the national board to accredit education and training

programs required for continuing professional development across the range of professions.

So that its role is clear, and to avoid duplication with other agencies (for example the proposed workforce improvement agency), its functions should be clearly set in an education and training context. It should, however, enter into dialogue with other bodies, advising on the accreditation implications of major job innovation proposals and, where necessary, develop relevant accreditation procedures to respond to those changes, as well as to changing models of care. Chapter 13 provides an example of how the national accreditation board would operate within the new regime proposed by the Commission.

Governance

As AHMAC commented, governance of such a national accreditation body would need to be carefully designed to ensure appropriate membership, responsibilities and accountabilities (sub. 166, p. 41). In the Commission's view, the nature and composition of the governing board is particularly important in this regard.

Adopting the governance structures of existing accreditation agencies as the basis for the new board could undermine its impartiality and independence in the context of the cross profession perspectives required. For example, broadening the functions of the Australian Medical Council, and its governance structure, to progressively embrace the other professions could be seen by many other stakeholders as detrimental to achieving the cross profession benefits potentially on offer from a single national accreditation agency.

Some participants called for a body that provided for representation from professional interest groups. For example, in advocating a 'peak national body to oversee all aspects of accreditation and registration', the Council of Deans of Nursing and Midwifery (Australia & New Zealand) commented that:

> We would expect that nursing is represented on all panels and that nursing courses were accredited by nurses. (sub. PP215, p. 1)

Others, including the Victorian Government, argued for membership to focus on the broader public interest with:

> … balanced representation from professions, universities and training providers, educational experts, government and consumers to ensure the public interest remains paramount. (sub. 155, p. 50)

As discussed further below, the Commission recognises, and supports, the contribution of health professionals in the detailed accreditation processes for their

particular professions. However, while the new national accreditation board will need access to expert input, the Commission rejects the concept of 'representation'. The comments on governance made in chapter 4 in relation to the national workforce improvement agency and in chapter 7 to registration boards are equally relevant here. Thus, as for these other entities, membership of the national accreditation board should contain the necessary health, education and training knowledge and experience, structured to reflect the public interest generally, rather than 'represent' the interests of particular stakeholders.

Operation

The new national board would assume *statutory responsibility* for the range of existing accreditation functions carried out by such bodies as the Australian Medical Council, Postgraduate Medical Education Councils, the Australian Dental Council, the Optometry Council, the allied health accreditation agencies, professional bodies and, in some cases, registration boards.

However, as noted above, it is important for its detailed operating arrangements to maintain and build on the existing professional commitment to the accreditation function. In this regard, a method of operation which sought to subsume, from the outset, existing profession based agencies and arrangements is unlikely to be successful. At the very least, it would put many professionals offside, disrupt current arrangements and cause delays to accreditation processes.

Another option would be to *delegate*, initially at least, accreditation responsibilities from the new national board to appropriate existing entities. As well as helping to maintain professional commitment to the accreditation process, such an approach would continue to support international profession specific links which have been established under existing arrangements.

Of course, the national board would need to ensure that the objectives underlying its formation were being achieved and that the broader public interest was being promoted. Thus, delegation to existing bodies would need to be on terms and conditions set by the board with those bodies selected on the basis of their capacity to contribute to the overall objectives of the new accreditation regime. In this regard, in areas such as medicine, nursing and allied health, the new board should consider whether delegating to a limited number of entities — or even to just one national body in each area — would be more effective than delegating to the multiplicity of existing accreditation agencies.

This delegation approach has considerable similarity to the proposal of the Australian Medical Council, a major difference being in where formal statutory

responsibility for accreditation would lie — with the new national board under the Commission's approach, and with existing profession based agencies under that of the AMC (subs. PP306, PP365).

Operating procedures would need to be reviewed periodically by the accreditation board, with the aim of building on strengths and overcoming weaknesses and assessing the relative merits of alternatives.

RECOMMENDATION 6.1

The Australian Health Ministers' Conference should establish a single national accreditation board for health professional education and training.

- ***The board would assume statutory responsibility for the range of accreditation functions currently carried out by existing entities.***
- ***VET should be included as soon as feasible, although there are grounds for excluding it until the new arrangement is implemented and operating successfully in other areas.***
- ***Collectively, board membership should provide for the necessary health and education knowledge and experience, while being structured to reflect the public interest generally rather than represent the interests of particular stakeholders.***
- ***Initially, at least, the board could delegate responsibility for functions to appropriate existing entities, on terms and conditions set by the board. Such entities should be selected on the basis of their capacity to contribute to the overall objectives of the new accreditation regime.***

6.5 Assessment of overseas trained professionals

Overseas trained professionals are an important part of the Australian health workforce. For example, the Department of Health and Ageing noted that overseas trained doctors now constitute around 25 per cent of the overall medical workforce and a significantly higher percentage of doctors in rural and remote areas (sub. 159, p. 27). Recognition of the skills and competencies of overseas professionals, and allowing them to practise in areas appropriate to their competencies, supports good workforce deployment (see the discussion about 'national self sufficiency' in chapter 3).

However, in the wake of recent incidents, there have been widespread concerns about various aspects of the current arrangements for assessing and recognising the competencies of overseas trained doctors (box 6.5). In particular, the rigour of the different assessment procedures for temporary resident doctors has been questioned.

While there is recognition that removal of the existing alternative assessment paths for this group could lead to major short term disruption to service delivery (particularly in rural areas), several participants questioned whether current controls are sufficient to protect patients and whether there would be value in a more uniform approach.

Box 6.5 **Assessment of overseas trained doctors**

The assessment path for overseas trained doctors depends on whether the practitioner is seeking general/unconditional registration (required for permanent residency) or conditional registration in Australia.

Overseas trained medical practitioners who have trained in medical schools that have not been formally reviewed and accredited by the AMC and who are seeking to practise medicine in Australia under *general* registration, must sit a national examination administered by the AMC. This exam assesses whether practitioners are at the same or a better standard than newly qualified graduates of Australian medical schools who are about to go into intern training. Practitioners must also complete a period of supervised training approved by the State or Territory registration board (usually of 12 months duration).

However, sitting and passing the AMC exam is not a requirement for overseas doctors seeking *conditional* registration. For example, practitioners who wish to enter Australia as temporary resident doctors (TRDs) to work in medical positions designated as 'areas of need' by a State or Territory health authority, undergo a different assessment process. These practitioners have employment sponsorship, and their qualifications and credentials are assessed against the specific requirements of the sponsored position by either the State or Territory Medical Board or the relevant specialist college (with college recommendations forwarded to the relevant registration board). Other groups taking up conditional registration include TRDs entering Australia in order to undertake training, teaching or research, OTDs working towards the AMC exam, and OTDs seeking specialty-specific registration.

Indeed, participants were generally supportive of national assessment criteria and processes for overseas trained doctors (box 6.6). For example, the South Australian Government (sub. 82, p. 39) recommended the development of 'national guidelines to ensure consistency around the supply, appointment and support of overseas trained professionals'. Similarly, the Victorian Government considered that standards and assessment procedures for international practitioners should be functions for its proposed National Accreditation and Education Council (box 6.2).

However, the Australian Medical Council considered any problem lies not in the standards setting process, but in the selection of workers for employment:

> The problem here is not an absence of agreed national standards but a confusion regarding the standards required for registration and those required for employment. In

other words, it is not that [overseas trained medical graduates] are being assessed at the wrong levels rather that they are being *employed* at levels for which *they have not been assessed*. They have also been registered on the basis of qualifications which are not recognised as meeting the agreed national standards required. (sub. PP306, p. 11)

Box 6.6 **A national approach to OTDs — participants' views**

Many participants supported the idea of national standards for assessing overseas trained doctors.

> Assessment is a critical issue. The AMC pathway is highly regarded but there are a number of alternative routes to registration and employment for IMGs [International Medical Graduates] in Australia and no uniformity about the minimum standards of assessment for entry point to clinical practice. This is of major concern to CPMEC and its State and Territory PMCs as the majority of IMGs are working in Australian hospitals and IMGs are a mobile workforce. (Confederation of Postgraduate Medical Education Councils, sub. 85, p. 3)
>
> A single national assessment process of the qualifications of overseas trained doctors is required to ensure that doctors entering Australia with the same qualifications are assessed in the same manner around the country. … Given the different State and Territory requirements, it is feasible for a doctor to fail our assessment processes, but obtain employment in another State or Territory where requirements or assessment processes may be less stringent. A national streamlined and coordinated approach to assessment across the various categories of OTDs including permanent and all categories of temporary residents is to be encouraged. (Rural Workforce Agency Victoria, sub. 146, pp. 17–18)
>
> ARRWAG supports a nationally consistent approach to OTD assessment processes in order to achieve safe, high quality primary health care for the Australian community. (Australian Rural & Remote Workforce Agencies Group, sub. 136, p. 8)
>
> Insurers must be confident that the registration authority has rigorously assessed the qualifications of the doctor to practice in the area into which they are to be placed, and the expectation would be that the medical boards would be undertaking a nationally consistent, timely, rigorous and effective assessment of the qualifications of each doctor who applies for registration, irrespective of the geographic need. (Medical Indemnity Industry Association of Australia, sub. 62, p. 9)
>
> [We] support national standards for assessing OTDs. (Australian Divisions of General Practice, sub. PP320, p. 4)

And there were concerns about the impacts of any changes that reduced the flexibility of current arrangements. For example, while recognising quality and safety issues, the Queensland Government warned against restricting the inflow of overseas trained doctors:

> The special purpose registration for medical practitioners in designated areas of need must not be used as a mechanism to restrict the inflow of overseas trained doctors, but must ensure that the quality and safety of medical practice equals that expected of Australian medical school graduates. (sub. 171, p. 18)

For similar reasons, ACOPRA recommended that all jurisdictions include a

provision for registration of health professionals at the discretion of the registration board, similar to that contained in the Physiotherapists Act:

> … for the purpose of enabling an unmet area of need to be met if the [registration board] is satisfied that the person has suitable qualifications and experience to practise physiotherapy in that area of need. (sub. PP184, p. 6)

Further, some participants argued that while a national approach should be adopted it should be on a profession specific basis. For instance, the Society of Hospital Pharmacists of Australia stated that it:

> … supports development of a national approach, but to protect consumers the health professions need to continue to assess overseas applicants. The Australian Pharmacy Examining Council already undertakes this for pharmacy on a national basis. (sub. PP207, p. 10)

Similarly, the Nurses Board of Victoria stated its view that:

> The Board has already adopted from the ANMC national standards for the assessment of overseas trained professionals. …Therefore, the Board believes that nursing, through the ANMC, could be considered as the model for a national approach for an accreditation agency. The Board also considers that established organisations such as the ANMC are well placed to take on this role. (sub. PP232, p. 9)

In the Commission's view, the proposed national accreditation board should be given statutory responsibility for accreditation functions in relation to overseas trained health professions, taking over responsibility from the existing profession based bodies.

Its role in relation to those trained overseas would parallel, but be somewhat more extensive than, its role in relation to those trained in Australia. Thus, it would assess whether overseas education and training courses and qualifications are suitable preparation for practise in Australia. It would also accredit such things as written examinations, clinical assessments and bridging training which are required to assess the qualifications and experience of those trained overseas or to bring them up to Australian standards.

Responsibility for functions in respect of overseas trained health professions could be delegated to appropriate existing entities, at least initially, subject to appropriate terms and conditions. And, of course, the application of assessment tools and the delivery of training could be devolved to other agencies, or to commercial providers.

As noted, there was considerable comment about the standards which should be met by overseas trained professionals before they are allowed to practise in Australia. In the Commission's view, however, this is mainly an issue related to registration, not

accreditation. In chapter 7 dealing with registration issues, the Commission argues for the adoption of uniform national standards for (unconditional) registration to practise in Australia. Even so, in the Commission's view, the national registration board should continue to have the ability to set terms and conditions under which particular individuals can work in specified work situations in Australia, when they do not meet the standards required for unconditional registration. To close off this option would be simply unrealistic, given current workforce shortages particularly in areas of need.

RECOMMENDATION 6.2

The new national accreditation board should assume statutory responsibility for the range of accreditation functions in relation to overseas trained health professionals currently carried out by existing profession based entities.

7 Registration

Key points

- In licensing health professionals, registration aims to protect the community by assuring the quality and safety of health services provision.
- When a health professional is required to be registered to practise, it should be on the basis of uniform national standards for that profession.
- Overseas trained health professionals should be assessed against the same standards as those trained in Australia.
  - When they do not meet the standards required for unconditional registration, however, the registration authority could, if considered appropriate, allow them to work under specified terms and conditions.
- Health workforce registration functions should be consolidated into a single national registration board, operating across jurisdictions and professions.
  - Where appropriate, profession specific panels would deal with matters such as discipline particular to a profession.
  - Membership of the new national registration board should reflect the broader public interest, rather than the interests of particular stakeholders.
- This consolidation would facilitate an across profession approach to health workforce issues; lock in national standards; overcome the disadvantages associated with mutual recognition as it presently operates; deliver a consistent approach to such issues as reservation of title and recognition of professions and specialties; and offer administrative and compliance cost savings.
- Pending the development of a national approach to education and training standards by the new national accreditation board, the new national registration board should subsume the functions and processes of the existing jurisdictional registration agencies and boards.
  - This would immediately remove some impediments to more efficient workforce deployment, such as requirements for mobile practitioners to sometimes register in several jurisdictions and to pay multiple fees.
- Issues relating to registration of existing and 'new' unregistered professions, and recognition of specialties, need to be considered in a national benefit-cost framework on a case-by-case basis taking account of alternatives such as self-regulation, credentialing and delegation.
  - Particularly in view of these alternatives, registration should occur at as broad a level as possible, consistent with maintaining quality and safety.
  - Consideration should be given by the new board to the circumstances in which more explicit specification of practitioner delegation arrangements would be appropriate.

As noted in chapter 6, in broad terms registration is the process of legally recognising practitioners' qualifications, experience, character and fitness to practice. Its purpose is to provide assurances of quality and safety, helping to overcome the information asymmetry between health professionals and patients.

As they currently operate, most registration boards have discretion as to the qualifications they recognise and the conditions they impose on registration including, where applicable, limiting scopes of work and/or specifying professional codes of conduct. Thus, at present, the registration process is a key factor affecting the efficient and effective deployment of the health workforce.

Potential changes to registration processes must be considered in the context of the role of accreditation. In the previous chapter, a national accreditation board was proposed that would set, in effect, uniform national standards for health workforce education and training. Although the adoption of such standards as the basis for national uniform registration would reduce the scope of functions currently held by some registration boards, registration would remain an important function.

This chapter first outlines the current roles of registration boards across the range of health professions and considers deficiencies in present arrangements. It then reviews the arguments for a national approach to registration standards; considers the consolidation of administrative processes across jurisdictions and professions; discusses the implementation of a national registration board; and outlines alternatives to registration such as credentialing and delegation.

7.1 Current roles of registration boards

Registration of health professionals is a State and Territory function, with over 90 boards currently operating (see appendix B, box B.6). Many health professions are subject to registration requirements, although for some (such as occupational therapists) registration requirements apply only in certain jurisdictions. Other professions, such as clinical perfusionists, lie outside formal registration and rely on self-regulation. The decision to register a health occupation lies with the State and Territory Governments, with most registration schemes regulating on the basis of 'reservation of title' rather than 'reservation of practice' (see below).

Boards take responsibility for setting standards for registration, maintaining registers of practitioners, collecting data, overseeing continuing professional development requirements, and administering disciplinary procedures. In many cases, responsibility for setting appropriate standards, for education and training in particular, is effectively transferred to accreditation agencies (chapter 6). Boards may also issue or endorse practice guidelines and codes of conduct, which help to

shape practitioner scopes of practice. Some provide explicit advice on scopes of practice although, in many cases, these are not prescriptive. According to the Joint State and Territory Health CEOs:

> With the exception of some core practice restrictions for professions such as dentistry and optometry, jurisdictional health practitioner registration legislation does not define the scopes of practice for registered health professions. (sub. PP332, p. 24)

Hence, specific scopes of practice are usually more influenced by the practice context, patient requirements, the education/competence of the practitioner, and the policies of the employer (see, for example, the Queensland Nursing Council, sub. 137, p. 4).

Some professional groups are working towards common approaches to registration standards. For example, the Australian Nursing and Midwifery Council, in consultation with State and Territory nursing boards and the broader nursing and midwifery communities, has developed national competencies for enrolled and registered nurses and midwives, generic competencies for nurse practitioners, and national codes of conduct and ethical codes (sub. PP225, p. 6). Similarly, the physiotherapy profession has been working across the States and Territories to develop national standards within the constraints of State registration requirements (sub. PP312, p. 5).

Some jurisdictions, such as the ACT, have established multi-profession registration Acts. However, generally, registration standards and administrative processes differ currently both between professions and between jurisdictions. And registration boards usually have discretion to vary their requirements in particular cases.

Mutual recognition arrangements apply within Australia (and between Australia and New Zealand). Their intended purpose is to allow practitioners who are registered in one jurisdiction to be registered in an equivalent occupation in other jurisdictions, without the need for further assessment of their qualifications and experience. In so doing, these arrangements are intended both to facilitate the mobility of practitioners across borders and to encourage the development of national standards. As part of their activities, registration boards handle applications for registration under mutual recognition.

7.2 Issues and proposals

Deficiencies in present arrangements

Many participants considered that the current registration arrangements have

considerable deficiencies. In particular, many contended that the current fragmented and uncoordinated multiplicity of registration boards with their variable standards inhibits workforce efficiency and effectiveness, hinders workforce innovation and flexibility across jurisdictional borders, and increases administrative and compliance costs (box 7.1).

These problems would not be as severe if mutual recognition were working well. However, many participants considered that this is not the case (see box 7.1).

Some initiatives to deal with the mutual recognition problems have begun to emerge. For example, the Australian Nursing and Midwifery Council and the State and Territory nursing regulatory bodies have a cross border policy whereby all States and Territories (except the ACT) have the capacity to waive fees in certain circumstances (sub. PP225, p. 6). And the recently endorsed approach by Health Ministers for medical registration, where registration in one jurisdiction will allow national practice, has the potential to overcome a number of problems with the current State-based arrangements. No additional fees or applications will be required, and standard and consistent registration categories will also be adopted (AHMC 2004a).

Notwithstanding such developments, many participants saw only limited chances for improvement under existing registration arrangements — indeed, as noted below, the State and Territory Governments were among the strongest supporters of an alternative approach to overcoming present problems with jurisdiction/profession based registration.

Adopting a national approach

In its Position Paper, the Commission proposed the adoption of uniform national standards for registration across Australia. There was almost universal support from participants for this, although a number of administrative models were canvassed.

Some participants considered that uniform standards should be adopted within the context of present registration arrangements. For example, the Australian Nursing and Midwifery Council strongly supported uniform national standards within nursing and midwifery, but considered existing processes to be adequate:

> The nursing and midwifery professions in Australia have well established regulatory processes supported in legislation in each state and territory which compare favourably with regulatory best practice standards worldwide. The ANMC works in partnership with the State and Territory Nursing and Midwifery Regulatory Authorities to attain the goal of national consistency in regulation. (sub. PP225, p. 6)

Box 7.1 **Participants' views about current registration deficiencies**

There were concerns that current registration arrangements reinforce professional boundaries. The Queensland Government said:

> Whilst it is essential that each profession takes responsibility towards regulation of its members, the jurisdictional and siloed approach to regulation undermines the capacity for the development or expansion of roles that might best, flexibly provide the health care of the future. Role expansion will certainly include some work practices moving from one occupational group to another. … the current system will not provide for this change. (sub. 171, p. 8)

Administrative inefficiencies are also an issue — the Victorian Government considered that duplication of board administration is inefficient and costly, and discourages sharing of important expertise across boards and the establishment of consistent processes for managing common statutory functions (DHS 2005, p. 3).

There were also concerns that the current arrangements hinder geographic mobility. The Australasian College of Dermatologists said:

> … current registration processes are sufficiently dissonant between jurisdictions as to impede free movement of professionals between States and Territories. This is of particular importance for practitioners located in border regions who may be required to practise in more than one jurisdiction. (sub. 104, p. 5)

The AMA noted:

> If [health professionals] practise near State or Territory borders, they are required to be registered (and pay registration fees) in two or more places and are subject to scrutiny by multiple medical boards. (sub. 119, p. 8)

Moreover, mutual recognition was seen as being ineffective in dealing with cross border practice. The Royal College of Nursing, Australia said:

> It should be pointed out that mutual recognition legislation in its present form does not provide for fee waivers for mobile practitioners or for short term cross border assignments, despite these provisions being in the overall spirit of mutual recognition. (sub. PP266, p. 8)

The various State-based registration regimes were viewed by some as a barrier to recruitment. The Aged Care Association of Australia said:

> A major barrier to efficiency in recruiting nurses into aged care (and other areas of the health system) is the current state-based registration system. ACAA believes that nursing registration should be centralised nationally to facilitate national standards and reduce the duplication of administration. (sub. 115, p. 9)

There were also concerns about conflict of interest between professional bodies and the registration boards. The Health Services Union commented:

> It is noted that there are sometimes conflicts of interest in the functions performed by professional bodies and their relationship with providing information regarding registration and practicing requirements. (sub. PP323, p. 25)

And, while noting that it intended to develop a national model framework for uniform registration of pharmacists, the Council of Pharmacy Registering

Authorities took a similar view, advocating:

> … use of AHMAC as a vehicle for achievement of uniform national (but State and Territory-based) registration of the professions and for agreement of operation of the legislation in relation to cross-border issues. (sub. PP206, p. 7)

But other participants argued not just for national standards, but for registration boards to be established at a national level on a profession by profession basis, whereas still others considered registration should be consolidated across professions at a national level.

The Commission notes that the creation of national registration boards has been given broader endorsement in a Cross-Jurisdictional Review Forum report to COAG in 2004, in response to a Productivity Commission evaluation of the Australian Mutual Recognition Agreement and the Trans-Tasman Mutual Recognition Arrangement (PC 2003a). The Forum, made up of representatives from each State and Territory and New Zealand, considered that registration boards which experience frequent service provision across jurisdictional borders should be asked to give consideration to developing national registration systems or alternative arrangements, guided by cost–benefit analysis. The Forum also endorsed a reduction in differences in registration requirements and standards across jurisdictions (CJR Forum 2004, pp. 8–9).

In support of national, but profession specific, registration the Queensland Nursing Union, for example, stated:

> There is certainly a need for improvements to regulatory processes but it is essential that these occur in a manner that does not compromise the professional autonomy of different health professional groups. Nursing, for example, is a separate and distinct professional group that has struggled for years to be free from the 'medical model'. The QNU would strongly oppose any action that would see nursing lose its autonomy and professional status. (sub. 80, pp. 4–5)

The Australian Council of Physiotherapy Regulating Authorities also supported the retention of profession-specific boards, saying:

> … each profession requires a statutory authority to ensure appropriate protection of the community from unsafe and inappropriate practitioners. … profession-specific boards are more likely to implement appropriate sanctions than generic/universal boards because they have a better understanding of the context [of] a complaint or misdemeanour. (sub. PP184, p. 2)

Similarly, the AMA did not:

> … support a single registration board covering all health professions. (sub. PP315, p. 10)

And the Australian Psychological Society considered that:

> The concept of national registration of professions is eminently sensible. … But if this proposal suggests that there can be one national registration structure across all health professions, then … it is both impractical and unrealistic. … There would still need to be profession-by-profession regulation structures heavily involving members of the profession within that regulatory process. (sub. PP283, p. 3)

However, supporters of a single national registration board covering all the health professions saw it as an important mechanism to help overcome profession based workforce rigidities, administrative inefficiencies and shortcomings in mutual recognition. In supporting consolidated national registration, the Royal Australian College of General Practitioners commented that it:

> … has been a consistent supporter of a national approach to medical registration, provided that appropriate safeguards, including the protection of personal privacy are incorporated. In this context, the RACGP would also support consideration of an appropriately configured national registration board for health professionals generally. (sub. PP329, p. 10)

The Australian Sonographers Association said that:

> The formation of a national body to oversee the operations of all registration boards and advise on legal and ethical matters would appear to be a logical, cost-effective alternative to the current range of systems operating across the healthcare professions. (sub. PP286, p. 3)

The Australian Physiotherapy Association argued that:

> … a national registration agency [should] be established to replace State and Territory registration and that agency [should] have profession-specific panels to respond to complaints relating to the standard of clinical practice within that discipline. (sub. PP271, p. 4)

And the Royal College of Nursing, Australia canvassed the likely benefits of:

> A single national registering authority with uniform umbrella legislation and heads of power for the core regulatory activities such as registration requirements, disciplinary processes and requirements for ongoing competence, with separate sections for each profession in the legislation to provide regulatory integrity. (sub. PP266, p. 6)

Supporters of such a national approach included State and Territory Governments — the majority of which, as noted in chapter 6, supported a single national accreditation/registration board rather than two separate national boards. As well, the Department of Health and Ageing commented favourably on a national approach to registration. It considered that:

> The Department believes that the mobility and flexibility of the health workforce will be better enhanced by a national registration scheme than by attempting to apply a nationally consistent set of standards to each State and Territory regulatory authority.

Also, the process of enacting legislation for each jurisdiction against national standards would be extremely complex. (sub. PP293, p. 5)

7.3 Adoption of national registration standards

The current jurisdictional approach presents a particular barrier to the efficient and effective deployment of health workforce practitioners — differences in registration standards and professional practice requirements across jurisdictions hinder movement of practitioners across borders, despite the operation of mutual recognition.

The Commission acknowledges that some flexibility is required in particular situations, for example to fill work positions in areas of need, or to extend the normal scope of practice of workers in particular roles. However, the need for flexibility is more appropriately met through such means as placing conditions on registration, and by delegation and credentialing (see below), than through lowering of the standards for registration themselves. Thus, for example, overseas trained health professionals should be assessed against the same standards as those trained in Australia — but when they do not meet the standards required for unconditional registration, the registration authority could, if considered appropriate, allow them to work under specified terms and conditions.

Particularly given the almost universal support from participants for uniform national registration standards, including from governments, the Commission considers that such national standards should be adopted as soon as possible. The national approach to education and training standards developed by the new national accreditation body proposed in chapter 6 would effectively form the basis for such national registration standards. For example, medical education and training accredited by the national accreditation board as appropriate and adequate should 'automatically' be accepted for medical registration anywhere in Australia. Additional registration requirements relating to such matters as fitness to practise and to codes of conduct should also be standardised (within a profession) across Australia.

RECOMMENDATION 7.1

When a health professional is required to be registered to practise, that should be on the basis of uniform national standards for that profession.

- ***Education and training qualifications recognised by the national accreditation board should provide the basis for these national registration standards.***
- ***Any additional registration requirements should also be standardised nationally.***

- ***Flexibility to cater for areas of special need, or to extend scopes of practice in particular workplaces, could be met through such means as placing conditions on registration, and by delegation and credentialing.***

7.4 The case for a single consolidated national registration board

In its Position Paper, the Commission concluded that national accreditation (as proposed in chapter 6) and the adoption of uniform national standards for registration (as proposed above) would reduce the magnitude of the deficiencies associated with the current fragmented registration arrangements. It suggested that the costs and benefits of supplanting state-based regimes with national arrangements should be assessed on a case-by-case basis. In consequence, the Commission did not make any proposals regarding the formation of registration boards on a national basis, either within professions or more broadly — although it did suggest jurisdictions should consider opportunities to consolidate administrative arrangements across health professions at a jurisdictional level.

However, in view of strong representations from some participants, the Commission has assessed the merits of two further options: multiple national profession based boards; and a single national cross profession board.

The establishment of multiple national *profession based* registration boards would have several advantages:

- It would 'lock' in national standards, not just for initial registration, but also for such matters as re-registration, continuing professional development, codes of practice, and disciplinary matters. In so doing, it would overcome the problems created by the apparent lack of commitment by some registration agencies to mutual recognition principles and requirements.
- The need for mutual recognition processes and procedures could be avoided (except possibly in application to New Zealand) — the need to reregister for across border practice and to pay multiple fees would be eliminated entirely.
- The process of adopting uniform national registration standards would be facilitated. Similarly, appropriate revisions to standards would be easier to undertake.
- There would be administrative efficiencies from reducing the overheads consequent on as many as eight or more registration boards per profession, leading to lower registration fees. As well, the compliance burden placed on practitioners would be reduced. And relevant data would become easier to compile.

- It would provide an opportunity for a review of governance and a reconstitution of registration boards in the public interest, and thus address concerns that current arrangements give undue weight to the interests of particular stakeholders.

However, taking the process even further and consolidating to a single national board *across professions* would bring further advantages:

- efficiencies in liaising with other bodies, including the innovation agency and the national accreditation board;
- even greater reductions in administrative and compliance costs; and
- most importantly, reinforcement of a whole of health workforce approach to improving efficiency and effectiveness of service delivery. With the proposed health workforce improvement agency, national accreditation agency and health and education council all working towards breaking down barriers to the better use of health workers, it would be crucial that registration processes not unduly hinder the implementation of appropriate new roles, multidisciplinary working and new scopes of work.

Of course, there will be some disruption and other transitional costs as existing arrangements are changed. However, as for consolidated national accreditation (chapter 6), the Commission believes that these can be minimised through intelligent design of the new arrangements. Thus, some functions such as monitoring codes of practice and discipline might best continue to be handled on a profession specific basis, and possibly even on a regional basis (see below). Given this, and in the light of the significant benefits it would bring, the Commission considers that a single national across profession registration board should be established as soon as possible.

7.5 Implementation of a single board

For the reasons discussed in section 6.4 of chapter 6, the Commission considers that the national registration board should be established as a statutory entity separate from the proposed national accreditation board. As with that latter board, planning and implementation of national registration will be critically important. To assist in that process, the Commission has set out its views on some important implementation considerations.

Timing

As noted above, a prime rationale for a unified national approach to registration is

to facilitate the adoption of national education and training standards stemming from the work of the proposed accreditation board. However, such standards will obviously take time to develop, even after that board itself is established.

Rather than wait, however, the Commission considers that there would be benefits from establishing the statutory national registration board as soon as possible. The new board would in effect subsume the operations of all existing registration boards and agencies. Even though jurisdictional based standards and processes initially would largely continue to operate, registration itself would essentially become 'national' under this approach. This would immediately remove impediments to efficient workforce deployment, such as multiple registration and fee requirements for practitioners working in more than one jurisdiction.

Functions

The new national body would have functions relating to registering professionals for practice, imposing conditions on registration if appropriate, ensuring requirements for continuing registration such as professional development are met, monitoring professional behaviour against codes of practice, attending to disciplinary matters, and so on. In this regard, the new board would effectively take over that range of functions currently exercised by existing boards. Through its operation, the new board would have an influence on scopes of practice as existing boards do now. However, it would not perform accreditation functions.

In addition, the Commission considers governments should empower the new national board to decide which professions to register, and to decide which specialties within registered professions should be formally recognised. Absence of such powers would undermine the national approach.

Coverage

On establishment, the new national registration board should become the legal authority for registration at least in respect of all those professions which currently require registration across the eight jurisdictions.

Questions arise, however, as to the inclusion of professions which require registration in only some jurisdictions, or which are currently entirely unregistered. Also questions will arise, from time to time, about the recognition of specialties in professions which are currently registered. In the Commission's view, such specific questions cannot be answered except on the basis of case-by-case evaluation — section 7.6 outlines some relevant criteria. Nevertheless, one conclusion is clear — given a national approach to registration, a profession should be registered

nationally, or not at all. But where a profession is currently registered in only some jurisdictions, there might be grounds for grandfathering that registration pending evaluation of the merits of national registration by the new board.

Governance

There are indications of problems with the governance arrangements of some existing boards. For example, the Victorian Government commented:

> In the Victorian experience, this occurs most commonly where new roles (such as support workers) have been proposed and/or introduced. However there are instances where the standards set for entry (and re-entry) to practise also appear to reflect professional interests, rather than those of the broader public. (sub. 155, p. 52)

In the Commission's view, membership of the new national registration board must be constituted to reflect the broader public interest, rather than directly represent particular stakeholders. Thus, while the new board will require an appropriate mix of people with the necessary qualifications and experience to guide its work, members should be appointed in their own right, through a transparent appointment process, rather than as representatives of particular organisations. The board should include at least one member with appropriate consumer knowledge and expertise, reflecting the principal purpose of registration. Governance principles are discussed further in chapter 13.

Operation

The Commission envisages that a number of functions, such as the initial registration of professionals trained in Australia, could be undertaken within the administrative secretariat of the new board.

However, as noted above, some functions such as monitoring codes of practice and discipline in regard to particular professions, might best continue to be handled on a profession specific basis. Establishment of profession specific panels, nationally (and sub-nationally as appropriate), and delegation to them of appropriate functions and powers, would facilitate this process. Such panels would only operate under the authority of the central board.

RECOMMENDATION 7.2

The Australian Health Ministers' Conference should establish a single national registration board for health professionals.

- ***Pending the development and adoption of national registration standards by the new board, the board should subsume the operations of all existing***

registration boards and entities, including the authority to impose conditions on registration as appropriate.

- ***The new board should be given authority to determine which professions to register and which specialties to recognise.***
- ***Initially, however, the new board should cover, at a minimum, all professions which currently require registration across the eight jurisdictions.***
- ***Membership of the board should contain an appropriate mix of people with the necessary qualifications and experience, and be constituted to reflect the broader public interest rather than represent the interests of particular stakeholders.***
- ***Profession specific panels should be constituted within the board to handle matters such as the monitoring of codes of practice and those disciplinary functions best handled on a profession specific basis.***

7.6 Extension of registration

A number of participants argued for an extension of the scope of registration to additional jurisdictions and professions (box 7.2). This question, and those of how to deal with 'new' professions, and whether to recognise specialties, raises the broader issue of whether registration is the best way to ensure public health and safety without impeding effective workplace deployment.

A national benefit–cost framework

In any assessment of the merits of registration, the benefits from protecting public health and safety must be weighed against the potential for reducing workforce flexibility and supporting anti-competitive behaviours, as well as the administrative and compliance costs involved. Alternatives to formal registration should be similarly assessed (see below). The balance is likely to vary across situations, in concert with differences in the level of risk and information asymmetry between patient and provider — the key rationales for legislated requirements. Criteria established by AHMAC are set out in box 7.3.

Without prejudicing the outcome of such consideration in particular cases, the Commission considers that formal registration is likely to become the more difficult to justify, the more detailed are the explicit or implicit associated scopes of practice. In its view, registration should occur at as broad a level as possible, consistent with maintaining quality and safety, rather than at ever increasing levels of specification.

Box 7.2 **Examples of calls for extensions of registration**

Participants put forward several arguments to support wider registration of current health professionals. Some claimed that while there is a degree of self regulation of existing professions through professional societies, formal regulation is required to ensure service quality and safety:

> Perfusion is one of those groups where there is no minimum qualification required to practice and Australian hospitals are under no obligation to hire appropriate qualified personnel. The ASCVP [Australasian Society of Cardio-Vascular Perfusionists] and ABCP [Australasian Board of Clinical Perfusion] both believe that there is an issue of public safety if hospitals are not using appropriately qualified Perfusionists. … we propose (a) that the Commonwealth Government recognise the ABCP training regime and Diploma and (b) that State Governments establish Registers of Diploma-qualified clinical perfusionists. (Australasian Society of Cardio-Vascular Perfusionists, sub. 37, pp. 1–2)

> A nationally consistent process of statutory regulation or registration for occupational therapists is required. The status quo of partial regulation of the profession poses unacceptable levels of potential harm to the Australian public. This is especially significant as the workforce is growing rapidly and the profession is advancing into non-clinical or consultancy based services in the private sector. (OT Australia, sub. 54, p. 2)

Some also argued that introducing registration confers benefits to a profession. For example, the Royal Australian and New Zealand College of Psychiatrists considered that as well as improving the recognition and status of Aboriginal and Torres Strait Islander Mental Health Workers, registration via Commonwealth or State mechanisms would assist in the development of a career structure (sub. 79, att. 2, pp. 2, 5).

Alternatives to registration

Existing features of the service delivery environment may provide an acceptable alternative to registration for ensuring appropriate quality and safety standards — these features include, for example, the discipline exerted over professions through self regulation activities, the rules imposed by employers and health funds, and the demands of other practitioners.

In the case of clinical perfusionists, for instance, there appears to be a fairly robust regime underpinning the delivery of perfusion services, particularly given the close collaboration with the Royal Australasian College of Surgeons and the Australian and New Zealand College of Anaesthetists (who, together with the perfusionist and specialist nurses, are the key members of the surgical team for cardiac surgery) on training and recertification of clinical perfusionists (sub. 37, p. 2). Indeed, standards defined by the Australasian Society of Cardio-Vascular Perfusionists and the Australasian College of Surgeons recommend that perfusion during cardiopulmonary bypass may only be conducted by people who have undergone recognised training and certification in perfusion science (sub. 37, att. 1, p. 4). In

such an instance, the case for registration will be less strong, as the responsibility for quality and safety has already been accepted by the surgeon.

Box 7.3 **AHMAC's criteria for assessing the need for statutory regulation of unregulated health occupations**

Criterion 1: Is it appropriate for Health Ministers to exercise responsibility for regulating the occupation in question, or does the occupation more appropriately fall with the domain of another Ministry?

Criterion 2: Do the activities of the occupation pose a significant risk of harm to the health and safety of the public?

Criterion 3: Do existing regulatory or other mechanisms fail to address health and safety issues?

Criterion 4: Is regulation possible to implement for the occupation in question?

Criterion 5: Is regulation practical to implement for the occupation in question?

Source: Supplied by the AHWOC secretariat.

Similarly, greater involvement by employers, professional bodies and colleagues, via credentialing and delegation processes (box 7.4), may be an effective, more flexible and less costly approach in many situations than formal registration.

The benefits of credentialing received mixed support in submissions (box 7.5). While some argued that 'credentialing' by professional bodies potentially 'locks in' current workforce roles and arrangements and is, in many respects, little different from statutory requirements, others saw employer credentialing as a positive way of better tailoring scopes of practice to the work environment. Importantly, credentialing enables employers such as public hospitals to better utilise the competencies of their workforces without the associated rigidities of specialty and sub-specialty registration.

Delegation was generally viewed favourably by participants, being seen as a useful way of supporting greater workforce flexibility (box 7.6). Several participants noted that task delegation already operates widely and works well in rural and remote areas in particular.

In conclusion, arrangements such as credentialing and delegation offer the potential for health professionals to practise, in particular work situations, in a safe and controlled manner without requiring formal registration. Of course, as participants noted, such approaches also have costs which will need to be considered before applying them in any particular situation.

Box 7.4 **Defining credentialing and delegation**

Credentialing is a formal process used by employers to verify the qualifications, experience, professional standing and other relevant professional attributes of health practitioners, for the purpose of forming a view about their competence, performance and professional suitability to provide safe, high quality health care services within specific organisational environments.

Service providers may use credentialing as a base to *define the scope of clinical practice*, where the extent of an individual practitioner's clinical practice within the organisation is delineated, based on the individual's credentials, competence, performance and professional suitability, and the needs and the capability of the organisation to support the practitioner's scope of clinical practice. This is also sometimes called 'clinical privileging'. In effect, by undertaking credentialing processes as part of their clinical risk management, employers are taking on some of the responsibility and accountability for determining the limits of practice.

The Australian Council for Safety and Quality in Health Care has published a national standard for credentialing and defining the scope of practice of medical practitioners, for use in public and private hospitals. The standard was developed in response to the rapid increase in the availability of new and complex clinical services, procedures and interventions and the increasing mobility of practitioners, and is intended to enhance the rigour of credentialing processes.

Delegation of tasks occurs when practitioners authorise another health care worker to provide treatment or care **on their behalf**. In making the decision to delegate, practitioners make the judgment that the person to whom they are delegating tasks is competent to carry out the procedure or provide the therapy involved.

Delegation procedures are relatively informal, with guidance for practitioners often contained within registration boards' guidelines or codes, but often without formal legal backing.

Source: Draws from ACSQH (2004).

Should delegation provisions be formalised?

Delegation guidelines have sometimes been spelt out by registration boards, but have not always had legislative backing. Hence, Duckett (2005b, pp. 6–7) argued that the introduction of formal powers of delegation within Registration Acts would facilitate the delegation of tasks to appropriately trained staff:

> … by extending the reach of a health professional registration board to cover the work of any person to whom a professional registered with that board has delegated tasks … [this] would establish a regulatory framework for health professionals delegating to other professionals or assistants, and would allow professionals to delegate tasks, knowing they were doing so within an accepted regulatory framework.

Box 7.5 **Participants' views on credentialing**

The Royal Australian and New Zealand College of Radiologists argued:

> … credentialling should be an integral aspect of a modern health workforce, and should explicitly recognise that the scope of practice for each practitioner be considered in conjunction with the capacity of the practice environment to provide the required infrastructure and related clinical services. (sub. 78, p. 19)

And the Medical Training and Education Council of NSW said:

> There are many doctors working in senior roles in public hospitals but who do not have specialist qualifications. It is often difficult for these doctors to access structured or formal training and professional development.
>
> … There are plans in NSW to develop a hospital training program which will be specifically designed to enhance and credential the skills of doctors not in a specialised training program. (sub. 154, p. 3)

However, employer credentialing was considered to have workforce mobility implications:

> One distracter that has impacted upon the ambulance profession is the fact that the employers are the credentialing authority. This affects the portability of ambulance qualifications between states. (Australian College of Ambulance Professionals, sub. 145, p. 3)

Some concerns were also expressed about credentialing by professional bodies:

> … while Australia retains this plethora of organisations that 'register and/or credential' individuals, and while these are focused on narrow professional categories, their concentration will remain on delineating roles and protecting patches rather than on creating an environment in which more effective team structures can evolve. (Australian Healthcare Association, sub. 151, p. 6)

Others, such as Resthaven, were of the view that credentialing by accreditation or registration bodies would create greater workforce flexibility:

> The role of national accreditation or registration bodies may include the approval of such competency-based programs in specific areas under defined conditions or protocols as a means of creating greater flexibility across health worker roles whilst maintaining quality and not requiring a significant growth in the regulation process by way of registration of individuals but rather linked to the accreditation and quality monitoring processes of the service provider. (sub. PP186, p. 5)

Indeed, the Australian Nursing and Midwifery Council noted that the State and Territory nurse/midwife regulatory authorities are currently developing a national decision making framework that will operate through existing jurisdictional legislation and will clearly articulate issues such as task delegation, supervision and professional responsibilities (sub. PP225, p. 9).

And the Rural Doctors Association suggested that an expansion of delegation could provide recognition and regulatory protection to rural practitioners who are 'forced by circumstances into work beyond their formal scope of practice' (sub. 161, p. 10).

Box 7.6 **Participants' comments on delegation**

A number of submissions suggested delegation of tasks would encourage workforce flexibility. For example, James Cook University Faculty of Medicine Health and Molecular Sciences said:

> … the devolution of 'medical' tasks to other members of the health team under the local supervision and delegated authority of a Medical Practitioner … has a number of attractions: clear clinical governance in diagnosis, investigation and technical management; greater likelihood of uptake and acceptance by the medical profession; less regulation, red-tape and external constraint on scope of practice; opportunities for participation by a broad range of health professionals …; easier uptake by the private sector; Medical Practitioners able to focus on complex and technically difficult cases; and simpler indemnity arrangements.
>
> To formalise 'delegated' practice arrangements, State and Territory Medical Act Regulations need amendment to provide a clear legal framework for responsible delegation of tasks by registered Medical Practitioners. While 'guidelines for good medical practice' that have been developed by most Medical Boards contain guidance on delegation and represent an interim solution, they lack legal weight. This should be identified as an area for early action by COAG. (sub. 106, p. 3)

Rural Doctors Association of Australia noted that task delegation was evolving in rural and remote locations:

> RDAA sees new models already evolving through greater flexibility in the delegation of care by rural doctors to an expanding range of other health care professionals at the local practice level. Practice nurses have been employed in rural practices for several generations and RDAA strongly supported the introduction of the Commonwealth Practice Nurse subsidy to support and expand their work. This practical incentive to employ registered and enrolled nurses and Aboriginal Health Workers in general practice has been followed by access to new Medicare item numbers for wound dressings, immunisations and pap smears performed by practice nurses on behalf of the medical practitioner. RDAA supports extending this access to other services and procedures to enhance the holistic care a general practice can offer a community … (sub. 161, p. 9)

The AMA supported task delegation where that was:

> … to appropriately trained nursing and allied health colleagues. This approach would build on the long history in health of providing health services in clinical teams. (sub. 119, p. 5)

Professor Wayne Gibbon commented on the scope for further delegation:

> A Radiologist is often required to check a patient's suitability for contrast, consent patient to receive contrast, insert cannula for venous access, inject contrast and monitor for possible contrast reactions. Most, if not all of these functions could be delegated to a nurse, radiographer or 'physician's assistant' so that the radiologist can concentrate on reporting/consultation functions etc. Although some sites already allow such multi-skilling it requires greater formalisation and expansion for universality and appropriate training and credentialing systems put into place. Safeguards should include suitable training and back-up, agreed protocols, participation in regular audit and formal arrangements for delegation. (sub. 48, att. 1, p. 8)

On the basis of such comments, the Commission, in its Position Paper, argued that giving formal legal backing to delegation, and supporting this through clear

guidelines on the circumstances under which delegation may take place, would encourage a more appropriate distribution of tasks across health professionals.

Some participants supported this approach. For example, the Optometrists Association Australia commented:

> The legal and ethical complications of delegation are a significant deterrent to delegation. The community is currently deprived of the benefits that delegation can confer because of the uncertainty that practitioners have. … A formal regulatory framework would be of considerable assistance in promoting delegation. (sub. PP319, p. 5)

Kathleen Mary Puls, drawing on her experience in clinical nursing and health law, said:

> Legislative change that would provide a formal framework for delegation is highly desirable. The current informal arrangements may function effectively on most occasions but they create a legally uncertain situation. (sub. PP349, p. 6)

However, the Joint State and Territory Health CEOs considered that incorporating delegation provisions into law might reduce flexibility, rather than promote it:

> … delegation … if incorporated into statute, may actually reduce the current flexibility that exists in the jurisdictional health registration systems. (sub. PP332, p. 26)

Similarly, Duckett also acknowledged that legislative prescription could be counterproductive in some circumstances:

> In States where there is scope of practice regulation, there may need to be specific legislative authorisation to validate delegation of tasks that fall within the scope of practice. There is no such requirement in States which reserve a title, indeed legislative prescription in these states may undesirably constrain flexibility in task substitution. (sub. PP197, p. 2)

Thus, rather than move immediately on this issue, the Commission considers that the circumstances in which more explicit specification of practitioner delegation arrangements would be appropriate should be a matter for consideration by the new national registration board. (Chapter 8 covers some issues relating to delegation and the MBS.)

RECOMMENDATION 7.3

The new national registration board should consider and determine the circumstances in which more explicit specification of practitioner delegation arrangements would be appropriate.

8 Payment mechanisms for health care services

Key points

- Health care funding and payment arrangements affect patient demand for health workforce services and the career choices of health workers, where they locate and whether they practise in the public or private sectors. They also affect professional boundaries between health workers and work practices generally.
- Many funding issues affecting the health workforce cannot adequately be addressed in this study. They require a broader review.
- But some changes to payment mechanisms and funding structures can be made within the confines of current arrangements to improve the provision of health workforce services.
- The operation of the MBS may not always facilitate the provision of health services by the most appropriate health professional.
  - An independent review committee should be established to advise the Australian Government on changes to the range of services and health professionals covered, referral rights for diagnostic and specialist services, and prescribing rights under the PBS, that would improve health care outcomes and/or provide more cost-effective service delivery for the same level of outcome.
  - To further encourage more efficient deployment of the workforce, and to complement some expansion in direct access to the MBS, rebates (discounted) should be payable for a wider range of delegated services.
  - In time, these measures should lead to a gradual increase in MBS-supported health care services by a wider range of medical and non-medical health professionals, in a more cost-effective manner, while maintaining or improving safety and quality.
- The Department of Health and Ageing should investigate the extent of the bias in the MBS in favour of procedures over consultations and how any significant bias should be addressed. This investigation should be taken over by the proposed independent review committee when it is fully functioning.
- Governments should ensure that, as far as possible, expenditure control mechanisms are consistent with the objectives of health workforce policy, and that the instruments employed in health care are well coordinated with those in health education and training.

8.1 A pervasive influence on the health workforce

A common theme in previous reviews and in submissions to this study has been the need for more government funding to overcome shortfalls in health workforce numbers or skills. With governments meeting nearly 70 per cent of total health care costs (see box 8.1), the level and nature of such financial support is clearly a major influence on both the consumption of health services and the capacity of the system to meet the underlying demand.[1] Indeed, several recent workforce-related initiatives have involved additional public funding to allow more services to be delivered and for training additional health workers.

But equally important to the health workforce are the efficiency and effectiveness of payment arrangements for disbursing available funding. For example, they can affect:

- decisions by consumers about what sort of health care services to consume and from whom they acquire them;
- the career choices of health care workers — both as to fields of study and to the extent of specialisation within chosen fields;
- the location decisions of those workers and whether they practise in the public or private sectors;
- the boundaries between health professions; and
- methods of practice, including referral patterns and the willingness to assess different models of service delivery, or to countenance changes in scopes of work.

Moreover, while the mechanisms for disbursing public funds are clearly influential in such decisions, the instruments used to mobilise the 30 per cent of expenditure that is not government funded, including patient co-payments, private health and compensation insurance arrangements, are also germane. So too are the variety of expenditure control measures attached to the broad funding instruments to contain budgetary risk for governments and private health insurers.

Getting funding and payment arrangements ‘right’ poses enormous challenges for policy makers. Ensuring that the reasonable health care needs of those with limited capacity to pay are met, while at the same time minimising wasteful consumption of health care services, is a challenge that virtually all countries struggle with.

1 The House of Representatives Standing Committee on Health and Ageing commenced an inquiry into Health Funding in March 2005.

Box 8.1 **Funding of health care in Australia**

In 2003-04, expenditure on health care in Australia totalled $78.6 billion, or over $3900 per person. It represented 9.7 per cent of GDP, up from 8.3 per cent a decade earlier. Governments funded 68 per cent of this expenditure (or about $53 billion), with the rest funded by patient contributions ($15.9 billion), private health insurers ($5.6 billion) and others such as compulsory motor vehicle, third-party and workers' compensation insurers ($3.6 billion).

Government funding is split between the Australian Government (about 46 per cent of total health care expenditure) and State and Territory Governments (about 23 per cent). The Australian Government's contribution includes:

- direct expenditure on health programs (including Medicare, the Pharmaceutical Benefits Scheme, residential aged care, and programs designed to improve access to health services in particular areas — eg rural and remote — and/or for particular groups — eg Indigenous Australians);
- payments through the Department of Veterans' Affairs for the treatment of eligible veterans and their dependants;
- health-related specific-purpose payments to the States and Territories;
- rebates and subsidies under the *Private Health Insurance Incentives Act 1997*; and
- taxation expenditures — for example, rebates to individuals or families incurring high out-of-pocket costs in any particular tax year.

State and Territory government expenditure, in combination with assistance from the Australian Government, funds the public hospital system, and a range of community-based and other health care services, including for remote and Indigenous communities.

- Funding of public hospitals is largely governed by the Australian Health Care Agreements. Over 90 per cent of all funding of public hospitals comes from governments — about 46 per cent from the Australian Government and a similar share from the States and Territories, which have the major responsibility for operating and regulating public hospitals.

Private health insurance provides the bulk of funding for private hospitals and for private patients in public (non-psychiatric) hospitals. Funding for private hospital services accounted for 49 per cent of the $5.6 billion provided by health insurance funds in 2003-04. Other major areas of expenditure were dental services (13 per cent) and medical services (10 per cent).

Of the $16 billion out-of-pocket expenditure by individuals, about 31 per cent was spent on pharmaceuticals, 20 per cent on dental services, 14 per cent on aids and appliances and 10 per cent on medical services. In the case of dental services, individuals contributed 68 per cent of the total expenditure of $4.4 billion.

Sources: AIHW (2004a; 2004c).

Given that third parties (government and private insurers) meet the majority of health care costs, the financial incentives on patients and practitioners to exercise due restraint on the demand for, and supply of, health care services are muted. This is exacerbated by the opaque and indirect nature of the impact of over-consumption of health care services on costs for taxpayers and those who pay private health insurance premiums.

Moreover, judgments by health professionals will be influenced to varying degrees by a range of 'external' considerations such as rules governing the referral of patients for specialist or other supporting services, limitations on access to certain diagnostic tests, remuneration arrangements (fee-for-service or salary) and medical indemnity considerations.

One of the significant complexities in Australia's funding and payments arrangements is the division of government responsibility for health care, with the ensuing problems frequently referred to in submissions to this study. In the communiqué issued after the June 2005 meeting of CoAG, all governments agreed that:

> … there is room for governments to discuss areas for improvement, particularly in areas where governments' responsibilities intersect. … Further, governments recognised that the health system can be improved by clarifying roles and responsibilities, and by reducing duplication and gaps in services. (CoAG 2005)

In a health workforce context, divided responsibilities can have a range of undesirable outcomes. For example, the New South Wales Government said that:

> The joint funding responsibilities of the Australian and state governments in the provision of health care services affect how those services are delivered in Australia. … Sometimes care is delivered to the community in a way that is based on the source of funding for the care and not what is clinically the most appropriate way to deliver the care by the most appropriate health care provider. (sub. 20, p. 6)

It also contended that many distortions arise from existing funding arrangements, citing the 'strictly hospital based' Australian Health Care Agreements (and their 'rigid funding and performance regime'), the MBS and its safety net arrangements, private health insurance, and the PBS. It further argued that the control of program budgets by different fund holders:

> … does not encourage horizontal integration of services across the primary, secondary and tertiary provision of care, or for specific care areas such as mental health and aged care. (sub. 178, p. 20)

From the above, it is evident that a wide range of 'high level' features of current funding and payment arrangements determine the broad incentives framework facing the health workforce. Among other things, they affect how much emphasis is

given to particular institutional arrangements or models of care, and the extent to which variations from the status quo are encouraged or hindered. They can also lead to similar services being funded differently — particularly at program boundaries, where different incentive structures become evident (and cost shifting becomes an issue). Examples include funding for salaried hospital staff compared to VMOs; emergency departments compared to after-hours GP clinics; and MBS-supported GPs compared to dentists and other allied health professionals dependent on private sources of funding.

However, altering high level funding and payment arrangements would significantly change the overall structure of the health system. Thus it would not be appropriate to propose major changes based on workforce considerations alone.

The parallel Senior Officials Group review is examining some of these broader issues, with the CoAG communiqué recognising that responsibilities between levels of government may need to change. More broadly, in its recent *Review of National Competition Policy Reforms*, the Commission proposed a 'holistic' review of Australia's overall health care arrangements.

Consistent with the Commission's terms of reference for this study, the remainder of this chapter looks at reform options within the broad confines of current funding and payment arrangements. The focus is on improving institutional and procedural frameworks, rather than on the potential role of more specific programs and approaches such as the Practice Incentives Program. However, some of these are considered in later chapters to the extent that they relate to rural and remote issues, areas of special need and after-hours care.

8.2 The MBS and the health workforce

Medicare subsidises access by patients to, mainly, medical care. The key services covered are shown in table 8.1. Among other things, the Medicare program provides benefits, as listed in the Medicare Benefits Schedule (MBS), to patients who use the services of general practitioners and specialists. It also provides benefits for the use of diagnostic services such as pathology tests, X-rays and ultrasounds.

Total spending by the Australian Government on the MBS was $9.9 billion in 2004-05, of which about a third was for GP services. In the case of GPs, MBS benefits accounted for about 90 per cent of income derived from consultations (Department of Health and Ageing, sub. 159, p. 34). About 75 per cent of all GP services are bulk billed.

Table 8.1 **MBS benefits, by broad type of service, 2004-05**

	Benefits	*Services*	*Average number of services per capita*
	$m	*'000*	
GP attendances[a]	3 321	100 872	5.0
Pathology	1 522	77 719	3.8
Specialist attendances	1 212	20 808	1.0
Diagnostic imaging	1 483	14 136	0.7
Operations	907	6 898	0.3
Optometry	215	5 110	0.3
Anaesthesia	220	2 016	0.1
Obstetric services	142	1 429	0.1
Other	900	7 327	0.4
Total MBS	9 923	236 316	11.6

a Includes 2.7 million services by practice nurses, for which benefits of $26 million were paid.

Source: DoHA, *Medicare Statistics - September Quarter 2005* (www.health.gov.au).

For the most part, the MBS does not cover non-medical services — such as those provided by nurses and allied health professionals. In part, this may reflect its origins, as Medicare was designed and introduced at a time when the nature of health care and health workforce requirements were somewhat different from today. The few non-medical services that are covered include: optometry consultations; a very limited range of dental services; and some delegated services provided by practice nurses under the direction of medical practitioners in whose name the MBS claim is made. In addition, some allied health services are covered where the patient has been referred for a program of care by a medical practitioner (for example, under the Enhanced Primary Care Program).[2]

8.3 What are the key workforce-related concerns?

Aside from the ongoing debate about the overall level of public funding for health care, there are several aspects of the operation of the MBS that have important implications for the deployment of the health workforce:

- the very limited access to the MBS for non-medical practitioners;
- limited encouragement for delegation of MBS-supported services;
- seemingly inappropriate relativities between MBS rebates for some services; and

2 Eligible services include those provided by Aboriginal health workers, audiologists, chiropractors, chiropodists, diabetes educators, dietitians, mental health workers, occupational therapists, osteopaths, physiotherapists, podiatrists, psychologists and speech pathologists. There are limits on the number of MBS-funded services per patient per year.

- constraints on who can refer patients for specialist treatment or diagnostic tests (or prescribe drugs subsidised under the PBS).

The remainder of this chapter discusses these matters in detail and proposes initiatives to help address the problems they create for efficient and effective workforce outcomes.

Access to the MBS for non-medical practitioners

The MBS is primarily a mechanism for facilitating patient access — by way of subsidies — to services that are 'personally provided' by medical practitioners. This restriction on the range of subsidised services was viewed by most participants as creating a variety of problems and workforce inefficiencies.

From the point of view of patients, the current limitations can undermine equity of access objectives and detract from health care outcomes for certain groups. In this regard, for example, some participants contended that lack of subsidies for private dental services has contributed to long waiting times for public dental services (with major implications for health outcomes for lower income groups). Also raised in this context was the concern that desirable usage of unsubsidised allied health services, such as podiatry and physiotherapy, has been discouraged.

This chapter focuses on the major concerns relating to the impacts that limited MBS coverage has on the efficient and effective delivery of care services by health workers.

Firstly, it is widely perceived that a range of health care services now provided by medical practitioners could equally well be provided by other health professionals without diminishing quality or safety. For example, the Commission was informed by many participants that there is much greater scope for technicians and other health professionals to undertake and report on routine diagnostic tests in their own right, with provision to refer more complex cases to medical specialists in the usual way. Thus, in regard to radiography, Professor Wayne Gibbon contended that:

> No plain film reporting is occurring within many hospitals due to the absence of sufficient radiologist resources to formally read and report these. It is imperative that radiographers are trained to read and report plain films, particularly films that require rapid reporting such as those within an emergency department. International evidence substantiated through meta-analysis and published in February 2005 indicates radiographer competence as being equivalent to radiologists in this function, if appropriately trained. (sub. 48, pp. 5–6)

Similarly, the Australian Sonographers Association saw potential for sonographers with advanced education and training to substitute for sonologists in preparing

formal reports on ultrasound examinations, particularly as under current work practices:

> … the report produced by the sonologist is often a repetition of the sonographer's interpretation of the examination … (sub. PP286, p. 2)

In pointing to the scope for task substitution in the allied health area, the Department of Health and Ageing (DoHA) commented that:

> Allied health professionals such as dieticians, diabetes educators, podiatrists, psychologists and physiotherapists can provide a number of primary care services currently being met to a lesser or greater extent by GPs. (sub. 159, p. 31)

And Professor Stephen Duckett has recently identified a wide range of areas where there is potential for task substitution (see table 8.2).

Table 8.2 **Areas of potential[a] task substitution**

Task[b]	*Traditional professional*	*Substitute professional/assistant*
anaesthesia	anaesthetist	nurse anaesthetist
clerking of new hospital patients	hospital medical officer	nurse
closure of wound	surgeon	nurse
foot care	podiatrist	foot care assistant
foot surgery	orthopaedic surgeon	podiatric surgeon
laryngoscopy/naso-endoscopy	ENT surgeon	speech pathologist/nurse
maternity care	obstetrician	midwife or GP
mobilisation assistance	physiotherapist	physiotherapy assistant
patient management	medical practitioner	nurse practitioner
plain X-ray	medical imaging technologist	X-ray assistant
refraction	optometrist	orthoptist
reporting pathology	pathologist	scientist
reporting X-rays	radiologist	medical imaging technologist

a Task substitution in some of these areas is already occurring under delegation arrangements (see later).

b Performance of the substituted tasks will generally require additional training and clear protocols, and will also depend upon the complexity of the condition and the comorbidities of the patient.

Source: Duckett (2005b).

But because provision by these other professionals does not attract an MBS subsidy, out-of-pocket costs for patients who chose to use their services would often be higher, even though the overall cost to the community would be lower. Hence, such 'task substitution' is discouraged.

This results in less cost-effective provision of the services in question. In addition, medical practitioners' time is diverted from the delivery of other more beneficial services (and in some instances, the patient is subsequently on-referred to an allied

health professional in any case). Synthesising these impacts, the Victorian Government argued that costs are increased:

> … by generating avoidable duplication of effort, delaying initiation of treatment and impeding the optimal deployment of available workforce skills.

It went on to note that:

> … approximately 50 per cent of the caseload of general practice involves counselling, emotional support and mental health assessment. Social workers or psychologists could handle much of this. (sub. 155, p. 32)

Moreover, the limited coverage of the MBS may potentially discourage the emergence of new models of care. In this regard, the New South Wales Government (sub. 178, pp. 21–22) claimed that while greater emphasis on integrated or multidisciplinary models of care will be required in the future, the involvement of some health professionals in such teams may be discouraged by the current structure of MBS rebates, particularly in rural areas. And the Centre for Midwifery and Family Health (sub. 41, pp. 2, 5) argued that new and evolving models of maternity care are being hindered in part because women do not have access to Medicare funding for midwifery services.

Also, if wider access to the MBS led to non-medical practitioners utilising a broader range of skills, retention and re-entry rates could improve — a point made by the Australian Sonographers Association (sub. PP286, p. 2).

Some within the medical profession saw risks in changing the focus of the MBS. For example, the Australian Medical Association cautioned that substitution of tasks from medical practitioners to other health staff could lead to diminished quality and safety outcomes:

> Many of the proposals for substitution would have a marginal impact on the availability of medical practitioners and create very significant quality and safety issues at first consideration. … there are significant limitations on the extent to which tasks can be taken out of the hands of medical practitioners or away from their supervision. These limitations include the inability of lesser trained groups to appreciate the complexity of medical decision making and treatment options. (sub. 119, p. 4)

Similarly, the Australian Society of Anaesthetists argued that:

> … the introduction of "alternate providers" with shorter and likely poorer training programs must compromise the recognised high standard that has been achieved over a significant period of time by a large number of committed anaesthetists. (sub. PP195, p. 3)

And, while supporting the introduction of 'appropriate mechanisms for the delegation of activities' (see below), the Royal Australian College of General

Practitioners, said that the sort of task substitutions listed in table 8.2 reflect a misunderstanding of the existing role and capacity of general practice:

> [They ignore] that general practitioners are the traditional professional, along with obstetricians, in maternity care; that general practitioners are the traditional professional, along with anaesthetists, in anaesthesia, especially in rural locations; that general practitioners undertake plain x-rays (along with medical imaging technologists), and that general practitioners report x-rays (along with radiologists). (sub. PP329, p. 5)

The view was also put that widening the coverage of the MBS would simply 'transfer' workforce shortages, as well as involving some new costs. Thus, the I-MED/MIA Network, which operates 240 radiology clinics and accounts for about one-third of the private radiology market, said that giving radiographers and sonographers direct access to Medicare would:

> … exacerbate existing staff shortages of radiographers and sonographers, have a cost impost for training and require the development of appropriate protocols for supervision by radiologists. (sub. 176, p. 2)

Nonetheless, as a means of improving access to care and efficient and effective workplace deployment, the majority of the evidence presented on funding and payment matters supported the extension of the coverage of the MBS to a wider range of services (see box 8.2).

Importantly, there was little support beyond some within the medical profession for the contention that safety and quality would be compromised by *appropriate* task substitution (see chapter 4).

However, given the potentially significant fiscal costs for the Australian Government of extending the coverage of the MBS, several participants raised the possibility of focusing such extensions on 'priority areas'. Thus Duckett argued that:

> Task substitution in many of the procedural items may be appropriate wherever they are performed, but … substitution for the consultation items might be restricted to areas where there is a designated short supply of practitioners, such as rural and remote practice. (sub. PP197, p. 4)

The Victorian Government (sub. 155, pp. 33, 34) similarly suggested that the MBS could be explicitly configured to provide incentives for task substitution to suitably qualified practitioners (such as nurses and/or allied health providers) in areas of workforce shortage.

Box 8.2 **Support for extending MBS service coverage**

The Queensland Nurses' Union argued for consistency of approach between the various health professional groups:

> If we are to truly examine appropriate extension of roles within the health care team then this must also involve an examination of remuneration arrangements and a consistent approach must be taken. (sub. 80, p. 7)

The Australian College of Midwives claimed that the restriction of MBS maternity payments to doctors creates incentives for over-servicing and that:

> Midwives have no access to relevant MBS rebates despite having the professional expertise to provide an equivalent service to healthy pregnant women. (sub. 99, pp. 20, 21)

The Australian Psychological Society said that while psychologists are highly skilled and qualified to provide psychological interventions for mental health problems:

> Many patients have little choice but to use the funded (and hence cheaper), less well-trained practitioner. … Enabling psychologist access to the Medicare items for Focused Psychological Strategies would … provide access to best practice psychological interventions in specialised areas of great need, such as youth and aged mental health. (sub. 118, pp. 19–20)

The Australian Society of Anaesthetists said it has been attempting over the past 15 years to have anaesthesia consultations (as distinct from the provision of anaesthesia services) recognised by both Medicare and private health insurers to provide appropriate incentives for best practice.

> Medicare funding for services should be subject to review and a more outcome-based approach must be adopted and not one solely based on direct impact on health expenditure. (sub. 40 to House of Representatives Standing Committee on Health and Ageing inquiry into Health Funding, p. 3)

The Australian Physiotherapy Association argued that an MBS rebate should apply to physiotherapy services in cases where the patient is referred by a medical specialist.

> In such cases physiotherapy intervention is the best available care for the patient, it is substantially cheaper than surgery, and places less pressure on the health workforce. … If physiotherapy management is available to substitute for surgical management, clearly there are workforce advantages and cost savings. (sub. 65, p. 10)

The National Rural Health Alliance and College of Medicine and Health Sciences (sub. 126, p. 10) and the Australasian College of Podiatric Surgeons (sub. 131, pp. 3, 7) noted that services provided by podiatric surgeons that are 'identical' to those provided by orthopaedic surgeons are not covered by Medicare. The College also noted that there are no rebates for 'medical practitioners (eg. anaesthetists, pathologists, radiologists) who provide services to the patients of podiatric surgeons and are integral in the surgical care of patients'.

The Pharmacy Guild of Australia argued that current MBS-supported care plans and case conferencing items should be extended to remunerate other health care professionals, including pharmacists, working as part of health practice teams:

> … so that they can work with general practitioners as part of the health care team in accordance with their training and skills set … (sub. 165, p. 39)

Delegation of MBS-supported services

Another avenue for promoting more efficient and effective deployment of the health workforce that is particularly relevant in an MBS context, is 'task delegation'. Delegation of less complex tasks by highly trained practitioners can help to ensure that their expertise, and that of the professionals to whom such tasks are delegated, is used to its best advantage. Hence, to the extent that MBS rebate structures encourage delegation in appropriate circumstances, they can enhance workforce outcomes.

There is currently some limited provision for MBS funding of delegated services undertaken by, for example, practice nurses acting on behalf of a medical practitioner (box 8.3). However, Duckett (2005b) and many submissions to this study argued that there is a variety of other instances where such delegation would deliver efficiencies without compromising the safety and quality of patient care, and which should therefore be supported through the MBS rebate structure.

Indeed, James Cook University Faculty of Medicine, Health and Molecular Sciences argued that:

Box 8.3 **MBS items for practice nurses**

In 2004, the Australian Government introduced new MBS rebates for a practice nurse — an RN or EN employed by, or whose services are retained by, a general practice.

- Under these arrangements, GPs can claim for an immunisation or wound management service provided by a practice nurse on their behalf. For these items, the schedule fee is $10.
- In regional, rural and remote areas, GPs can also claim for pap smears taken by a practice nurse. The schedule fee for these items is $10.20.

As these services are provided on behalf of, and under the supervision of, the GP, the GP retains responsibility for the health, safety and clinical outcomes of the patient. The practice nurse must be appropriately qualified and trained to provide these services and must comply with any particular state or territory requirements.

However, to claim these items, the GP is not required to see the patient first, or be present with the practice nurse while the service is being provided. It is up to the GP to decide whether they initially need to see the patient. If so, the GP is eligible to separately claim a Medicare item for that consultation.

In 2004-05, Medicare paid out $26 million for 2.7 million services by practice nurses.

Sources: Health Insurance Commission (www.hic.gov.au) and table 8.1.

> The greatest expansion in the delivery of clinical care is likely [to] come through the devolution of 'medical' tasks to other members of the health team under the local supervision and delegated authority of a Medical Practitioner.

It went on to say that wider delegation would have a range of attractions, namely:

> … clear clinical governance in diagnosis, investigation and technical management; greater likelihood of uptake and acceptance by the medical profession; less regulation, red-tape and external constraint on scope of practice; opportunities for participation by a broad range of health professionals … easier uptake by the private sector; Medical Practitioners able to focus on complex and technically difficult cases; and simpler indemnity arrangements. (sub. 106, p. 3)

Significantly, the Australian Medical Association, which as noted above opposed giving a wider range of non-medical service providers direct access to the MBS (in effect, 'task substitution'), supported task delegation under the control of medical practitioners, commenting that:

> … pressure to deliver health care in a timely, effective and safe manner in complex environments, requires new models of care to be investigated. … The key to safe practice in new models of care is that non medical health professionals work in an interdependent, co-operative and supervised relationship with medical practitioners. (sub. 119, pp. 4–5)

Other participants, however, emphasised that extended support in the MBS for delegated services should be a complement to, rather than an alternative for, wider professional coverage of Medicare. For example, Resthaven, a provider of aged care services, cautioned that focusing solely on providing incentives for delegation by medical practitioners would reinforce the role of the GP as gatekeeper for the MBS in an environment where:

> … there are a number of procedural matters that can be undertaken by other appropriately qualified and certified groups in their own right. A mixture of delegation and independent access pathway options to the MBS system by these new groups would seem appropriate … This would ensure those responsible for the care of the elderly … can explore a range of options to ensure timely care is offered in situations where general practitioners are [unavailable]. (sub. PP186, p. 6)

More forcefully, the Queensland Nurses' Union argued that if new MBS items are created for services provided by non-medical health practitioners, payment should be made directly to the practitioner performing the service (or to the practice where the practitioner is an employee) and no delegation from a medical practitioner should be required. It went on to suggest that a focus on delegation approaches:

> … will serve to reinforce a medical model rather than a multi-disciplinary model of health service delivery. (sub. PP270, pp. 8–9)

The MBS rebate structure

The structure of MBS rebates and the relativities between Schedule fees can affect the number of health care services provided, how they are provided, and in what institutional settings. For example, as well as impacting on the scope for, and level of, task delegation, they influence the extent to which services are provided at a surgery or on a home visit, in business hours or after hours. The career choices of graduates are also affected. Consequently, the structure and relativity of MBS rebates can have significant impacts on health care outcomes.

The Commission received many submissions arguing the inadequacy of particular MBS rebates. For example, the Brotherhood of St Laurence reported the views of GPs and GP organisations that:

> … current levels of MBS rebates discourage them from providing services to residents of aged care facilities … (sub. 45, p. 2)

There was also some commentary on the implications for the size and distribution of the GP workforce of the generally lower MBS rebates paid for services provided by the 3000 or so GPs who are not vocationally registered (see box 8.4)

The relative value of procedural items

However, by far the biggest concern raised in regard to MBS relativities was the perceived bias in favour of procedural over consultative care services (see box 8.5)

There can be little doubt that, relative to costs, medical procedures are generally more highly remunerated under the MBS than consultations and other non-procedural services. This seemingly reflects the fact that relativities were set some time ago and have not been adjusted to take account of technological change that has, in many cases, reduced the cost of procedures and the time they take. In contrast, the essential nature of consultative medicine has changed little over the years.

MBS fee relativities were the subject of considerable analysis and debate during the so called ‘Relative Value Study’, undertaken during the late 1990s and early 2000s.

However, several participants said that little came of that process. Reasons included the inherent complexity of the task, the ‘tremendous variation in actual costs across ranges of GPs and general practices’ and ‘much unresolved debate as to assumptions about cost and income structures’ (DoHA 2005a, pp. 88–89). The budgetary implications of major changes in rebate structures may also have been a factor.

Box 8.4 **Rebates for non-vocationally registered GPs**

According to the Australian College of Non VR GP's, these medical practitioners:

> … are mainly Australian graduates from Australian universities. Most graduated before 1996 and have refused to or not been able to sign on to the government register by virtue of year of graduation. [They] have identical qualifications to those of two thirds of Australian GP's.

However, their patients generally receive lower MBS rebates than patients of vocationally-registered GPs — currently $21 versus $31 for a standard consultation (sub. 128, p. 3).

A non-vocationally-registered GP can access the standard MBS rebates by moving to an 'area of need'. And after five years, their services will continue to attract the higher rebates, regardless of where they later practise.

This rebate structure has led to some relocation to rural and remote areas. But, according to the college, others have left general practice entirely, or have moved into women's health, cosmetic surgery or skin clinics, or into insurance companies or workcover clinics, where the pay is more attractive.

The college went on to suggest that increasing the rebates payable to non-vocationally-registered GPs to standard rates would help reverse this drift out of general practice. And Dr Heinzle — who labelled the current differential as 'out-dated and quite arbitrary' — argued that:

> The government should consider whether it would in fact be preferable to expand the role of local [non-vocationally-registered] and post-1996 graduates, rather than expanding the roles of nurse practitioners, allied health practitioners, retired general practitioners and finally, doctors recruited from developing countries … (sub. 174, p. 8)

For such reasons, the bias in MBS rebate relativities towards procedural medicine remains, and it appears to be detracting from efficient and effective health workforce outcomes in two ways.

First, it is affecting career choices and contributing to shortages in some key workforce areas. Professor Peter Brooks contended that:

> There is little doubt that the gross disparities in remuneration between procedural and non-procedural work in Australia is driving people to take up those higher remuneration specialties … (sub. PP194, p. 3)

More specifically:

- DoHA commented that the current relativities are discouraging medical graduates from entering specialties with a heavy emphasis on consultation such as geriatric medicine, rehabilitation medicine, psychiatry and renal medicine.
- The Australian Medical Association similarly observed:

> Ever since the sinking of the Relative Value Study … consultative practice has been lagging behind procedural practice with declining numbers of renal, thoracic and rheumatology specialists and no growth in the specialties of geriatric medicine and rehabilitation so essential to an ageing population. Addressing this disparity with the MBS could effectively redress this. (sub. PP315, p. 10)

- And the Royal Australian and New Zealand College of Psychiatrists argued that the MBS rebate for psychiatric consultations should be increased so as to boost the incentive for doctors to enter the speciality and reduce the cost to patients (sub. 79, p. 11).

Box 8.5 Views on relative rebates for procedures and consultations

The existence of a bias in relativities

> Throughputs of procedures are proportional to income generated given the open-ended nature of MBS funding … the time to undertake a procedural item of physician practice relative to that of cognitive consultative practice has decreased markedly without there being any recognition of this element in the fee for Medicare benefit quantum. (Royal Australasian College of Physicians, sub. 108, p. 5)

> Procedural disciplines (eg endoscopists, cardiologists, radiologists) receive better remuneration for their work than non-procedural disciplines (eg geriatrics, rehabilitation). (South Australian Government, sub. PP343, p. 10)

Some consequences

> Some areas of specialisation offer significantly higher financial rewards, through MBS reimbursements, which can lead to imbalances in supply. Such imbalances can become particularly acute when there is an overall shortage of qualified staff. (New South Wales Government, sub. 20, p. 6)

> [There is] a not-surprising maldistribution of trainees and specialists to those specialties that have a number of profitable procedures as part of their practice, particularly some surgical subspecialties. (Australasian College for Emergency Medicine, sub. 76, p. 7)

> … the rebate system does little to encourage appropriate … use of the medical workforce. Addressing the problem of inappropriate relativities would assist by sending a signal to patients about the value of general practice, and may also have an impact on the attractiveness of general practice as a career choice … (Royal Australian College of General Practitioners, sub. 143, p. 11)

General Practice Education and Training similarly said that that lower remuneration for GPs relative to specialists is one reason for the difficulty of attracting graduates to general practice (sub. 129, p. 27).

Second, relatively generous remuneration for certain procedural specialists has apparently made it more difficult for public hospitals to attract and retain their services under salaried or VMO arrangements. In this regard, the Victorian Government said that:

> … the time spent in private practice and the remuneration rate for surgical interventions is far greater for adult orthopaedics than for paediatric orthopaedics, which has a heavier consultative load. (sub. 155, p. 34)

Indeed, the Commission was told that remuneration from MBS-supported private practice in procedural areas can be several times greater than the level of remuneration available in the public hospital system.

Moreover, looking to the future, the current bias in MBS relativities may make it more difficult to encourage medical practitioners to delegate less complex procedural services, even if wider provision is made for such delegation in rebate arrangements (see section 8.4).

Limits on referral and prescribing rights

Under Medicare, access to most subsidised specialist services is subject to a referral from a GP. For example, the Australasian College of Podiatric Surgeons (sub. 131, p. 7) referred to the lack of MBS rebates for the services of medical specialists in cases when a patient is referred by a podiatric surgeon. Similarly, pathology tests must generally be ordered by medical practitioners. Such referral restrictions aim to minimise the inefficient use of more specialised and high cost services, and to contain budgetary costs for government.

But referral restrictions have their own set of costs. In this respect, the Australian Physiotherapy Association argued that the inability of physiotherapists to directly refer patients for diagnostic imaging results in 9500 hours of unnecessary GP consultations each year, at an annual cost to the taxpayer of $1 million, as well as additional time and monetary costs for patients (sub. 16, p. 18). Additionally, the Association contended that there would be further efficiency gains from granting physiotherapists the right to refer patients for MBS-supported consultations with specialists such as orthopaedic surgeons and obstetricians and gynaecologists.

Restrictions on who can prescribe drugs subsidised under the PBS similarly have some adverse consequences for the efficient deployment of the health workforce. For example, the Victorian Government referred to data collected by the Optometrists Association Victoria, suggesting that:

> … approximately one out of eight patients who required a script were referred to a medical practitioner in order to be eligible for PBS subsidies, and that any increased costs associated with making PBS available to suitably qualified optometrists would be offset by savings to Medicare. (sub. 155, p. 33)

The Victorian Government went on to cite work by Halcomb et al. (2005), which suggests that the potential value of making MBS benefits available to a wider range of non-medical providers would be compromised by the current restrictions on PBS prescribing rights.

And in relation to the current restrictions on both referral and prescribing rights, the Australasian College for Emergency Medicine argued that:

> While there are good reasons for some of these restrictions, they do limit the ability to transfer roles to other staff members. (sub. 76, p. 4)

8.4 What should be done to address these problems?

From the preceding discussion it is clear that several aspects of the MBS warrant examination if the health workforce is to be used efficiently and the objectives underlying Medicare are to be effectively met.

However, addressing some of the problems canvassed above would have wider implications, including for the overall level of health care services provided to the Australian community and for the fiscal costs to government of supporting those care needs. Hence there needs to be careful analysis of the costs and benefits of potential changes to the MBS, particularly in view of competing calls from within the health sector and elsewhere for public funding.

It also needs to be recognised that, while extensions to the coverage of the MBS would ameliorate some problems, they would create others — that is, the boundary that separates services that are subsidised from those that are not, and hence the area of inconsistency, would simply shift. As the Royal Australasian College of Physicians noted:

> … whenever MBS item numbers are introduced or revised, there is a risk of distorting relativities between health practitioners. A more recent example has emerged from the Co-ordinated Care Trials with the enhanced primary care (EPC) items in the MBS … The level of benefits has been struck … so as to almost obliterate the relativity between primary care and consultant practice. (sub. 108, p. 5)

Further, the Commission emphasises that detailed issues concerning what particular services ought to be covered by the MBS, who should be able to refer patients to other health practitioners for MBS-supported services, and the appropriate relativities between MBS fees for procedural and consultative services, are not matters that can be resolved in a study of this nature.

However, there are some institutional changes that could be made to progress these matters in a considered way. In particular, the Commission sees benefits in bringing greater transparency to the assessment of the broad MBS coverage issues raised by participants during this study. It also notes the evidence of participants that there is scope within the current MBS structure to encourage greater delegation of tasks without compromising the safety and quality of care. And it sees the need to put in

place a process that will formally assess, and as appropriate address, the concerns about the relativities between rebates for procedural and consultative services.

An ongoing evaluation mechanism

While the MBS is amended from time to time to reflect, for example, the availability of new medical technologies and procedures, changing medical practice and the implementation of new government policies, there is no formal independent mechanism by which arguments for inclusion of a wider range of services (such as those provided by allied health professionals) can be evaluated transparently against some form of public net benefit criteria.

There are two main ways by which changes are currently made to the MBS (box 8.6). One is through the addition of new medical items. The Medical Services Advisory Committee (MSAC) advises the Minister as to the safety, effectiveness and cost-effectiveness of new medical technologies and procedures and whether new MBS items should be provided to support them (MSAC 2004, p. 2).

Changes to the MBS are also made through periodic reviews of professional services already listed on the MBS. This is undertaken by DoHA in conjunction with the medical profession, through the Medicare Benefits Consultative Committee (MBCC). These arrangements:

> … ensure that the medical profession plays a key role in ensuring that the MBS reflects current and appropriate medical practice. (MSAC 2004, p. 2)

The MBCC may, for example, review current MBS items in terms of adequacy of descriptions, fees and the existing structure of the Schedule 'but not so as to involve a general review of the overall fees throughout the Schedule'.

Importantly, the deliberations of the MSAC and the MBCC are broadly confined to new medical technologies or current MBS items — that is, they operate within the limits of the current, essentially medical services based, scope of the MBS.

Hence, requests for broader changes to the MBS of a kind made during this study are not encompassed by these arrangements. Where such changes are made, they generally flow from the development within government of new policies or programs, in consultation with key stakeholders, rather than through a standing assessment body process. Recent illustrations include new MBS items for practice nurses and for chronic disease management, and extensions to the Practice Incentives Program.

Box 8.6 **Changes to the MBS**

There are two main procedural routes by which changes are made to the MBS:

- One route involves the Medical Services Advisory Committee (MSAC), which advises the Minister for Health and Ageing on evidence relating to the safety, effectiveness and cost-effectiveness of new medical technologies and procedures (for example, a new technique for an existing surgical procedure). This advice informs government decisions on public funding for new and in some cases existing medical procedures. The Committee includes people with a mix of clinical expertise — covering pathology, surgery, specialist medicine and general practice, as well as in clinical epidemiology and clinical trials — health economists, consumers, health administrators and planners.
- The second route relates to reviews of existing items on the General Medical Services Table of the MBS. The Medicare Benefits Consultative Committee (MBCC) provides an informal forum for consultation between medical practitioners and the Minister/Department of Health and Ageing to review particular services, including consideration of new items (referred to MSAC for independent evaluation) and appropriate fee levels. It operates on a cost neutral basis, except for genuinely new items where consideration is given to additional funding.

Separate committees operate when items covering optometrical or certain dental services (such as those relating to cleft lip and palate conditions) are being reviewed, and there are separate consultative arrangements for the Diagnostic Imaging and Pathology Services tables.

If the Minister endorses a recommendation for public funding of a new medical procedure, an MBS listing and fee will be negotiated through the MBCC (or the Consultative Committee on Diagnostic Imaging or the Pathology Services Table Committee as appropriate). Following the introduction of new items or major amendments, it is usual for a review of the changes to be made after two years.

Sources: MSAC (2004); DoHA (sub. 34 to Productivity Commission study into Medical Technology, p. 8).

Evidence presented to the Commission (section 8.3) strongly suggests that there are other instances where support through the MBS for some services provided by new (non-medical) health practitioners would improve patients' access to quality care; enhance the convenience of care; lead to a more efficient use of the mix of skills in the workforce without compromising safety and quality; and/or increase job satisfaction for some health workers. Moreover, while such extensions in coverage would generally involve some increase in budgetary outlays for the Australian Government, the cost of acquiring the accompanying health and other benefits would be lower than under an alternative approach of expanding service provision by the existing range of subsidised practitioners.

For such reasons, the Commission sees a strong case for implementing an independent and transparent process for assessing requests to extend the coverage of the MBS (and for extensions of referral and prescribing rights) against broad public interest criteria, according to their safety, effectiveness and cost-effectiveness. In particular, an approach whereby all such proposals are transparently and independently assessed via a single review mechanism, and the results of those assessments are publicly available, would promote rigour and consistency in decision making. It might also assist closure in cases where requests to government to extend coverage are denied.

As noted by the Australian Physiotherapy Association (sub. 65, p. 11) — which advocated such an approach in its initial submission to the study — the review body could operate somewhat like the Pharmaceutical Benefits Advisory Committee**.** That committee is an independent statutory body that recommends which drugs should be added to the PBS schedule.

Responses to this proposal — as outlined in the Commission's Position Paper for the study (PC 2005a) — were for the most part supportive. For example:

- State and Territory Health CEOs considered such reform to funding and payments mechanisms to be 'an essential step towards achieving the best possible utilisation of the health workforce'(sub. PP332, p. 27).
- The South Australian Government commented that:

  An independent review by an independent reviewing body may be a suitable strategy for revealing the impediments within the current MBS arrangements that impinge on appropriate workforce development and planning. (sub. PP343, p. 10)
- The Australian Medical Council observed that the relationship between remuneration (rebates) and workforce supply has been identified for many years and that:

  If this issue can be effectively addressed, many of the current workforce problems may be able to be resolved. (sub. PP306, p. 3)
- And Resthaven saw this as 'a key proposal' that has 'considerable potential importance' to the aged care workforce and related requirements in rural and remote environments — though it added that it would be important that the review body appreciates the differences within the health sector when such matters are considered (sub. PP186, p. 5).

(Some more specific comments on the possible role and functions for a review committee are provided in box 8.7.)

Box 8.7 **Some views on the role of an MBS review body**

As outlined in the text, there was generally strong support for an independent review body to assess requests to extend the coverage of the MBS (and for extensions of referral and prescribing rights). In their responses to the Position Paper, several participants commented on some specific functions for such a body, or referred to particular professional areas that its assessments should cover.

The South Australian Government (sub. PP343, p. 10) said that, beyond the functions identified in the Position Paper, the review body should also give consideration to: the appropriateness of different rebates for different groups of doctors who perform the same tasks; the key role of prescribing rights in role diversification; and the case for MBS item payments for teachers, supervisors and mentors within the public system. It further suggested that implementation of the body should make provision for a role for consumers in the development of proposals to alter what is funded; and for links between the MBS review body and the proposed innovation body (see chapter 4) in respect of changing services and emerging developments.

And, in endorsing the general approach, Professor Peter Brooks advocated a longer term focus on the cost-effectiveness of the full range of items subsidised under the MBS:

> Not only should this body review new items that might be subject to MBS reimbursement but over a period of time the MBS system itself should be reviewed and those treatments deemed not cost effective, be identified to the Minister. The Minister would still have the option of making a political decision as to whether to remove funding or not, but at least the evidence would be there for him/her to make that decision, as is the case with the [Pharmaceutical Benefits Advisory Committee]. (sub. PP194, p. 3)

More specifically, the Public Health Association of Australia argued that urgent consideration be given to inclusion of referrals to clinical psychologists on the MBS, in view of:

> … the paltry state of mental health service delivery in Australia. (sub. PP334, p. 5)

Also bringing a mental health perspective to bear, the Centre for Psychiatric Nursing Research and Practice couched its support for a review body in the context of the potentially important role of nurse practitioners in this area:

> … Nurse Practitioner roles potentially have considerable benefits for consumers of mental health services. The capacity for these roles to fulfil this potential requires changes to the Medicare Benefits Scheme and Pharmaceutical Benefits Scheme. (sub. PP342, p. 7)

Indeed, the only significant opposition came from some within the medical profession, who contended that extending direct access to the MBS to other health professionals would not be a good use of scarce health funds. For example, the Australian Medical Association said:

> The Commonwealth government is expressing increasing concern about its ability to fund health services for a rapidly ageing population. … the Commission is proposing that areas now quite adequately covered by [private health insurance] be covered

> instead (or, perhaps, as well) by Medicare (ie, that these elements of health insurance be nationalised). Given scarce funds, what does that imply? Further elements of Medicare would have to be de-nationalised to make room for the newly nationalised components. (sub. PP315, p. 10)

Similarly, the Rural Doctors Association of Australia and the Australian College of Rural and Remote Medicine contended that:

> The current MBS funds general practice. The process as outlined appears to be facilitating the funding of a broader range of health professionals without indication of additional financing. (sub. PP313, p. 6)

Representatives of the medical profession also raised concerns about a 'lack of engagement' with medical expertise were MSAC and the MBCC to be subsumed into a new committee with wider functions. Thus the Australian Medical Association said that:

> … there is a significant risk that the quality of advice will decline when advisory bodies are broadened. … Making MSAC and MBCC subsidiary committees in a deeper hierarchy will only add to delays and inefficiencies. (sub. PP315, p. 11)

However, as noted above, soundly based extensions to the coverage of the MBS are likely to reduce, not increase, the cost of meeting any particular level of care services. In this regard, the principle put forward by AHMAC (sub. 166, p. 9) is particularly germane — namely that 'wherever possible, services should be delivered by staff with the most cost effective training and qualification to provide safe, quality care'. Moreover, with appropriate governance arrangements in place (see below), such a body would engage appropriately and effectively with the relevant medical experts.

Some key features of the new arrangement

In the light of the above, the Commission sees no reason to change the thrust of the proposal in the Position Paper. Specifically, it recommends that a single, broadly-based and independent advisory committee replace, and have a broader role than, the committees that now advise the Australian Government on the coverage of the MBS (primarily, the MSAC and the MBCC). Its primary functions would be to make formal recommendations to the Minister for Health and Ageing on the coverage of the MBS, rebate levels for new subsidised services, referral rights under the MBS and prescribing rights under the PBS.

In the Commission's view, essential components of the advisory committee's approach ought to be:

- independence;

- transparency of process;
- whole of community perspective; and
- public reporting on the reasons for its recommendations.

Good governance arrangements will also be fundamental to the success of the committee. The make-up of the committee will need to provide the necessary range of expertise to allow it to effectively fulfil the functions spelt out above. And as for the other new bodies which the Commission is proposing, it will need to be structured in a way that gives primacy to the public interest in the conduct of those functions. (Some further general commentary on good governance requirements are provided in chapter 13.)

Some participants suggested that to give the new arrangements 'teeth', the committee should have the capacity to independently implement particular policy or program changes. However, in the Commission's view, this would not be appropriate — given the fiscal implications of the changes that the committee would be examining, final decisions should clearly be made by the Australian Government. Also, the Commission envisages that, in making its assessments and recommendations, the Committee would draw on the expertise of others, rather than undertaking primary research of its own.

There was some discussion in responses to the Position Paper on how to handle functions currently undertaken by MSAC and the MBCC that potentially lie outside the proposed brief for the new committee In this regard, the State and Territory Health CEOs said that:

> … consideration must be given to how other key functions of MSAC including assessment of technologies and procedures, assessment of nationally funded centres and support for the health policy advisory committee on technology are provided. (sub. PP332, p. 27)

Similarly, the Tasmanian Government (sub. PP339, p. 9) saw the need to 'retain or carefully relocate' the new health technology horizon scanning and impact assessment functions of MSAC.

In the Commission's view, the MBS advisory committee should take over all of those functions of current committees that are needed to fulfil its role as the independent advisor to the Minister for Health and Ageing on the coverage of the MBS and related matters. Thus assessment of, for example, medical technologies and procedures for these purposes would become a role of the new committee. Any residual tasks (such as health technology assessment work currently referred to MSAC by AHMAC) could either be added to the new committee's list of functions or be reallocated.

Finally, it is very important to recognise that fiscal considerations will constrain both the extent and speed of any extensions to the coverage of the MBS, or of wider referral and PBS prescribing rights. Indeed, from a fiscal perspective, there could be merit in the new committee focusing initially on changes that would improve outcomes in areas where shortages or other workforce related problems are most acute. In this regard, the Victorian Government (sub. 155, p. 33) raised the possibility of a trial to provide limited access to MBS rebates and PBS prescribing rights for non-medical practitioners in areas of designated GP shortage. Such trials could also be contemplated in some of the key special needs areas.

One way of facilitating such trials, and a focus on priority areas more generally, would be to incorporate provision in the new arrangements for the Minister for Health and Ageing to refer such matters to the committee for its attention.

RECOMMENDATION 8.1

The Australian Government should establish an independent standing review committee to advise the Minister for Health and Ageing on:

- ***the safety, effectiveness and cost-effectiveness of proposals for changes to:***
  - ***the range of services (by type and provider, whether medical or non-medical) covered under the MBS (including the rebate to apply);***
  - ***referral arrangements for diagnostic and specialist services subsidised under the MBS; and***
  - ***prescribing rights under the PBS; and***
- ***other relevant matters referred to it by the Minister.***

The new committee should subsume the relevant functions of the Medical Services Advisory Committee, the Medicare Benefits Consultative Committee and related committees, and report publicly on its recommendations to the Minister and the reasoning behind them.

A review of rebate relativities

Determinations made on the basis of advice from the new advisory committee could over time have significant impacts on the overall structure of MBS rebates, and relativities between rebates for particular services. However, as experience with the Relative Value Study illustrates, effecting such change can be a time consuming process, especially in the light of the fiscal considerations involved.

Accordingly, the Commission considers that more immediate and specific action is required to address the particular issue of the relativities in MBS rebates between

procedural and consultative services. As spelt out earlier, the apparent bias in relativities in favour of procedural services is widely perceived to be detracting from efficient and effective workplace outcomes by:

- distorting career choice and thereby contributing to workforce shortages in a number of the consultative medical specialties; and
- augmenting the difficulties for the public sector in recruiting procedural specialists.

The Commission notes that for some medical specialties, patient contributions additional to MBS rebates are an important part of practitioners' total remuneration. Alterations in rebates are likely to lead to some offsetting changes in patient contributions, in turn diluting the impacts of the rebate change on provider behaviour, career choices etc.

But though constraining the capacity to leverage change through the rebate structure, this feature of the medical market is unlikely to remove that capacity completely. Indeed, in specialty areas where rebates comprise a high proportion of practitioners' incomes, changes in those rebates could potentially have a significant impact on behaviour.

The Commission notes that DoHA is currently:

> ... reviewing the payment methodologies used under the MBS and is obtaining information from a range of sources, with a view to better aligning these with contemporary clinical practice. (sub. 159, p. 35)

As part of this review, the Commission therefore considers that, until the independent standing review committee is operational, DoHA should give particular priority to assessing the extent of the bias in the MBS in favour of procedural services. If that assessment confirms that the bias is significant, DoHA should advise on how to address the bias, such as by imposing a temporary freeze on rebates for services that are considered to be 'over-remunerated'.

RECOMMENDATION 8.2

The Department of Health and Ageing should, as a matter of priority, determine the extent of the bias in the MBS in favour of procedural services, and how any significant bias should be addressed.

That assessment should be taken over by the proposed independent review committee when it is fully functioning.

Extension of delegation arrangements

To reinforce and complement the wider coverage of Medicare subsidies that would be expected to ensue, over time, from the activities of the new advisory committee, the Commission considers that there should be greater encouragement for the delegation of services within the MBS arrangements. As was widely acknowledged by participants in this study, delegation of less complex tasks can be an important mechanism for improving cost-effectiveness without compromising the safety and quality of care.

While provision for delegation is currently limited to some particular services provided by practice nurses (see box 8.3), those arrangements provide a potentially useful model for wider application of the approach. Specifically:

- the service is provided under the authority of the delegating practitioner, who is responsible for the health and safety of the patient, and who bills Medicare; and
- a lower rebate is payable for the delegated service, which allows the government and the community to share in the savings from its more cost-effective provision.

The delegation proposal in the Position Paper based on these principles received widespread support — including from those areas of the medical profession which opposed extending direct access to the MBS to non-medical practitioners. For example:

- The Royal Australasian College of Surgeons said it:

  > … is broadly supportive of task delegation as outlined in the Commission's paper. It is already used in general practice and would allow greater efficiencies in many surgical groups. If the medico legal burden is to remain primarily with the delegating doctor then it must only happen with the express wish and supervision of that doctor. (sub. PP318, p. 6)

- The Australian Council of Deans of Health Services said that it:

  > … welcomes recognition of the importance of developing a 'delegated practice' framework to support expanded clinical roles by allied health practitioners. This will be the major opportunity to increase workforce flexibility in clinical practice. (sub. PP302, p. 1)

- And in commenting on the particular value of delegated service provision in rural and remote communities, the Western Australian Government contended that:

  > Over time it should facilitate greater innovation in service provision, with health professionals, such as practice nurses, allowed to deliver a determined range of services … (sub. PP333, p. 10)

Several participants emphasised, however, the importance of simultaneous scope for wider direct independent access to the MBS as provided for in recommendation 8.1 above. The Tasmanian Government, for instance argued that:

> Without some capacity for independent access, this proposal risks reinforcing existing professional hierarchies and operating as a disincentive to innovation. (sub. PP339, p. 10)

Some specific implementation issues

The broad approach outlined above could be implemented in several different ways.

- There could be a 'blanket' delegation provision such that all delegated services were remunerated at a fixed percentage of the standard rebate.
- There could be single MBS item numbers for all delegated tasks carried out by particular types of health worker — for example, practice nurses.
- Or there could be case-by-case introduction of discounted rebates for a wider range of delegated services.

While the Commission does not have a firm view on this matter, the latter approach seemingly has some considerable advantages — especially in terms of preventing unintended or excessive increases in budgetary costs (see below). It could also allow for targeting of the new arrangements to help improve access to services where workforce shortages are particularly acute — for example, in rural, remote and Indigenous communities and in outer metropolitan areas, and/or in relation to particular groups with special needs.

But whatever approach is chosen, careful consideration will need to be given to the rate of discount for delegated services. As noted above, the Commission is strongly of the view that there should be a discount to enable the government and the community to share in the savings that result when provision of a service is appropriately delegated to a less highly qualified health professional. However, there are a range of competing considerations in setting the precise discount rate and trade-offs will inevitably be involved (see box 8.8).

Moreover, as discussed in chapter 7, the case for changes to current registration arrangements as they apply to delegation was the subject of some debate (see for example, Duckett 2005b, p. 8 and sub. PP197, pp. 2–4; the Victorian Government, sub. 155, p. 32; and James Cook University Faculty of Medicine, Health and Molecular Sciences, sub. 106, p. 3). One consideration is that the scope for delegation is likely to vary according to the setting in which care is provided. Thus the Australian Medical Association cautioned that:

> … role delegation is specific to the location of care and the infrastructure support available in the work setting. What is acceptable role delegation in a major teaching hospital with plentiful other professional support may not be appropriate in other situations. (sub. PP315, p. 2)

Box 8.8 Setting rebates for delegated services under the MBS

Achieving the right balance in the level of discount to apply to rebates for delegated services under the MBS will not be easy.

If the rebate is similar to that applying when the service is provided by the delegating practitioner, there will be a strong financial incentive for that practitioner to delegate, freeing him or her to provide other services that are more medically valuable. However, this could lead to a possibly significant increase in the total supply of services, and hence to a sizeable expansion in the overall budgetary costs of subsidies. (That said, like increased service provision that would result from giving a wider range of health professionals direct access to the MBS, the cost of these additional services would be lower than under an alternative approach of, say, boosting the number of GPs.)

On the other hand, while setting a very low rebate for delegated services would lessen the fiscal impact, it would also reduce the incentive for delegation. As the Australian Sonographers Association observed:

> We are concerned … that a lower rebate would discourage the employment of sonographer practitioners for the purposes of delegating duties, and therefore the present anomalies within the workplace would continue. (sub. PP286, p. 4)

Hence, many of the benefits potentially on offer from subsidising delegated services would not be realised, with little or no change in the actual pattern of services provided.

A further complication is that the discount rate for delegated services would need to take account of any continuing bias in MBS rebates in favour of procedural medicine (see earlier). This may discourage delegation of better funded but straight-forward procedures if the alternative for the practitioner is to undertake consultations that are less financially rewarding (notwithstanding that this reallocation of tasks may make better use of available workforce skills).

It may well be that the weighting attaching to each of these considerations will vary across services, implying that the relationship between the standard rebate and the rebate for delegated provision should also vary. Such complexities serve to reinforce the case for periodic review of the new delegated service provision arrangements that the Commission is recommending (see text).

This in turn suggests that reliance on mechanisms such as clinical protocols and credentialing arrangements may often be a better means of facilitating efficient and safe delegation, than prescriptive and potentially inflexible, legally specified, requirements in registration provisions. Accordingly, the Commission has recommended (7.3) that the new national registration board investigate what action,

if any, is necessary in regard to professional registration requirements to facilitate appropriate delegation, generally and within the context of the MBS.

Other implementation issues that would have to be addressed, include:

- the nature of monitoring arrangements and other safeguards to prevent delegation leading to excessive increases in budgetary costs or over-servicing; and
- the nature of measures to deter any fraudulent use of delegation arrangements. (While the Commission received no specific input on this matter, it understands that this was a concern when delegation arrangements operated more widely at the time Medicare and its predecessor arrangements were set in place).

Such implementation issues, and especially the need to contain the fiscal impact, suggest that some progressive fine-tuning of the recommended changes in this area will be required. Accordingly, the Commission is proposing that the new arrangements be reviewed after three years and again after a further five years.

Finally, the Commission reiterates that greater encouragement within the MBS for delegated service provision should be a complement to, not an alternative for, independent assessment of the case for extending direct access to the MBS to a wider range of service providers (see recommendation 8.1). Both measures have an important role to play in future efforts to better and more flexibly match the needs of patients with the services of a wide range of health professionals. Hence, the Commission concurs with those participants who argued that a focus on delegation alone could encourage excessive reliance on medical practitioners and be of limited value in improving the efficient and effective utilisation of the health workforce overall.

Indeed, the two measures are clearly linked. That is, as a result of assessment by the proposed independent MBS review committee, particular services directly provided by non-medical health professionals may be incorporated into the MBS. Delegation of these services by that non-medical professional would in turn be encompassed by the arrangements outlined in this section.

RECOMMENDATION 8.3

The Australian Government should increase the range of MBS services for which a rebate is payable when provision is delegated by the (medical or non-medical) practitioner to another suitably qualified health professional. Where delegation occurs:

- ***the service would be billed in the name of the delegating practitioner; and***

- ***rebates would be set at a lower rate, but still sufficiently high to provide an incentive for delegation in appropriate circumstances.***

Implementation should have regard to the fiscal impacts, with the arrangements reviewed after three years and again after a further five years.

Greater consistency in expenditure control mechanisms

Given the extensive public subsidisation of health care costs, measures to limit governments' budgetary exposure will be an ongoing feature of the health workforce environment. Some of these have been specifically mentioned in the chapter, with further examples of measures in the primary medical care area provided in box 8.9.

Box 8.9 **Multiple expenditure control measures for health care**

Measures in place at least partly to contain the Australian Government's budgetary exposure on health care services include:

- limits on the number of training places at universities;
- restrictions on the number and type of providers eligible to claim public funding via the MBS and the PBS;
- restrictions on the range of subsidised medical and diagnostic services and drugs;
- dollar limits on rebates for subsidised items;
- the system of referrals to specialists;
- limitation to regional areas of the provision of subsidised services by some overseas trained doctors;
- monitoring by the HIC of servicing and prescribing patterns;
- restrictions (via location controls) on the number of pharmacies eligible to dispense subsidised PBS drugs; and
- limits on the scope for private health insurers to cover patients' residual out-of-pocket costs for publicly subsidised items.

Viewed in isolation, there may well be a sound rationale for each of these measures — recognising that, in several cases, these measures are also in place to pursue other goals. However, such expenditure control measures will often have adverse implications for efficiency and effectiveness, including in a workforce context. For example, as noted earlier, constraints on the coverage of the MBS, PBS and other subsidies can lead to inefficient substitution between health care providers. Thus,

while government fiscal controls are warranted, not all controls seem well-aligned in terms of supporting a common set of objectives.

In the future, it will therefore be important to ensure that, as far as possible, expenditure control mechanisms are consistent with the objectives of health workforce policy, and that the instruments employed in health care are well coordinated with those in health education and training. The Commission's recommendation (3.1), which is directed at bringing the finance and central policy coordination areas of government within the purview of the NHWSF, should be helpful in this regard.

9 Workforce planning — projecting future workforce needs

Key points

- Projections of the numbers of health workers required in the future, such as those currently provided by AMWAC and AHWAC, are planning tools.
- The role of such workforce projections should be to assist governments and other stakeholders in their considerations of the supply requirements — particularly in relation to education and training — of various health services demand scenarios.
- Governments and other relevant stakeholders should retain responsibility for integrating that advice into their broader health policy frameworks.
- Given their inherent imprecision, projection methodologies should:
  - be kept as simple as possible;
  - be based on a range of relevant demand, supply and productivity scenarios;
  - concentrate on the major health workforce groups, while recognising that projections for smaller groups may be needed from time to time; and
  - be updated regularly, consistent with education and training planning cycles.
- Current institutional structures for this workforce planning should be rationalised, with the secretariat undertaking this function reporting directly to AHMAC.
  - This would result in some small administrative savings, and address any residual concerns regarding inappropriate influence by particular stakeholder groups.

This chapter concerns the processes currently adopted by the Australian Medical Workforce Advisory Committee (AMWAC) and the Australian Health Workforce Advisory Committee (AHWAC) in their consideration of the *numbers* of health workforce professionals of various descriptions likely to be required to sustain health services delivery into the future. Thus, throughout this chapter, the term 'workforce planning' has a narrower interpretation than elsewhere in the report.

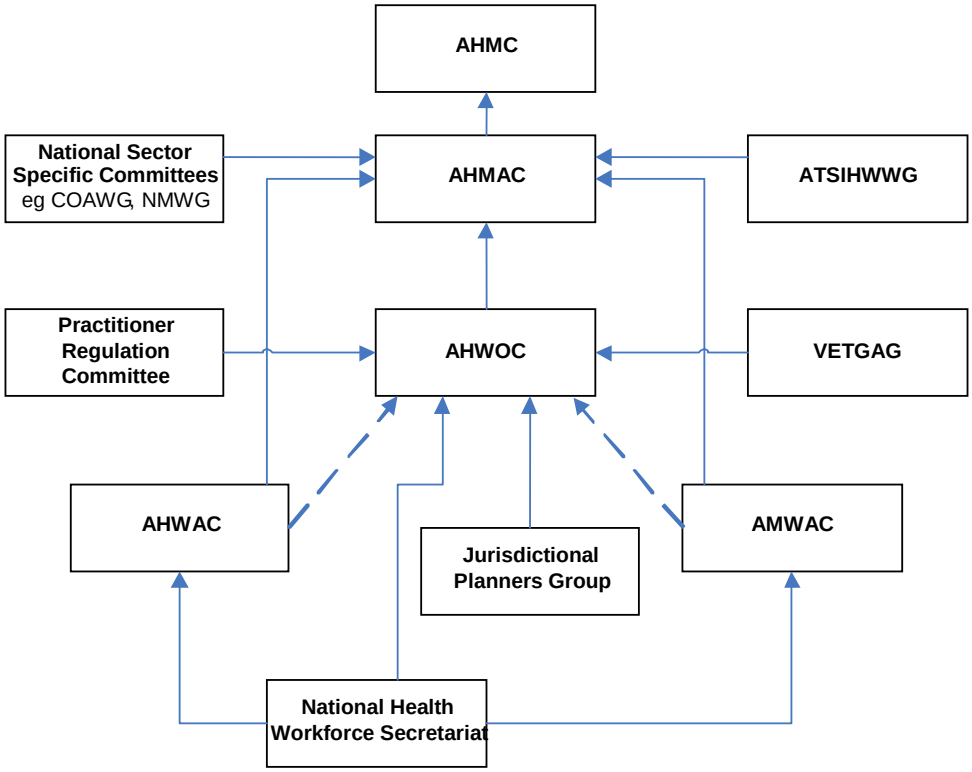
AMWAC was formed by the Australian Health Ministers' Advisory Council (AHMAC) in 1995, followed by AHWAC in 2000. They are both ultimately under the control of the Australian Health Ministers' Conference (AHMC) (figure 9.1).

Under the existing framework, AMWAC is responsible for medical workforce planning and has undertaken planning reviews on general practice and most of the

medical specialties. AHWAC is responsible for non-medical workforce planning and has to date conducted planning reviews for specific nursing fields (for example, midwifery and critical care nursing). It has also foreshadowed, but not yet undertaken, planning projections for the allied health professions.

States and Territories also undertake some workforce planning activities at the jurisdictional level. According to the Victorian Government, their scope and complexity vary significantly, as do the datasets and assumptions used (sub. 155, p. 38). For example, the model being developed and tested by the Northern Territory Government to predict future workforce needs is based on burden of disease and injury data (sub. PP182, p. 24).

Figure 9.1 **National health workforce planning reporting structure**



Source: Victorian Government (sub. 155, p. 37).

9.1 The role of workforce planning

Governments intervene in the provision of health services for reasons of equity and market failure (chapter 1). They heavily subsidise service provision and, at the State and Territory level, are major employers of health workers. In doing so, they have a

particular interest in ensuring that health services are neither under supplied nor over supplied — under supply would deny the community some of the health services it requires, whereas over supply would waste expensive resources, not only in the direct provision of health services (including through any supplier induced demand), but also through education and training. Thus, governments have a clear need for health workforce planning.

For several reasons, planning exercises are far from trivial. There can be lags of 10 years or more in the supply of some health professionals after their first entry into education/training. This introduces considerable uncertainty into the projection process, as does making allowance for likely future workforce participation trends (box 9.1). It is in this context that AMWAC and AHWAC were established.

Participants put forward a number of differing views about the appropriate role for AMWAC and AHWAC's work — in particular, some expressed disappointment that their advice is not 'automatically' put into effect. For example, the Committee of Deans of Australian Medical Schools (CDAMS) stated that:

> [An] urgent priority is the creation of a coordinating mechanism to implement the specific recommendations of AMWAC as they become available from each of the detailed studies on individual components of the medical workforce. CDAMS therefore strongly supports the continued funding of AMWAC but also recommends the creation of mechanisms to ensure that its recommendations are effectively implemented. (sub. 49, p. 9)

A disconnect between the conduct of planning and the implementation of advice by government was also raised during the 2002 review of AMWAC (AHMAC 2002).

Many participants argued that greater engagement of the Department of Education, Science and Training (DEST) in the planning process would be helpful in improving the translation of workforce needs to education and training places. While DEST is currently a member of the Australian Health Workforce Officials Committee (AHWOC), its involvement is commonly viewed as nominal only. AHMAC noted:

> Engagement of DEST on health workforce issues through State and Territory Education and Training agencies has had limited success … (sub. 10, p. 7)

However, in the Commission's view, the role of those bodies undertaking technical projections of future workforce needs is to provide advice to governments on the numerical workforce requirements for meeting particular levels and structures of health services demand. That advice should centre around the numbers of students required, over time, at various points along the education and training pathway.

Responsibility for decisions that draw on that advice must necessarily remain with governments, their appropriate agencies (such as their health and education

Box 9.1 **The inherent difficulties of workforce planning**

A range of factors present sizeable challenges for workforce planners, rendering projections of future workforce requirements an inherently imprecise activity.

A complex environment

Planners face a multitude of uncertainties in relation to factors influencing the demand for, and supply of, health workers. On the demand side these include the impact of:

- increased demand for health services, due to higher incomes and expectations;
- changes to the types of health services needed in response to population ageing; and
- policy changes that may alter 'prices' paid for health services by consumers or the uptake of private health insurance.

And, on the supply side, they include the impact of:

- broad economy-wide pressures that affect the general strength of the labour market, and thereby entries and exits to the health workforce and participation levels;
- structural pressures, like workforce ageing, lifestyle balance and increased feminisation, which are contributing to reductions in average hours worked; and
- enhancements to labour productivity (mainly through technological advancements and improved work practices) that affect future requirements for health workers.

Long lead times for education and training

The lead times required to train many types of health workers (and especially medical specialists) are lengthy. There is uncertainty regarding the level of workforce need that will exist at the completion of training programs, the number of students that will satisfactorily complete the necessary training, year by year, and the number that will be retained in the health workforce beyond their first few years.

Data problems

There are often considerable 'gaps' in required data, terminology is inconsistent and available information is frequently dated.

departments) and high level coordinating bodies such as the AHMC. Responsibility for decisions on such matters as health and education expenditure levels, the acceptable degree of reliance on overseas trained professionals, the number of education and training places for the various professions, and health workforce distribution across Australia cannot be readily ceded to technical bodies. Indeed, as discussed in chapter 4 in relation to the proposed health workforce improvement agency, to require that such bodies should have power to implement their own recommendations would detract from the sovereignty of the various jurisdictions in managing their health and wider budgets.

9.2 Methodological issues

Projections of health workforce numbers, and the associated implications for education and training, can be made at varying degrees of sophistication. The broad methodology which generally has been used by AMWAC and AHWAC is briefly described in box 9.2.

Box 9.2 AMWAC and AHWAC's approach to workforce planning projections

National health workforce planning agencies, AMWAC and AHWAC, adopt similar methodologies to estimate the workforce numbers required to meet future health care needs. The broad stages of the approach are outlined below, with predictive elements typically calculated using a spreadsheet based model (usually over a 10 year period). Notably, the approach requires some fundamental judgments (which usually input directly as parameters into the calculation model) about demand and supply for particular health professions. Perhaps the most critical of these involves determining an appropriate 'baseline' level of service *need* (as distinct from the demand by consumers for subsidised health services) on which to base workforce projections.

Requirement analysis Future workforce needs are projected by applying a growth factor to the baseline level of need. This growth factor reflects expected changes over the projection period in a range of parameters, including: demographic changes (eg population growth and ageing); technological advancements; and disease trends.

Supply analysis Future supply is generally projected using a 'stocks and flows' method, based on five year age and gender cohorts. Current (baseline) supply is estimated and then projected over future years by adding in new entrants to the workforce, subtracting losses, and accounting for the impact of changes in the age and gender balance of the workforce, and in hours worked.

Gap analysis Following projections of the two key analytical elements — workforce needs and supply — an analysis of the remaining 'gap' is undertaken, with options proposed to remedy any imbalance. These most often focus on adjustments to education and training intakes, but also sometimes note that overseas trained health workers might be needed to completely fill a gap.

Sensitivity and scenario analyses Some sensitivity analyses of projections is often conducted through modifying key modelling assumptions — such as disease incidence and workforce participation trends. More recently, a wider array of key workforce need and supply assumptions have been varied to generate a series of scenarios. Such scenario analyses can highlight the range of variability and uncertainty within the judgments and assumptions adopted.

Sources: AHWAC (2004a); AMWAC (2003).

Since its inception, workforce planning has been subject to various refinements (box 9.3). Some concerns, however, still remain — including, for instance, that broader factors that influence supply and demand have yet to be sufficiently accommodated. Participants' views about methodology are given in box 9.4. Of course, possible methodological changes and 'advances' need to be considered in a benefit–cost framework — with some more 'sophisticated' proposals possibly involving considerable additional effort for only marginal gains in 'accuracy' or usefulness.

Box 9.3 **Some improvements to health workforce planning methods**

Since the adoption of formalised planning in 1995, there have been significant refinements in method, within the context of the broad approach outlined in box 9.2.

Some of these refinements were made in response to criticisms of particular planning exercises. For example, AMWAC's 2000 review of the general practice workforce was criticised on the basis that it adopted rather rudimentary assumptions concerning the utilisation of GP services; did not sufficiently account for price and income information as a supply indicator; relied too heavily on MBS data that failed to account for many of the activities undertaken by GPs; and consulted inadequately with the profession.

Many of these concerns were also echoed in the 2002 external review of AMWAC. While that review provided broad support for AMWAC's role, structure and methodology, it also identified some specific areas where planning methods could be improved. For instance, it recommended that:

- there be more transparent use of indicators or benchmarks to gauge the adequacy of the workforce, so as to avoid any ambiguous interpretation; and
- more dynamic scenario modelling and sensitivity analysis be undertaken to frame projections that would, for instance, take into account both likely and desirable changes to health services delivery (AHMAC 2002).

Most of these concerns have now been addressed, with almost all methodological recommendations made in the 2002 AMWAC review having been adopted.

Other changes have been driven from within the planning bodies. In particular, there has been a transition from using a single 'off the shelf' approach to more tailored planning assessments. This recognises that the considerable variations across the health workforce (eg the size of the different professions) mean that a methodology that may be effective for one area of the workforce may not necessarily be the most appropriate for others.

The extent of the changes made since the inception of formalised planning are evident in AMWAC's most recent review of the general practice workforce (AMWAC 2005). The review departed from a benchmarked approach to demand and adopted a disaggregated 'bottoms up' method to measure service utilisation and project demand. Extensive consultations were also undertaken with stakeholders, including on methodology issues.

Box 9.4 **Participants' views about methodology**

Participants provided a range of comments regarding planning projection methodologies. In relation to factoring in demand for health services, the Committee of Deans of Australian Medical Schools (CDAMS) stated:

> There is currently no agreed statement of overall medical workforce needs which could serve as the basis for future planning. Provision of such a statement by AMWAC should be an urgent priority. (sub. 49, p. 9)

The Australian Divisions of General Practice (ADGP) emphasised the importance of recognising more localised factors influencing demand:

> ADGP suggests that Australia's health workforce planning, certainly in respect of general practice, has been inadequate. In particular there is poor articulation between the AMWAC 'top down' national approach and the particular circumstances and needs of different regions.
>
> There is wide diversity of need across different regions of Australia driven by factors such as the geography of the area, the age structure of the population, other demographic factors and the pattern of morbidity.
>
> … it would be unfortunate if the focus remains on 'getting the workforce numbers right'. ADGP suggests that it may be fallacious to think in terms of 'solving' workforce issues by just responding to abstract estimates of demand and that what is needed are established processes and structures that facilitate on-going management. (sub. 135, p. 24)

Similarly, the Medical Training and Education Council of NSW said:

> While AMWAC was established ten years ago to advise government on the future medical workforce requirements at a national and state level, there has never been an agreed method or best practice model for linking national requirements with local medical workforce planning activities. The latter tends to be historically based and driven by hospitals' reliance on specialist trainees for delivery of 'front-line' acute medical care rather than the community's requirement for trained specialists. (sub. 154, p. 1)

The Royal Australasian College of Physicians raised a number of concerns:

> Current modelling tools used to guide decision making to address future workforce needs tend to be deterministic and static — with little or no capacity to anticipate changes in key determinants. 'Ideal' workforce numbers are typically based on historical doctor to population ratios or utilisation rates with little consideration given to examining the relationship between:
>
> 1) models of care and service delivery;
> 2) type, skill-mix, number and distribution of health professionals required to staff such service delivery models; and
> 3) health outcomes expected from service implementation (health production).
>
> AMWAC, for example, uses a simple 'stock and flow' model to generate predictions on future workforce imbalances within the specialist medical workforce. The utility of its current recommendations rests ultimately on simplistic assumptions that workforce needs can be modelled by matching the projected population health needs of Australia with current service utilisation rates. (sub. 108, p. 25)

(Continued next page)

Box 9.4 (continued)

The Australian Medical Association raised issues about both the demand and supply sides of the projections:

> The AMWAC methodology has been particularly weak on the demand side and used crude doctor visits per population ratios (themselves affected by shortages) to calculate medical workforce requirements. AMWAC recently sought to improve its demand side capability in its most recent GP workforce modelling and to us, this is a welcome development.
>
> Although their supply side modelling was better, it did not take the vital issue of remuneration into account. It is not always possible to do econometric modelling of the medical workforce as some specialist groups are small and clustered around hospitals and other institutions and require large minimum populations for their existence. But it is possible in relation to General Practice in our view. That said, workforce modelling is still relatively crude and underdeveloped, with much room for improvement. (sub. 119, p. 6)

It also commented on the relevance of allowing for productivity change:

> Without implying any criticism of AMWAC, their methodology is not good at factoring in the impact on workforce projections from productivity increases from various sources including technological change. (sub. 119, p. 12)

Factoring in demand

Assumptions made about the future health care requirements of the community are of central importance to the usefulness of workforce number projections, as are the assumptions concerning the models of care and service delivery, levels of subsidy and the like.

In terms of the associated demand for the health workforce, two broad approaches can be taken:

- A single 'best guess', or benchmark, approach can be used. In the past, such benchmarks have often been developed from the advice of committees or working parties, drawing on input from a range of stakeholders and technical experts.
- A number of differing demand scenarios can be modelled — indeed, scenario planning is a specific inclusion in AMWAC's terms of reference.

The first approach runs a number of risks including a possible lack of realism, and greater risk of undue influence from particular stakeholder groups. Further, as illustrated by Australia's experience with health workforce benchmarks, point estimates are difficult to get 'right' (box 9.5). The Australian Doctors' Fund commented:

> Predictions of future workforce demand and workforce requirements are at best speculative. This is particularly the case when long training times are envisaged in an environment of changing technology and medical breakthroughs that can make skills redundant overnight. What looks like an area of future shortage can quickly become an oversupply or vice versa. (sub. PP192, p. 2)

The second approach has the advantage that it can be used to illustrate the workforce requirements — in particular, for education and training — of different policy responses to the community's fundamental health needs and burdens of disease, nationally and on a regional basis, in an environment where demand is so heavily dependent on the level of government support. In this way, it can help meet AHMAC's concern that 'health workforce planning and health service planning are better linked' (sub. 166, p. 12).

Box 9.5 **Benchmarking problems**

- AHMAC set a benchmark of 200 practitioners per 100 000 population in 1992. AMWAC 1996a (p. xxi) commented that this lacked 'an empirical foundation' — in particular, it was unclear whether this was to represent all practitioners or FTEs.
- In 1996, the Australian Institute of Health and Welfare (AIHW) established benchmarks per 100 000 population for 1994 of 222.0 FTE practitioners or 205.1 FTE practising clinicians (AIHW 1996). These were lower than the number of practising clinicians of 229.0 per 100 000, suggesting practitioners were oversupplied at that time.
  - The 1996 methodology was jointly reviewed in 1998 by AMWAC/AIHW. The review concluded that the benchmarking methodology was 'fundamentally sound' (AMWAC 1998, p. xiii). However, the setting of new benchmarks was deferred pending an AMWAC review of the GP workforce.
- AMWAC, in 2000, found that on the basis that 'the situation in large rural centres, as a whole, was acceptable as a benchmark for use in metropolitan and other rural/remote comparisons' (p. 1) the GP workforce in total was oversupplied in 1998 (AMWAC 2000).
  - Access Economics, commissioned by the AMA, published its estimates of GP demand and supply in early 2002, based on econometric analysis of demand (Access Economics 2002). It considered that there was an overall shortage of GPs in Australia, as well as maldistribution.
- A review of AMWAC in 2002 called for increased transparency about the benchmarking system (AHMAC 2002, p. 39). It noted that 'there is generally no correct ratio [of practitioners to population], but rather the most suitable ratio has to be derived on the basis of available information'.
- No further aggregate benchmarks have been published since 1996, although a series of studies into particular medical workforce areas have been undertaken.

Workforce participation and productivity trends

On the supply side, information about likely future workforce participation trends is of prime importance. Of course, this will depend on a whole range of somewhat unpredictable factors, including fee structures and remuneration relativities across professions. Nevertheless, an adequate foundation of data about current trends is an essential starting point (see section 9.3).

Another central supply side influence is the productivity of the workforce. In its submission, the AMA recommended a study into its impact:

> … organisations with expertise in workforce modelling in Australia and overseas [should] be canvassed to determine if there are available methods to predict the impact of productivity improvements in workforce modelling in Australia. (sub. 119, p. 12)

Certainly, workforce participation and productivity trends can have an important influence on future workforce requirements. However, the Commission reiterates that the benefits arising from greater modelling sophistication need to be set against the costs of making those improvements. Further, the routine use of demand scenarios should lessen pressure for enhanced supply side precision.

Coverage issues

Some participants argued that planning projections should be undertaken across the whole of the health workforce, including the allied health professions, rather than just for the medical and nursing fields as presently occurs. Other participants criticised what they perceived as a profession-centric approach to current workforce planning (box 9.6).

The Commission has assessed these views against what it considers should be the main purpose of workforce numbers projections — that is, to advise governments of the education and training implications, over time, of meeting various possible future levels of health services demand. More precisely, the projections should help governments plan (after factoring in the portion of demand to be met by overseas trained professionals) the required numbers of:

- students who should enter universities and VET institutions, over time;
- students/graduates who should enter the various forms of clinical training; and
- students/graduates who should enter the various forms of post graduate vocational and higher training.

These estimates might be provided at a number of levels, for example, on a national, state and regional basis.

Box 9.6 **Participants' views on the scope of planning projections**

Many participants considered planning projections should extend into the allied health fields. For instance, Services for Australian Rural and Remote Allied Health (SARRAH) stated:

> … planning processes need to be improved — across whole of workforce and crossing the Federal/State divide. In order for future workforce planning to meet the needs of the community and to enable a responsive adaptation to changing needs … There has been minimal planning for future allied health needs. (sub. 71, p. 12)

Others stressed the limitations of the current profession-based approach. In this respect, the Australian Healthcare Association stated:

> Fragmentation of health system planning impedes … planning. It 'locks in' established structures and impedes innovation. Any workforce planning that does occur reflects the historical 'silo' approach to service provision based on a structure characterised by professional monopolies (dominated by the medical profession), with strong protocols delineating work boundaries between professionals. (sub. 151, p. 6)

Further, General Practice Eduction and Training (GPET) said:

> … health workforce planning in Australia analyses and makes recommendations about individual specialties. There has been little attempt to develop processes that look at the needs of all professions required to deliver specific health services.
>
> For example, there has been little consideration in Australia of the relationship, from a medical workforce perspective, between requirements for general practitioners and requirements for specialists. AMWAC considers each specialty, including general practice, quite separately. While the case could be overstated, there are significant interdependencies. (sub. 129, p. 26)

The need for a broader perspective was also argued by the Royal Australasian College of Physicians:

> Most planning currently takes place within narrow professional silos, with little modelling of future needs as to the right balance of professions and skill-mix within service delivery models that have been shown to improve health outcomes. AMWAC, for example, is concerned solely with the medical workforce, which is kept separate from any other planning of the broader health workforce; and indeed, no planning of the health administration workforce occurs at all. (sub. 108, p. 26)

And the Committee of Deans of Australian Medical Schools (CDAMS) advocated a service-based approach:

> … there is a need to consider planning based on service needs rather than as silos of discipline-based planning efforts conducted in isolation. Flexibility in patterns of service delivery can be factored into future care delivery and planning and therefore should incorporate the opportunity for some role substitution around the edges of traditional job demarcations. (sub. 49, p. 10)

In the Commission's view this, in turn, means that focus should be accorded to those groups of professions which have the greatest impact at the education and training level, namely, medical practice in the broad, nursing, dentistry and some of

the larger allied professions. Further, because of their importance, those numerical projections might justify frequent updating, in accordance with education and training planning cycles.

Such an approach to workforce planning was widely supported by participants in their responses to the Position Paper.

Within this broad approach, workforce requirements for the smaller professions (including some of the medical specialties and the smaller allied health professions) could be handled less frequently without major modelling exercises — either to feed into the estimates of *ab initio* entry, or to plan for their particular clinical and advanced training needs. Similarly, estimates could be made of the supply requirements for addressing the needs of rural and regional Australia, Indigenous Australians and of those with special needs.

9.3 Data and research issues

A sound information base is as important for workforce numbers projections as it is for effective reform and good policy formulation more generally. In this regard, the Australian Institute of Health and Welfare (AIHW) pointed to some considerable deficiencies in available health workforce data (box 9.7). And similar concerns were echoed by many other participants, particularly in regard to the allied health area. AHMAC listed the following data limitations:

- 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;
- 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. (sub. 166, p. 11)

AHMAC also considered that improvements are needed in the information required to support productivity analysis within the sector and to make comparisons with other sectors of the economy. And in arguing that ‘improved data collection for the health workforce is a priority’, the Department of Health and Ageing noted

particular problems with workforce data for the community based aged care sector (sub. 159, pp. 54–5).

Box 9.7 **Australia's health workforce data**

The AIHW considered that a comprehensive information base for Australia's health workforce would include measures such as:

- the demographic characteristics of health workers, such as age, sex and birthplace;
- qualifications, such as type, where obtained, when obtained etc;
- workforce characteristics, such as labour force status, job tenure, specialty area, classification level, hours worked, hours spent in patient care, industry and sector of employment, earnings etc; and
- geographic location.

It added that, for analyses of changes in the health workforce, it is desirable to have measures such as:

- entrants to the workforce (contemporary and projected) — student completions of health courses in higher education and VET institutions — migration data for health workers into and out of Australia (short- and long-term visitors; permanent and temporary migration); and
- exits from the workforce (contemporary and projected) — retirement, death, career change — temporary leave for travel, family responsibilities, training, sabbatical, and so on.

And for analyses of the supply of and demand for services provided by health workers, it is desirable to have measures such as:

- demography, including geographical distribution of the subpopulations who need various health services;
- health needs, dissected by subpopulation and geographical area; and
- the characteristics of service delivery entities, both public and private.

In AIHW's view, currently available data sources provide information on many of these features. But it saw the information base as far from ideal because:

- it must be patched together from a variety of sources, which are not based on consistent concepts — so judgment or synthetic methods must be invoked to construct the data needed for policy design and evaluation;
- some key segments of the workforce are unmeasured or poorly measured or suffer from significant problems of data quality; and
- some data that are important for policy design and evaluation are available only with a long time lag.

Source: AIHW (sub. 58, p. 4).

However, information collection and compilation are not costless. Moreover, it would clearly not be possible in this study to undertake analysis to determine which of the many particular data enhancements proposed by participants would deliver a net benefit. But the Commission considers that, subject to there being an overall benefit for the community, strategies to give effect to the commitment in the National Health Workforce Strategic Framework (NHWSF) that 'health workforce policy and planning must be informed by the best available information' are important. Among the strategies identified in the framework are: encouragement, support and leadership for health workforce research; the continued development of information sharing; and ongoing improvement in health workforce data collections through 'putting in place common language, minimum data sets; and consistent collection and processing arrangements'.

Indeed, AHMAC noted that, 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'. It also noted that it is currently undertaking work on a 'minimum health workforce data set and common terminology' (sub. 166, p. 11).

The Commission supports such initiatives and commends ongoing assessment of the benefits of improving data availability still further. In the particular context of workforce planning, the Commission suggests that AHMAC, in conjunction with the AIHW, could sponsor development of formal data exchange protocols between jurisdictions, registration bodies and relevant agencies. Such protocols would be designed to build on existing linkages between these bodies and could help to overcome current difficulties in accessing data and other relevant information, as well as facilitating cost effective improvements in the data base.

However, these initiatives, while useful, will not necessarily enhance the *quality* of the information available for decision making in general and for much needed productivity analysis in particular. For this to occur, such information needs to be collected and organised in an appropriately rigorous conceptual framework. The Commission has been undertaking its own analysis of the availability and quality of data that would enhance research into health workforce productivity. These issues are discussed in detail in appendix C.

9.4 Institutional arrangements

Rationalising the workforce planning structure

As outlined above, a relatively substantial institutional framework has been

established to undertake formalised health workforce planning — comprising various planning bodies, AMWAC and AHWAC, as well as secretariats, supporting committees and working parties. Total expenditure in 2003-04 was approximately $1.6 million.

In its initial submission, the Victorian Government proposed a rationalisation of this current structure, effectively combining the role of AMWAC, AHWAC, the Jurisdictional Planners Group and national sector specific committees into the one 'National Health Workforce Planning Council'. It considered that membership of the council 'would include experts in health economics and workforce planning and representatives from DOHA, DEST and jurisdictional health departments', with subcommittees comprising 'relevant health professionals and key stakeholders' pursuing its work program (sub. 155, pp. 38–9). The suggested functions centred on workforce numbers projections and associated methodological and data issues, although it was envisaged that the council would also 'develop planning methodologies that support innovative workforce models and work redesign'.

Particularly given its views about the role of workforce planning expressed above — that is, as a tool to aid government decision making — the Commission agrees that rationalisation of existing arrangements is called for. In its view, AMWAC and AHWAC should be disbanded — a view receiving considerable support from participants (box 9.8).

A number of alternative reporting arrangements for the numbers projections secretariat are possible — including those proposed by the Victorian Government and, in response to the Commission's Position Paper, by other participants. Another option would be to include this function in the proposed workforce improvement agency. But because the prime purpose of workforce number projections should be to provide advice to governments about future workforce supply requirements — a function distinctly different to those of other existing and proposed agencies, including those envisaged for the workforce improvement agency — the Commission considers that the workforce secretariat responsible for numerical workforce planning should report directly to AHMAC.

As well as bringing some administrative simplicity, such a rationalisation would also largely address any residual concerns regarding inappropriate influence on the projection process by particular stakeholder groups. In this respect, a report prepared for the ACCC on AMWAC's planning process recommended that practising medical practitioners should not comprise more than one third of the members of any review working party (Borland 2001).

The 2002 external review of AMWAC concluded that concerns about domination of the planning process by professional groups were largely unfounded. Even so, the

review did recommend the addition of new non-practitioner members to planning working groups (for example, from jurisdictions and consumer groups) that would effectively reduce the influence of professional interests (AHMAC 2002, recommendation 3.3).

Box 9.8 Participants' comments on rationalising the workforce planning structure

Many participants endorsed the Commission's draft proposal for abolishing AMWAC and AHWAC. For example, the Society of Hospital Pharmacists:

> …supports the integration of health workforce related activities into one national workforce body that should report directly to AHMC. (sub. PP207. p, 11)

The Australian Podiatry Council:

> … agrees with the proposal that the current institutional structures for numerical workforce planning should be amalgamated. (sub. PP281, p. 11)

The Royal Australasian College of Surgeons said:

> … the Australian Medical Workforce Advisory Committee and the Australian Health Workforce Advisory Committee should be abolished. Their performance over the last 10 years has been lamentable. (sub. PP 231, p. 5)

The Australian Nursing Federation said that it:

> … supports rationalisation of the health workforce planning processes and has been disappointed with the timeliness of the work undertaken by AHWAC and the government response to AHWAC's subsequent reports. (sub. PP291, p. 12)

Some participants considered that rationalisation would encourage the development of new models of care and a planning focus across all health professions. For example, the Department of Health and Ageing said:

> We also support the amalgamation of the Australian Medical Workforce Advisory Committee (AMWAC) and the Australian Health Workforce Advisory Committee (AHWAC), which would facilitate a more across-health-workforce, and less profession-specific, approach to workforce planning. (sub. PP293. p. 3)

The Joint State and Territory Health CEOs in its support for a single secretariat noted:

> The proposal should ensure new models of care and roles can be appropriately incorporated in projection modeling and should value the input of specialised stakeholder groups. (sub. PP332, p. 29)

However, the AMA said it 'cannot see the merit in subsuming the two bodies into one':

> … AMWAC is a potentially useful mechanism for engaging specialty-specific expertise and … with greater rigour in its methodologies (especially its quantitative work), it can make further progress in lifting its game of workforce projections. The AMA does not accept the argument that there has been undue professional influences in its processes, more the contrary. (sub. PP315, p. 12)

Moreover, while this recommendation has been implemented by AMWAC, jurisdictions have at times appointed clinicians as their representatives on reviews. Such appointments may be a factor in continuing concerns of excessive professional influence in the health workforce planning process. For instance, the Victorian Government stated:

> Membership of many [planning] committees comprise a majority of professional members, often solely from the profession under analysis, which can reinforce existing professional norms, militate against cross disciplinary comparisons and prevent exploration of more innovative workforce models. (sub. 155, p. 38)

Finally, while AMWAC and AHWAC would cease to exist under the Commission's proposal, the secretariat would obviously need to continue to consult with stakeholders (including professional associations) to draw on their knowledge and expertise as required, and establish working parties to assist with particular projection exercises.

Transparency and other issues

A number of transparency issues were canvassed by participants. For example, the Australian Association of Occupational Therapists commented:

> Despite their achievements to date on national coordination of workforce issues, current arrangements such as … AHWAC and … AMWAC lack independence and transparency. (sub. 21, p. 3)

In this context, some participants particularly raised the lack of connection between the output of modelling exercises and the implementation of that advice by government. However, as noted above, it is important that governments be free to consider such advice within their broader health and fiscal policy frameworks.

But there are a number of changes which, in the Commission's view, would improve the transparency and usefulness of the projection process:

- The proposal (as detailed in chapter 3) for wider endorsement of the NHWSF, including by those areas of government responsible for eduction and training, could be helpful in improving the linkages between health planning and education planning — the ultimate goal of these numerical projections.
- A requirement for those responsible for undertaking numerical planning projections to conduct analysis against alternative demand, supply and productivity scenarios could be made more explicit and given greater emphasis.
- And as noted above, there is a role for AHMAC in facilitating access to, and improvements in, workforce and other health related data.

Finally, there may be some merit in providing funding for the workforce planning secretariat on a three or five-year basis rather than the current annual funding arrangement. This would give the entity greater surety and provide it with more scope to undertake longer duration planning-related tasks.

RECOMMENDATION 9.1

Current institutional structures for numerical workforce planning should be rationalised, in particular through the abolition of the Australian Medical Workforce Advisory Committee and the Australian Health Workforce Advisory Committee. A single secretariat should undertake this function and report directly to the Australian Health Ministers' Advisory Council.

RECOMMENDATION 9.2

Numerical workforce projections undertaken by the secretariat should be directed at advising governments on the implications for education and training of meeting differing levels of health services demand. To that end, those projections should:

- ***be based on a range of relevant demand, supply and productivity scenarios;***
- ***concentrate on institutional entry for the major health workforce groups, while recognising that projections for smaller groups may be required from time to time; and***
- ***be updated regularly, consistent with education and training planning cycles.***

10 Rural and remote issues

Key points

- Health care provision in rural and remote areas poses particular challenges.
  - For patients, access to primary and emergency care services can be many hours away, potentially impacting on health outcomes. And access to more specialised services, only available in major population centres, involves even longer travel times, and greater financial costs and disruption to family life and work.
  - For health workers, there are concerns regarding remuneration levels, professional demands and, more generally, lifestyles and isolation.
- However, the health workforce outlook in rural and remote Australia is far from universally negative. In particular, it has been an 'incubator' for evolution in job design and other workplace innovation.
- Improved outcomes are attainable, especially if broader reform frameworks make explicit provision to address rural and remote issues. For instance:
  - The activities of the proposed health workforce improvement agency, and the Commission's suggested changes to accreditation and registration arrangements, would further encourage the widening of scopes of practice in rural and remote settings.
  - Proposed changes in funding arrangements would facilitate greater use of multidisciplinary team-based care.
- Other targeted initiatives (mooted or already in train) to improve health workforce services in rural and remote areas could also be helpful, including:
  - greater use of new technologies to enable 'arms-length care';
  - funding-related initiatives, such as practice improvement grants; and
  - a strong focus on regionally-based education and training — which may be particularly beneficial over the longer term.
- However, lack of comparative evaluation means that there is still considerable uncertainty about which broad approaches deliver the best value for money.
  - The Australian Health Ministers' Conference should address this deficiency by initiating a major 'cross-program' evaluation exercise.
  - As input to this exercise, there should be further trials of block funding for packages of care in particular rural and remote areas.
- It is also important that health workforce policies for rural and remote areas are formulated on a 'whole-of-workforce', rather than profession-by-profession, basis.

A major theme in submissions to this study has been that access to health services in rural and remote Australia is inferior to that in the major population centres, and that these access difficulties are worsening. In a health workforce context, the primary concern is insufficient numbers of health workers — especially general practitioners, medical specialists and some allied professions. However, a variety of problems relating to skills mix, scopes of practice and recruitment and retention have also been raised.

This chapter explores these concerns and looks at some possible broad approaches for reducing the gap in overall health workforce outcomes between metropolitan and rural and remote Australia. It also looks at some ways in which the processes for formulating policies and programs for health workforce services in rural and remote areas might be improved.

At the same time, the Commission emphasises that there are many positive aspects to health workforce arrangements in rural and remote Australia. In particular, given the premium on getting maximum value from the available workforce, these areas have been an 'incubator' for developing and testing new models of care and expanded scopes of practice. Many such innovations have the potential to provide the basis for system-wide changes in health workforce arrangements in coming years. Indeed, for this reason, the Commission considers that it is very important that health workforce frameworks facilitate two-way articulation of policy change and workplace innovation between the major population centres and rural and remote Australia.

10.1 Features of health care provision in rural and remote Australia

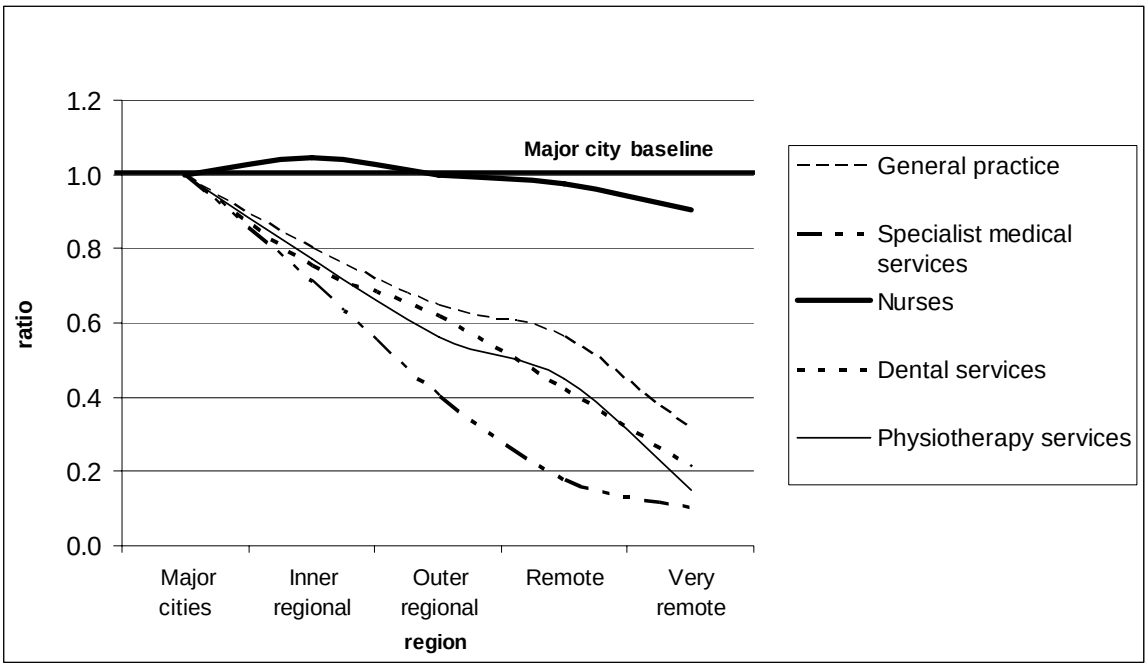
A range of access issues

For a number of reasons, people in rural and remote areas often have more difficulty in accessing health workforce services than those living in metropolitan areas.

Most broadly, apart from nurses, the number of health professionals relative to population diminishes for communities located further away from the major cities (figure 10.1). As a number of participants pointed out, such broad practitioner to population ratios conceal access difficulties within the cities — particularly in outer metropolitan areas. It is also the case that in major regional centres, access to both GPs and specialists is, on average, only slightly lower than in the capital cities. However, it is telling that in 'remote' areas, the GP to population ratio is only just

over a half of that in the cities, for physiotherapists it is less than a half and for specialists it is under one-fifth.

Figure 10.1 **Practitioner to population ratios relative to major city levels**



Data sources: AIHW (2003a; 2003b).

Moreover, such averages hide the fact that for many living in rural and remote areas, access to even primary care services can be many hours away. And to access more specialised services available only in the larger population centres, even longer travelling times are usually involved.

Travel-related delays in accessing services can sometimes affect ultimate health outcomes. In addition to the time factor, the need to travel significant distances to access health services can have sizeable financial costs, both directly related to that travel, and from lost income and potential interruptions to careers and education. Travel requirements may also have intangible costs in the form of disruption to family (and social) life, placing a burden on other family members.

Indeed, for patients in rural and remote areas requiring frequent care for a particular condition, travel for each individual treatment may not be feasible. In these circumstances, patients can end up temporarily relocating, with all the costs and disruptions to work and family life that this entails. With the increasing incidence of chronic conditions as Australia's population ages, the numbers of patients in rural and remote areas facing such costs and disruption will increase in the future.

In addition to these concerns, many Indigenous communities are in remote areas. Despite the poor standards of health in those communities, health practitioners are almost always under-represented there. Indigenous health issues are discussed further in chapter 11.

A greater emphasis on primary and less complex acute care

Limited access to more specialised health services in rural and remote areas partly reflects disincentives to working in these areas that operate across the health workforce as a whole (see section 10.2). However, it also reflects the fact that many rural and remote communities do not have the 'critical mass' necessary to support resident specialists — not only in terms of population, but also in meeting related infrastructure requirements:

> There are good and cogent reasons why many specialists are located in larger regional centres and major cities. Access to support, infrastructure, caseload and training opportunities are all important factors. (AMA, sub. 119, p. 15)

> … surgical services require much more than just the presence of a surgeon. The infrastructure requirements are an insurmountable barrier to providing services to all but the largest remote centres such as Mt Isa and Broken Hill … some services, which because of their technical nature require a modern tertiary hospital (e.g. neurosurgery, cardiothoracic surgery) or need high population levels for adequate demand (e.g. paediatric surgery), will be difficult to establish in … regional settings. (Royal Australasian College of Surgeons, sub. 148, pp. 10–11)

> A far higher standard of health care is delivered if surgery and anaesthesia is consolidated into large centres. This permits all members of the health delivery team to maintain and improve their skills due to the combination of collegiate support, enhanced medical infrastructure and the high volume of service being provided. (Australian Society of Anaesthetists, sub. PP195, p. 4)

But such realties in turn put a premium on access to effective primary and less complex acute care services. As the Department of Health and Ageing noted:

> Most rural people expect to travel some distance for specialist and major hospital services. However, reasonable regional access to primary care, such as general practice and dentistry, and emergency treatment, is very important in ensuring adequate rural health profiles. (sub. 159, p. 13)

As in other parts of Australia, in most cases, the general practitioner or the accident and emergency department of the local hospital, will be a rural or remote patient's first point of contact with the health profession. However, beyond this initial entry point, the care 'pyramid' begins to diverge, especially in relation to the role of public hospitals.

- There are few private hospitals in rural and remote areas, meaning that in many of these areas all hospital services are provided through public facilities.
- For the reasons outlined above, these hospitals cannot provide the range of services available in the major population centres — though some specialist services are provided through visiting health care teams or via telemedicine (see below).
- But while providing a more limited range of services, public hospitals in rural and remote areas typically service wide areas, extending well beyond the immediate community.
- In some communities, they represent the only means of accessing a range of primary care services (such as x-rays) and allied health services.
- And the presence of a nearby hospital may ease isolation concerns for GPs in rural towns, as it provides medical infrastructure and important 'back up' for primary care services.

Hence, public hospitals play a pivotal role in care delivery outside the major population centres. In addition, a much higher proportion of overall care services in the bush are provided by salaried health workers employed in the public system. This in turn has implications for outcomes from some broader features of Australia's health care system, including the resultant distribution of Medicare funding across Australia (see box 10.1).

Box 10.1 **Some consequences of greater reliance on salaried care**

As several participants observed, heavily reliance in many rural and remote areas on the public hospital system to provide both primary and acute care services affects the ultimate distribution of Medicare support for medical services provided on a fee-for-service basis. That is, usage of services supported under Medicare tends to be lower in rural and remote areas, and in jurisdictions with a relatively high proportion of the population living outside major population centres. Thus, for example, the Northern Territory Government (sub. 182, p. 8) noted that Territorians on average receive around six Medicare services a year, compared to the Australian average of eleven.

Also, the West Australian Government (sub. 179, p. 17) observed that the lack of private health services in many rural and remote areas means that private health insurance does not represent 'intrinsically' good value to those living in these areas. It went on to suggest that the financial penalties imposed on high income earners choosing not to take out private health insurance, or on those taking out insurance for the first time later in life, may therefore be inappropriate in a rural and remote context.

That said, there are a variety of offsets to such 'disadvantages'. In particular, those living in rural and remote areas benefit from a range of specific programs designed to improve the health services they can access (see text).

A variety of specific arrangements to enhance services

In addition to the broader structures applicable to the health workforce as a whole, an array of specific programs and policies is in place to improve access to health workers for those living in rural and remote areas. Broadly, these programs support the provision of particular services and the delivery of education and training in rural and remote areas, as well as provide a range of other assistance to practitioners working in these areas. All levels of government play a role in this regard, as do various community groups, professional bodies and private organisations.

In some cases, initiatives involve collaboration across levels of government, or between government and non-government entities. One example of the latter is provided by the work of Rural Workforce Agencies which exist:

> … in each State and the Northern Territory (NT) to recruit and retain doctors for rural and remote communities, through the Australian Government's Rural and Remote General Practice Program (RRGPP). RWAs also work closely with their respective State and Territory Governments to support recruitment, retention and professional development of rural doctors. (Australian Rural & Remote Workforce Agencies Group, sub. 136, p. 3)

Specific examples of current initiatives to promote access to health workforce services in rural and remote Australia are provided in section 10.3.

Some different models of care

While there is broad similarity in care provision across Australia, circumstances in rural and remote Australia have necessitated some variations to the models applying in the major population centres. For example, some services are delivered by visiting health professionals, or through 'telehealth' approaches allowing providers located in major centres to conduct consultations at 'arms-length'. And, as noted above, salaried medical care as distinct from fee-for-service practice is more prominent.

Also, as elaborated on below, the necessity and urgency of some types of health care, combined with the limited range of health professionals available in many rural and remote areas, means that professional boundaries tend to be less rigid and scopes of practice broader. As the AMA has noted:

> The further away the rural practitioner is from major hospital facilities and professional support, the greater the need for a wider skill set and the exercise of independent clinical judgement and decision-making. (AMA 2004a, p. 1)

In this regard at least, some health workforce arrangements in rural and remote areas are arguably more advanced, if less specialised, than in the major population

centres and are providing valuable insights into how the broader workforce regime could evolve in the future.

A changing focus in education and training

Education and training arrangements for health workers are also progressively recognising the needs of rural and remote Australia. There are a growing number of courses explicitly targeting rural practice — both entry level courses specific to rural and remote requirements, or programs designed to 'top-up' existing skills. Additionally, more education and training is being provided in rural and remote areas, either through the location of training facilities in these areas, or as part of course rotations.

The variety of Australian and State and Territory Government programs designed to increase health workforce education and training in rural and remote areas have been well documented by a number of participants (see, for example, sub. 155, p. 30; sub. 159, pp. 72–5; and sub. PP181). Education and training initiatives are explored in more detail in subsequent sections of the chapter.

10.2 Underlying causes of workforce maldistribution

In seeking to improve health outcomes in rural and remote Australia, a reduction in the maldistribution of the health workforce (evident in figure 10.1) has been, and will continue to be, a high priority for governments and other key stakeholders

The contributing factors are many and varied, encompassing such things as remuneration, professional and career development and lifestyle. Indeed, while each of these various factors are considered separately below, as the Western Australian Government observed, it is the overall 'package' which will determine location choices.

> Increasingly, those aspects that act as true workforce 'attractants' extend beyond the 'traditional' approach of more money. The focus of employees has undergone a considerable shift over the last ten years with greater focus being placed on 'the package' on offer from employers, rather than just salaries of wages. This incorporates … childcare, accommodation benefits, flexibility of hours, leave, vehicles, holiday benefits (inclusive of fares, destination choices) … (sub. 179, pp 18–19)

Moreover, over the longer term, access to health workforce education and training opportunities in rural and remote areas will also have an important impact on workforce availability.

Remuneration

Concerns about remuneration are frequently cited as a significant barrier to recruitment and retention in rural and remote areas.

First and foremost, remuneration levels for individual professions are perceived to be generally lower than in metropolitan areas — partly because of the socio-economic status of many smaller communities, but also because care needs can be more demanding and therefore involve greater treatment times.

> Many practitioners believe that they will receive less remuneration and become professionally isolated as a consequence of moving to a rural and remote area to work with Indigenous people. (Department of Health and Ageing, sub. 159, p. 45)
>
> ... the potential income for [rural] proceduralists is considerably lower than that of their city based colleagues. This naturally impacts on recruitment: who will join a rural practice when they can earn much more doing the same sort of work in a large city? (Rural Doctors Association of Australia, sub. 161, p. 32)
>
> Low levels of remuneration related to the low socio-economic status of many rural and outer urban areas [are] frequently identified as a disincentive to private practice in these areas. (Royal Australian and New Zealand College of Psychiatrists, sub. 79, p. 10)

However, there are other dimensions to the remuneration issue. Rural and remote areas generally offer fewer opportunities to advance to more highly specialised and financially rewarding positions. And some State Governments pointed to 'anomalies' in salary packaging and related FBT arrangements which they contended further increase the financial disincentive to practise in these areas (see below).

Professional demands

While many participants have emphasised that working in rural and remote areas can be very rewarding, a variety of professional considerations can nonetheless discourage health workers from practising in these areas:

- Hours of work tend to be longer than in the cities, and the pressure greater due to an expectation that practitioners will be able to perform a wider range of services, and be available to do so at any time, often resulting in a heavier load of after hours care. A lack of locum services can further detract from a desirable 'work/life balance'.
- The availability of supporting health care infrastructure, including diagnostic equipment and other advanced technologies, is often inferior. Additionally, access for GPs and allied health workers to supporting team members can be limited, as can be the ability to make referrals to readily accessible specialists.

- Professional development opportunities and career pathways are more limited, increasing the risk that those practising in these areas will become 'locked in'.

Lifestyle concerns

In the same way that practise in rural and remote areas can be professionally rewarding, living in these areas has some lifestyle benefits. But against these must be set a variety of offsetting lifestyle costs which add considerably to recruitment and retention difficulties.

Apart from work/leisure balance considerations, rural and remote areas usually have less well developed community infrastructure — including housing and transport services — than the major population centres. Also, in addition to professional and geographic isolation, social isolation can be a concern. And spouse and family considerations, especially relating to more limited employment and education opportunities and the greater difficulty of accessing childcare services, can further militate against practise in these areas.

Access to rurally-based education and training

Recruitment of qualified health workers to rural and remote areas has been made more difficult by the previous concentration of education and training courses in the major centres. This has reduced participation by students from rural and remote areas who are more likely to practise in the bush than their metropolitan counterparts. As the James Cook University Faculty of Medicine, Health and Molecular Sciences observed:

> … evidence indicates that training rural/regional students in a metropolitan environment greatly increases the chance of those students STAYING in the metropolitan area. (sub. 5, p. 3)

However, as noted above, more regionally-based education and training opportunities in the health area are now being provided, with several participants acknowledging that this should help to reduce workforce maldistribution in the future. Nonetheless, as discussed later, many saw further initiatives of this sort as being important in facilitating recruitment and retention in rural and remote areas in coming years.

10.3 The context for future policy

The severity of access problems varies

While it is clearly the case that, on average, rural and remote communities are less well served by health workers than those living in larger population centres, the sort of broad indicators shown in figure 10.1 conceal considerable diversity in access levels. For instance:

- Smaller communities immediately adjacent to larger regional centres can often access a reasonably wide range of health services without having to travel long distances.
- The Commission was provided with a number of examples of smaller communities which have successfully implemented innovative programs to recruit more health workers.
- And, as previously noted, the use of various 'outreach' delivery modes and telemedicine can considerably extend the range of health workforce services available to those living in more remote communities. A notable example is provided by remote 'mining towns' which, through 'fly-in/fly-out' arrangements, can have significantly better access to specialists and other health services than many communities closer to major population centres. Thus, a case study in Western Australia (Rankin et al. 2002) revealed that a mining town some 1500 kms from Perth with a population of just 800, had access to four visiting specialists, while an agricultural town with a population of 2500, only 400 kms from Perth, had access to one visiting specialist.

These examples point to the dangers of over-generalising in relation to the access issue. Further, while lesser access to health workers and services is one contributor to the poorer health outcomes observed in regional Australia compared with the major population centres — it is far from the only factor:

> … those who live outside Major Cities tend to have higher levels of health risk factors and somewhat higher mortality rates than those in the cities. … In addition, numerous rural occupations (for example farming, forestry, fishing and mining) are physically risky … (AIHW 2004a, p. 208)

Improvement is required

There are clearly limits on the degree of improvement possible in access to health workforce services in smaller rural and remote communities. Indeed, even without constraints on the amount of government funding available to enhance access and

service quality in these communities, parity with metropolitan centres would be an unrealistic goal in most cases.

Nonetheless, there is a need to pursue fiscally responsible ways of ameliorating the current difficulties and pressures facing both patients and health workers in rural and remote areas. This is especially the case as the underlying pressures on the health workforce in these areas in coming years may be even more acute than those on the workforce in metropolitan areas. By way of example, the Northern Rivers University Department of Rural Health (sub. 152, p. 10) noted that rural health professionals are, on average, older than their metropolitan counterparts. Thus, a potentially higher rate of age-related exits from the workforce could compound the already greater difficulties of recruiting and retaining health workers in rural and remote areas.

An array of arrangements are already in place

A number of the recent system-wide changes discussed in earlier chapters will be helpful in a rural and remote context. In addition, there are many specific initiatives in train to improve health workforce outcomes in these areas. These initiatives cover the spectrum of education and training, job design, service delivery and enhanced financial and other support for those health workers choosing to practise in these areas. Notably, they have not all come from governments. As noted earlier, community-based organisations, professional bodies, education and training entities and private service providers have all been actively involved.

The aims of the various specific initiatives have been diverse, including to:

- encourage health workers (or in the case of overseas trained doctors, require them) to move to, or remain in, regional areas;
- encourage re-entry to the regional health workforce;
- boost the number of students from regional areas that train to become health workers;
- equip practitioners with the additional or different skills required to deliver services in rural and remote areas;
- reduce the risk of ‘lock in’ for those practising in these areas; and
- enhance access to services that can only realistically be provided in larger population centres — through transport assistance policies, facilitating the use of telemedicine etc.

Some specific examples are provided in box 10.2.

Box 10.2 **Recent initiatives in rural and remote Australia**

In addition to job design and scopes of practice initiatives, examples of measures introduced to enhance workforce outcomes in the bush include:

By the Australian Government

- a range of financial incentives to encourage health workers, particularly GPs, to locate and practise in regional areas — for example, rural loadings in recognition of longer hours of work and rural retention payments for long serving GPs;
- requirements for overseas trained doctors to practise in areas of workforce shortage if they are to gain access to the MBS, and for non-vocationally registered GPs to practise in these areas in order to obtain the full MBS rebates;
- the provision of rural and regional training infrastructure and assistance to medical (and allied health) students from rural backgrounds; and
- bonded medical places which require students to work a minimum of 6 years in rural, regional and outer metropolitan areas.

By State and Territory and Local Governments

- financial assistance to patients who have to travel to see a specialist;
- support for practitioners, for example, housing assistance or scholarships; and
- grants for pre-school childcare payments, to help female GPs with young children in rural areas to remain in, or return to, the workforce.

By the education and training sector

- new undergraduate programs in regional areas — eg. new programs at James Cook University in occupational therapy, pharmacy and medical laboratory science are aimed at boosting the future health workforce in northern Queensland; and
- other rurally-focused training courses — eg the Remote Emergency Care course, managed by The Council of Remote Area Nurses of Australia, covering trauma management in situations where there may not be a doctor present.

By private/community organisations

- the 'Easy Entry, Gracious Exit' model, wherein a non-profit entity is contracted to provide practice infrastructure and support staff, financial services and subsidised housing, as well as to negotiate with Area Health Services. Aided by financial support from the Australian Government, this initiative has apparently increased the number of doctors in its area of operation.
- the Rural Training Stream (RTS), a vocational training program for general practice initiated by the Royal Australian College of General Practitioners and now supported by Australian Government funding. The RTS provides training in a rural context, for skills required in rural practice (such as obstetrics and surgery) and extra professional and social support. In 2000, some 70 per cent of graduates from the RTS were practising in rural Australia. (sub. PP329, p. 8)

Also, as noted previously, health workforce shortages in rural and remote areas have encouraged a variety of innovation in job design and scopes of practice. For example:

- The shortage of medical practitioners in these areas has been a key driver for the introduction of nurse practitioners in Australia (see chapter 4).
- Physician's Assistant and Perioperative Nurse Surgeon's Assistant roles are currently being trialled in a number of non-metropolitan areas.
- The Queensland Government has begun consideration of enhancing the role of paramedics in rural areas, seeing this as:

  > … a response to the shortage of specialist health care providers particularly in regional and rural areas of the State. Qualified, experienced paramedics would complete a two year post graduate degree as Paramedic Practitioners and would assist doctors in a variety of medical procedures such as minor surgery, investigative procedures such as endoscopies, anaesthetics and be able to request diagnostic tests such as x-rays and routine pathology. (Queensland Government, sub. 171, p. 8)

Such initiatives offer the prospect of more timely provision of services or, in some cases, access to services that would otherwise have been unavailable.

More flexible workplace roles have in turn been facilitated by the development of clinical protocols, providing guidance to practitioners performing tasks beyond their traditional responsibilities, as well as some protection against claims of negligence. Examples of these protocols include:

- the Central Australia Rural Practitioners Association Manual;
- New South Wales rural emergency clinical guidelines for adults; and
- Queensland's Primary Clinical Care Manual — aimed at practitioners in rural and remote areas, as well as Aboriginal Health Workers.

Indeed, several participants suggested that further development of such protocols will be very important in supporting future workplace redesign in rural and remote areas (see below).

10.4 What further changes are required?

Integration within broader health workforce frameworks

Recent efforts to improve rural and remote health outcomes have been guided by both the National Health Workforce Strategic Framework (NHWSF) and 'Healthy Horizons', a specific rural health framework (see box 10.3). An important

perspective embedded in 'Healthy Horizons' is that there should be recognition of rural and remote health as an important component of the Australian health system.

Box 10.3 **Addressing rural and remote issues within the NHWSF**

The NHWSF (see chapter 3) embodies previously developed frameworks for enhancing health workforce outcomes in rural and remote areas, including 'Healthy Horizons'. Developed in 2002, the Healthy Horizons framework aims to ensure that people in rural and remote Australia will be as healthy as other Australians. It has seven goals:

1. Improve the highest health priorities first;
2. Improve the health of Aboriginal and Torres Strait Islander peoples living in rural, regional and remote Australia;
3. Undertake research and provide better information to rural, regional and remote Australians;
4. Develop flexible and coordinated services;
5. Maintain a skilled and responsive health workforce;
6. Develop needs-based flexible funding arrangements for rural, regional and remote Australia; and
7. Achieve recognition of rural, regional and remote health as an important component of the Australian health system.

Source: AHMC (2004a).

Indeed, there are important complementarities between rural and remote health workforce policy and the broader health workforce system. As noted above, reforms to the broader system will often benefit those living outside the major population centres. Thus, many of the initiatives that could ensue from the broad institutional, procedural and funding reforms being proposed by the Commission would be beneficial for rural and remote areas. For example:

- The activities of the proposed health workforce improvement agency and the suggested changes to accreditation and registration arrangements would facilitate job redesign and wider scopes of practice, and thereby reinforce and augment the changes that are already occurring in this area in rural and remote Australia.
- The recommendations of the proposed advisory committee to examine possible extensions of the coverage of the MBS to a wider range of service providers could be particularly valuable in improving access to health services in remote communities. As the Nganampa Health Council (sub. PP188, p. 2) observed, Medicare funding is currently often of limited value to these communities because it is contingent on a GP, as opposed to a community nurse or allied health worker, seeing the patient. Similarly, the Northern Territory Government commented that:

> … in 2003/04 the per capita average for Medicare payments in the NT was $222, compared to the Australian average of $427. … These shortfalls are clearly the result of the dispersed population in the NT (including the distribution of the health workforce) but they are also a direct result of a lack of a health workforce that is able to access both MBS and PBS payments. (sub. PP182, p. 8)

As noted by the New South Wales Government (see chapter 8), access for a wider range of health professionals to MBS rebates would also facilitate the further uptake of multidisciplinary team-based care in rural and remote areas.

- And, the proposal to encourage task delegation within the MBS would reinforce developments of this sort in the bush — especially if accompanied by access to the MBS for a wider range of service providers.

But there are also flow-on effects in the other direction which will be more effectively captured if rural and remote health workforce policy settings are properly integrated within broader frameworks and processes. Apart from the previously mentioned wider applicability of some of the developments that are occurring in scopes of practice, experimentation with new education and training and funding models, telemedicine etc. may also provide the basis for subsequent system-wide changes.

In the Commission's view, such complementarities, and the more general requirement to ensure that the health needs of those in rural and remote areas are appropriately considered within the broad policy-making process, mean that health workforce issues in these areas cannot be addressed in isolation. Thus consistent with 'Healthy Horizons', the Commission considers that Health Ministers should ensure that all broad institutional health workforce frameworks provide for effective integration of rural and remote issues.

This requirement would of course apply to all of the Commission's proposed new national workforce bodies. Thus, for example, the brief for the health workforce improvement agency (see recommendation 4.1) could require that agency to:

- assess the implications for health outcomes in rural and remote areas of generally applicable changes to job design; and
- as appropriate, consider major job redesign opportunities specific to rural and remote areas.

RECOMMENDATION 10.1

The Australian Health Ministers' Conference should ensure that all broad institutional health workforce frameworks make explicit provision to consider the particular requirements of rural and remote areas. Progress in achieving this

objective should be monitored as part of the proposed regular evaluations of the National Health Workforce Strategic Framework (see recommendation 3.3).

The quality and safety baseline

While there are limits on the degree of improvement possible in accessing services in rural and remote areas, for those care services that are provided, maintaining and enhancing quality and safety remains paramount:

> No one will regard it as a particularly clever achievement to claim to have provided substantially more health services if those services are provided at a lower level of quality. (AMA, sub. 119, p. 4)
>
> The importance of providing appropriate, sustainable, high quality health care to all Australians, regardless of their socio-economic circumstances or geographical location, is paramount. The quest to get the right health professional to take up rural and remote practice should not be compromised … (Professor John Humphreys, sub. 96, p. 3)

As several participants pointed out, 'quality of care' can be interpreted in several ways especially if, as is sometimes the case in rural and remote areas, the alternative is no care. One way of setting a quality and safety 'baseline' is to consider whether care provided in a rural setting would be acceptable across the community as a whole. However, in the Commission's view, in formulating health workforce policies for rural and remote areas, the generic quality and safety requirement set out in chapter 3 represents a more practically useful test. That is, policy settings should, over time, *enhance* (or at least not detract from) the quality and safety of care provided in any particular setting. Several participants, such as the National Rural Health Alliance (sub. PP295, p. 2) and the Rural Doctors Association of Australia and the Australian College of Rural and Remote Medicine (sub. PP313, p. 2), considered this to be an important guideline for future health workforce reform.

Suggested targeted initiatives for rural and remote Australia

In the Commission's view, system-wide reforms of the sort proposed earlier in this report should be the 'first line' for pursuing better outcomes in rural and remote Australia. However, there are obviously limits on the extent to which some of the particular health workforce problems in these areas can be tackled in this way. Accordingly, there will be a continuing role for targeted initiatives — though these must be complementary with broader frameworks and processes.

In their submissions to this study, participants proposed an array of workforce initiatives to improve health outcomes in rural and remote Australia. Most of what

was put forward called for additional funding from governments. For example, there were calls from several participants for more generous fringe benefits tax (FBT) arrangements to be available to health workers practising in rural and remote Australia (see box 10.4), as well as further reforms to superannuation policy to delay exits from the health workforce, including by those in regional areas (see, for example, sub. PP332, p. 39).

Box 10.4 **Suggested FBT reforms for rural and remote health workers**

Several participants claimed anomalies can arise from the application of FBT to employees in rural and remote areas. For example, the New South Wales Government observed that while:

> … in the metropolitan area, employees may package directly into the mortgage of their principal place of residence … In remote and many rural areas the option is often simply not available to employees …[because] accommodation is poor or the family home has been tenanted whilst the employee is working in a rural or remote area. (sub. 178, p. 44)

Some further suggested that FBT arrangements be modified to favour those working in rural and remote areas, so as to facilitate recruitment and retention. Thus, the Joint State and Territory Health CEOs (sub. PP332, pp. 38–9) suggested:

- indexation of the existing $17 000 FBT free cap for public and not-for-profit hospitals;
- broadening the availability of the FBT cap to other employers;
- providing exemptions in relation to the provision of housing (beyond existing specific conditions for remote areas);
- providing exemptions for all relocation and living away from home costs; and
- providing exemptions for boarding fees and all childcare costs for children of rural and remote health workers.

Such changes could, to varying degrees, provide incentives for health workers to relocate to rural and remote areas by effectively increasing their salaries, without increasing costs to public health employers. However, they are not without costs, as FBT concessions represent a taxation expenditure for the Australian Government. Additionally, providing financial incentives through differential FBT concessions is a relatively complex method for assisting those health workers practising in rural and remote areas. To that extent, the role of such concessions should be evaluated in the context of alternative financial incentive mechanisms (see text below)

However, with growing fiscal pressure on government health budgets, it is essential that the funds available to enhance health workforce outcomes in the bush are spent efficiently and effectively. Accordingly, and in keeping with the emphasis in the rest of the report, the Commission has focused on initiatives that could help to deliver better value from whatever level of funding support is available to improve

the accessibility and quality of health workforce services in rural and remote Australia.

Making more efficient use of the available workforce

Scopes of practice

In an environment where access to health workers is often limited, it becomes even more important that the available workers have the right skills and that the best use is made of those skills.

Given the conditions prevailing in rural and remote areas, it is generally accepted that a somewhat different skills mix is required for practitioners working there. However, there is currently a debate about the most appropriate institutional model to support rural and remote specialist training (see box 10.5). More broadly, there are also different views on the required balance between generalist and specialist skills.

A significant number of participants argued that those practising in rural and remote areas will continue to need higher levels of generalist skills. For instance, the Royal Australasian College of Physicians commented that:

> If the aim is to enhance equity in the distribution of the work force across Australia, the likelihood of the outer urban, regional and rural health services each acquiring a 'critical mass' of consultant physicians and paediatricians will be enhanced if greater numbers can provide 'generalist' specialist services ... (sub. 108, p. 6)

And in pointing out that there is already a degree of cross-skilling in some remote area therapy services, such as between occupational therapists and physiotherapists, the Northern Territory Government argued that:

> This strongly suggests there is a role for more generalist allied health practitioners, who have a broader scope of practice than the existing individual Allied Health disciplines. While this would not preclude the ongoing need for specialist Allied Health disciplines, the latter would be better able to focus on the more complex discipline-specific client needs … while the generalist Allied Health practitioner could provide a more holistic, primary level of care. (sub. PP182, p. 18)

Box 10.5 **College arrangements for rural and remote medical practice**

An application to create a new Australian College of Rural and Remote Medicine is now in its final stages with the Australian Medical Council. The basis for this application is that:

> … rural and remote medical practice is a distinct specialty of medicine, requiring appropriate specialist training, support and ongoing professional development. (ACRRM, sub. 72, p. 1)

However, the need to differentiate rural and remote medical practice in this way, as distinct from making explicit provision for it within the currently non-geographically based college structure, has been called into question. For example, the AMA has previously observed that:

> … existing vocational programs are more than capable of providing rural and remote doctors with the skills that they require in order to face the challenges of delivering medical services. General practice training has a long history of supplying rural and remote areas with a well-trained workforce and practitioners taking advantage of up skilling programs can tailor their choices according to the specific health needs of the community in which they are located. (AMA 2004a, p. 4)

And there are some who consider that the college structure as a whole is not appropriate for providing clinical training services in the bush. In this regard, the National Rural Health Alliance and College of Medicine and Health Sciences argued that:

> … few, if any, specialist medical colleges have structures adequate to support rural streams of training or even to incorporate significant rural components into their programs. It is therefore timely for the current specialist training arrangements to be opened up to bring in other potential providers, including the universities. This could be done either through a semi-competitive model (as in General Practice) or a co-operative model between the Colleges, universities and other potential providers. (sub. 126, p. 13)

The particular directions pursued in this area will in turn determine whether any specific new policy initiatives from government are required. For example, if clinical training in the bush were to be undertaken exclusively through some form of college-based system, the RDAA considered that:

> … the primary responsibility for action will lie with the specialist colleges and other professional organisations, and the rural specialists themselves. (sub. 46, p. 11)

However, a shift to the sort of competitive models canvassed by some participants would require more active government involvement in the transition from the current regime (see chapter 5).

Greater emphasis on training generalist health workers was also endorsed in the recent review of Queensland's health system (QHSR 2005, p. xxxiv). Indeed, in this context, some have called for the creation of rural-specific generalist professions, such as a 'rural primary health care worker'. It is envisaged that such workers would assist in health promotion and screening of patients, operating under the supervision of other professionals:

> They could be employed in a variety of models including within general practices or Divisions, community health centres, and by the state health sector, but would be required to work as part of integrated teams to avoid the hazards of fragmentation of care. This would create the need for clear lines of authority and supervision. (Northern Rivers University Department of Rural Health, sub. 152, pp. 13–14)

However, some argued that a greater emphasis on generalist health workers, would diminish rather than enhance the quality of care. For example Australian Council of Physiotherapy Regulating Authorities said that it:

> … is opposed to the introduction of generic health care workers on the grounds that there is a high risk that the quality of service delivery will be compromised. It is not possible for an individual to possess the same level of knowledge and skill across a range of professional areas as profession-specific practitioners in each professional area. Consequently, the level of knowledge and skill in any one area will be less than that of a practitioner trained specifically in that area. (sub. PP184, p. 6)

Others, such as the Sydney South West Area Health Service, contended that what is in fact required outside the major population centres is a wider range of specialist skills:

> Allied health in these [rural] settings do not have more generalist skills than allied health in other settings, but rather have a need to have a wider range of specialist skills at their disposal. (sub. 30, p. 2)

In this context, some participants pointed to the importance of multidisciplinary team-based models in providing specialised care to rural and remote areas. For example, the Rural Doctors' Association of Australia commented that:

> There is an increasing realisation that in rural areas it is important to consider the concept of ***specialised*** (team-based) rather than ***specialist*** (individual–based) services.
>
> As part of a multidisciplinary team, rural specialists depend on nurses and allied health workers, particularly at hospitals (most rural specialists have attachments at hospitals), the goodwill of the hospital administration and the support of general practitioners. This becomes even more important in smaller centres. (sub. 46, p. 5)

However, notwithstanding such divergences in view on specific directions, the existence of debate on these issues is reflective of an environment in which there is considerable focus on workforce innovation and on trialling new models of care that make better use of available workforce skills. An important task for the Commission's proposed health workforce improvement agency would be to evaluate which of these approaches could have wider application across the health workforce and to assist in their dissemination through identifying any supporting changes required in education and training arrangements, accreditation and registration, funding models etc.

In this latter regard, recent experiences in rural and remote Australia have pointed to the role that clinical protocols can play in supporting the expansion of scopes of practice and the emergence of new professions. Indeed, as well as making better use of the competencies of the workforce, protocols establishing minimum levels of quality and providing clear guidelines and standardised processes for care, may well enhance outcomes for patients. As Dr Patrick Cregan commented:

> These protocols will reflect a local environment and be based on guidelines developed at a high, usually national level. Such guidelines and protocols reflect the best available distilled evidence … There is outstanding evidence that this approach improves care. (sub. 4, pp. 5–6)

Some, such as the the Royal Australian and New Zealand College of Obstetricians and Gynaecologists Provincial Fellows Committee, cautioned against over-reliance on protocols:

> Beware of the limitations of 'clinical best practice protocols' as a method of simplifying health service provision. The evidence bases for many so called best practices are seriously flawed, and what is deemed best practice today may not be shown to be best practice tomorrow. Reducing health care provision to a series of recipes is to oversimplify the complexities of human health and disease. (sub. 113, p. 7)

However, in the Commission's view, this is an argument for effective evidence-based protocols that are regularly evaluated and adjusted as appropriate, not against the use of protocols per se.

Remote service provision

Taking greater advantage of opportunities for 'remote service provision' will be important in the future delivery of health services to rural and remote Australia. While 'fly-in/fly-out' arrangements have long been used to deliver more specialised services in many remote areas, emerging telemedicine alternatives may sometimes be more cost-effective. A range of care services, including psychiatry, oncology and radiology services, are already provided in this way in some remote communities. Additionally, the joint Australian and State Territory Government initiative, 'HealthConnect', is trialling a network of electronic health records (see chapter 12).

Several participants drew attention to the potential for expanded use of telemedicine to further improve access to services in rural and remote areas. For example, the New South Wales Government suggested that:

> Opportunities need to be explored which promote greater use of telemedicine for diagnosis, development of treatment plans, education of the workforce and ongoing supervision and support. The enhanced use of information technology to support patient care and the health workforce should be explored especially where access to health care professionals is limited. (sub. 178, p. 37)

Professor Peter Brooks commented:

> Although these technologies are still in their infancy, there seems [to be] significant potential, particularly in a distributed country like Australia, to have telemedicine, for example, providing consultation and services to rural general practitioners or other primary health care workers. This has already been shown to be cost effective by a number of studies including those in Australia conducted by the Centre for Online Health at The University of Queensland. (sub. PP194, p. 3)

And Christopher Lewis observed:

> Admittedly, telemedicine is not the panacea for improved health services for the bush. However, with the current roll out of high band width telecommunications linkages to rural and remote hospitals and clinics, telemedicine can certainly play a far greater and very effective role and this needs to be recognised. (sub. PP202, p.6)

However, the scope for widespread use of telemedicine was not accepted by all. For instance, James Cook University Faculty of Medicine, Health and Molecular Sciences commented that telemedicine will have a 'limited role in [the] ability to greatly improve health services to rural/remote areas' (sub. 5, p. 3).

Moreover, whatever the precise scope for the use of telemedicine approaches, supporting changes in other areas may be needed for these initiatives to realise their full potential. For example, greater use of telemedicine (both in terms of video-conferencing and image transfer) will require appropriate communications infrastructure and, in some cases, changes to scopes of practice and associated professional regulation. As Professor John Humphreys said:

> While telemedicine has made significant differences in how health care can be delivered to rural and remote areas … it requires significant investment in developing adequate infrastructure, support and training. (sub. 96, p. 3)

More specifically, the Nganampa Health Council observed:

> IT networks across remote Australia are extremely fragile. … The technology does not permit us to develop PIRS (Patient Information Recall Systems) due to bandwidth limitations on satellite transmissions. This network limitation means that our health professionals are disadvantaged in their ability to call up patient records and to maintain efficient patient recall systems. (sub. PP188, p. 2)

And the Western Australian Government contended that a variety of other policy settings currently inhibit uptake of this form of care:

> Greater cooperation between the jurisdictions is also required to facilitate the increase[d] use of technology to provide access to health services in rural and remote areas. Current Commonwealth approaches act as barriers to developing and utilising telehealth services, eg, in restrictions on the funding of telehealth GP consultations and remote PBS prescribing and dispensing. (sub. 179, p. 18)

Further uptake of telemedicine will also require consideration of the appropriate assignment (and management) of risk and liability between the 'on site' health worker and the advising specialist.

The preceding observations highlight the need for effective planning, evaluation and coordination of any expansion of telemedicine. That said, while it may not be as ideal as resident, face-to-face, consultation, future technological developments are likely to render it a potentially cost-effective means for improving the access of those living in rural and remote areas to a wider range of more specialised health services. Additionally, telemedicine may facilitate further use of multidisciplinary team-based care in rural and remote areas. Indeed, a multidisciplinary approach is inherent in the use of telemedicine, as it entails rural health professionals consulting with a variety of specialised health professionals in larger population centres.

The Commission further notes that some of its proposed new bodies would have a role to play in facilitating wider use of this form of care delivery. Apart from evaluation of telemedicine approaches by the health workforce improvement agency, the proposed committee to advise on access to the MBS would provide a vehicle for addressing some of the associated funding and prescribing issues.

'Hub and spoke' models

In making more effective use of the available workforce in regional areas, further development of 'hub and spoke' models may also be helpful. This in turn highlights the role that effective transport infrastructure can play in improving health outcomes in the bush. Indeed, some see the use of outreach service provision based in major regional centres as the only realistic way of providing many more specialised services to smaller communities.

Provision of practice support

As outlined in section 10.2, the costs and challenges of establishing practices in rural and remote areas, the risks of 'lock-in' and problems in finding suitable housing, are amongst the factors that increase the difficulties of recruiting and retaining health workers in these areas. In elaborating on these difficulties, the NSW Rural Doctors Network commented that:

> … the effort and investment often seen to be required to find or acquire suitable housing, surgery facilities, skilled practice staff and locally available services (IT, accounting, practice nurse etc.) [has been a barrier to recruitment] … Many young doctors are reluctant (and untrained) to take on … [business management and] … A number of older doctors are now looking for ways to eliminate their business management workload ... (sub. 110, pp. 13–14)

To address such concerns, various 'practice support' initiatives are being used or trialled in smaller communities to improve recruitment, retention and re-entry. For example, some have adopted innovative approaches aimed at reducing the business management workload for doctors, as well as the risk of lock-in. In this regard, the Australian Local Government Association noted that:

> … in Queensland, the Kingaroy Shire Council has implemented its own Medical Workforce Strategy to help rebuild the town's medical workforce. … the council purchased and re-opened the town's private hospital, St Aubyn's, which had ceased operation in June 2001. The council now owns and operates the hospital and a medical practice, through a wholly owned council company. (sub. 172, p. 12)

The provision of infrastructure services on a contractual basis is another approach that has been employed by local communities or other parties (see, for example, the 'Easy Entry, Gracious Exit' model in box 10.2) to reduce the risk of lock-in that arises from the purchase of a practice of uncertain future value.

More broadly, several participants observed that salaried employment is likely to carry lower risks of lock-in than private practice and therefore be intrinsically more attractive in rural and remote areas than in the major population centres. As noted earlier, salaried practice already accounts for a higher share of service provision in these areas — partly because of the small number of private hospitals located outside the cities and regional centres. Even so, the National Rural Health Alliance and the College of Medicine and Health Sciences at the ANU, suggested that:

> Consideration should be given to increasing the number of salaried staff working in rural and remote communities, with packages that might include guaranteed infrastructure, support and relief. … The evidence suggests that a greater number of young heath professionals would prefer to operate this way than used to be the case, partly because they are uninterested in commercial business practice and because their indemnity risks can be borne or financed by the employer. (sub. 126, p. 11)

Education and training in rural and remote areas

In seeking to enhance health outcomes in rural and remote areas, many participants emphasised the relationships between rural background, rural undergraduate and postgraduate health workforce training, and subsequent practise in these areas. More specifically, the Rural Health Research Collaboration (sub. 34, p. 4) referred to the conclusions of a number of previous studies that have explored these relationships:

> … GPs who have spent any time living and studying in a rural location are more likely to be practising in a rural location. Those whose partners have also lived and studied for any period of time in a rural location are six times as likely to become rural GPs than those with no rural background. (Laven et al. 2003)

> … medical students who have undergraduate rural training, and … GPs who have rural postgraduate training, are more likely to become rural GPs. … of these factors, rural postgraduate training is the factor more strongly associated with rural practice than is undergraduate rural training. (Wilkinson et al. 2003)

Given such linkages, initiatives to provide regional education and training opportunities were seen as being a very important component of the future health workforce policy package. Synthesising these views, James Cook University Faculty of Medicine, Health and Molecular Sciences argued:

> … it is in the national interest to encourage training in regional/rural/remote locations for long-term workforce retention in these areas. (sub. 5, p. 2)

Participants went on to suggest a variety of new initiatives in this area, as well as reconfigurations of existing education and training structures to better meet care needs in rural and remote communities. Some illustrative examples are provided in box 10.6.

In submissions subsequent to the release of the Commission's Position Paper, there was a particularly strong focus on rural rotations within clinical training programs. For example, the State and Territory Health CEOs saw this as:

> … one of the more effective strategies to both expose practitioners to the rural environment and rural practice, whilst at the same time providing valuable services to rural communities. (sub. PP332, pp. 33–4)

To facilitate such rotations, they recommended investigation of subsidies to rural students; joint, national negotiations between the Australian and State and Territory Governments and the medical specialist colleges for mandatory rural rotations; and advanced recognition of those rotations. The Northern Territory Government (sub. PP300, p. 2) similarly proposed incentives and financial support for students undertaking rural and remote clinical placements.

From the evidence presented to this study, there seems little doubt that the provision of quality education and training opportunities in rural and remote areas can lead to material improvements over the medium to longer term in their access to health workers.

Education and training costs are, of course, generally higher in these areas than in the major population centres, as opportunities to benefit from economies of scale are much more limited. Also, the scope for student interaction across professional disciplines, and for specialised clinical training, is more limited.

Box 10.6 Some suggested health workforce education and training initiatives for rural and remote Australia

The NSW Government (sub. 178, pp. 5–6) put forward a wide ranging list of suggestions for boosting undergraduate and postgraduate training opportunities in rural and remote communities, including:

- increasing the number of undergraduate places for rural participants;
- establishing a co-ordinated undergraduate scholarship program across all health workforce groups;
- expanding bonded rural medical scholarships to all workforce groups;
- targeting cadetships in identified areas of skill shortage for school leavers and students in the second or third year of university;
- expanding the 'training in place' programs that offer career paths for local residents;
- establishing best practice in the use of communication technology for Continuing Professional Development; and
- creating training networks for all health specialties that include inner/outer metropolitan and rural centres.

The Tasmanian Government put particular emphasis on rural placements within broader education and training programs for health workers:

> By introducing structural imperatives for rural placement, this practice can be encouraged to become an accepted feature of training in Australia. Greater exposure to regional and rural practice will enhance the probability that students will consider employment options in those communities. This could assist in addressing geographic maldistribution, to the benefit of all jurisdictions with regional rural and remote supply issues … (sub. PP180, p. 17)

The Australian College of Nursing (sub. 137, p. 16) contended that efforts are required to 'assist potential health care practitioners already living in isolated areas to negotiate their way through the education maze'. The College went on to suggest that issues that need to be addressed in this context include:

- the cost of education in both the vocational and higher education sectors;
- access to local vocational and clinical education providers;
- admission to a higher education provider with a flexible distance education option;
- support from the employer to balance work, study and family; and
- support from colleagues and contact with a professional support network.

The Northern Territory Government called for the establishment of 'feeder' courses for health professions that do not have full courses outside the major cities, as well as drawing attention to the barrier to rural placements from high rental housing costs in some rural and remote areas (sub. PP182, pp. 27–8). And several participants pointed to scope for greater use of a 'hub and spoke' models in education and training to provide increased on-site training opportunities in more remote locations.

Nevertheless, provision of education and training in rural and remote areas *may* still be a more cost-effective way of improving access to health workers than, for example, seeking to entice less willing qualified practitioners away from the major population centres through the use of financial incentives. Notably, this view was shared by several key participants. For example, the AMA concluded:

> The early and continuing exposure of medical school students to regional/rural medicine and measures to encourage students from regional/rural areas to enrol in medical schools are the most likely of all initiatives to increase the workforce in these areas. (sub. 119, p. 14)

Moreover, education and training located in regional areas can provide broader benefits, over and above the increased supply of health workers:

> …it builds community capacity and viability, enhances professional retention and supports quality and safety objectives. (Australian Council of Deans of Health Sciences, sub. 67, p. 2)

For these sorts of reasons, the Commission supports a strong focus on the provision of regionally-based health workforce education and training. However, given recent initiatives that have significantly expanded such opportunities, the Commission considers that it would be timely to commence a rigorous evaluation process, before a further suite of programs are adopted.

That said, pending such evaluation (see below), there may be some areas where it is clear that specific initiatives or pilot programs would be beneficial. A greater emphasis on further rural and remote rotations in the clinical training of health professionals — especially for post-graduate medical specialist training, where suitable infrastructure can be provided — might be one such example.

Modifications to funding mechanisms

Changes to the structure of MBS rebates

Though salaried medical practice is more prevalent in rural and remote areas than in the major population centres, the level of government support for private medical practice in the bush continues to be the focus of considerable attention.

Support to encourage private medical practitioners to locate in rural and remote areas is already provided outside of the MBS. In particular, the Practice Incentive Program (PIP) provides a rural loading for general practitioners (as well as incentive payments for activities such as the delivery of teaching, after hours care and the use of information technology). And within the MBS, there is some limited geographic differentiation in rebates in relation to the provision of particular

services by overseas trained doctors (and non-vocationally registered GPs) in areas of workforce shortage.

However, several participants advocated much more extensive differentiation in MBS rebates for specific services to encourage practise in rural and remote areas:

> The Commonwealth Medical Benefits Scheme does not recognise the environment in which rural doctors work nor the type and complexity of services that they provide in an after-hours setting. Remuneration … should reflect the training and expertise of those who provide this essential service, taking into account the higher indemnity risks of emergency care and the rates paid for after-hours services in other industries … (RDAA, sub. 46, p. 11)

> Differential MBS fees weighted for rurality/remoteness should definitely be considered in support of general practitioners and specialists working outside metropolitan centres. (Royal Australian and New Zealand College of Obstetricians and Gynaecologists Provincial Fellows Committee, sub. 113, p. 3)

> The RANZCP supports the use of incentives such as altered funding arrangements, for example higher MBS reimbursement for those working in rural areas, and perhaps also in selected regional and outer metropolitan areas. (Royal Australian and New Zealand College of Psychiatrists, sub. 79, p. 10)

But others questioned the effectiveness of such differentiation in rebates in influencing location decisions:

> On the face of it, paying higher rebates in locations of workforce shortage would appear to be an administratively efficient way of supporting better recruitment and retention in such areas.
>
> However … alternative approaches seeking to pursue the same result through more targeted programs appear to be working effectively with considerable success in increasing the number of GPs practising in rural areas. ... [D]ifferential rebates … may be relatively blunt as a mechanism to achieve the same objectives. (Department of Health and Ageing, sub. 159, pp. 39–40)

Yet, in turn, questions were raised about the success of these alternative approaches, with the Western Australian Government contending:

> Despite a range of Commonwealth rural incentive programs these appear to have had limited or no impact on the accessibility of health services in rural areas. (sub. 179, p. 18)

The upshot is that there remains considerable uncertainty about the extent to which a change in the current focus of funding support for private medical practitioners would materially affect incentives to practise in rural and remote locations, especially when compared to other financial incentives. The Commission was not made aware of any formalised attempts at evaluation of the relative effectiveness of the different approaches.

Greater reliance on block funding approaches

The wide range of incentives currently provided to improve the availability and quality of health workforce services in rural and remote areas are for defined purposes — for example, locating a practice in a rural and remote area, performing a particular procedure, or undertaking a particular training course. While allowing for a diversity of support mechanisms, this compartmentalised approach increases the likelihood of program overlap and duplication, and even conflict between different mechanisms.

Also, the health needs and priorities of individual rural and remote communities can vary significantly — as participants frequently emphasised, rural and remote Australia is not a homogenous entity. This in turn means that programs targeting particular outcomes across rural and remote Australia as a whole, will be of differing value to individual communities. As the Western Australian Government (sub 179, p. 18) observed, such diversity instead argues for funding mechanisms that provide opportunities to tailor solutions to the specific needs of particular rural and remote areas.

One way to facilitate such tailoring would be to shift the focus of funding support for service delivery away from designated 'top-up' payments to individual providers, towards block funding to underpin delivery of specified levels of access and service quality in particular rural and remote areas. Under such an approach, there would be a controlling entity responsible for allocating available funding across different health workforce functions and areas, according to an agreed set of objectives and priorities:

- The controlling entity could be determined administratively — for example, as the locus of health services in many smaller rural centres, the public hospital could be well placed to perform this function. This controlling entity would then sub-contract, or otherwise engage, individual health professionals to deliver the services in question, on a fee-for-service or salaried basis, or some combination of the two.
- Alternatively, contracts for the provision of services in particular communities and regions could be let by government, with contracts awarded to the tenderer offering to meet access and quality requirements with the lowest level of subsidy. Depending on the community and the breadth of the services covered, winning tenderers could variously be individual providers or consortia of providers, hospitals, charitable organisations, community organisations, or specialist health managers.

The latter would effectively represent extension of a 'purchaser-provider' approach (see box 10.7) to a part of health care provision in rural and remote Australia.

Box 10.7 **What is meant by a 'purchaser-provider' approach?**

Many government-funded health and community services have been delivered by public sector agencies in a monopoly environment. However, over the last decade or so, there has been an increasing trend both in Australia and overseas to outsource the delivery of such services. In many areas, government has shifted from both funding and providing the service to a purchaser-provider model.

This model separates the responsibility for funding from the provision of the service. For example, the Department of Veterans Affairs, which previously provided hospital services to veterans through special repatriation hospitals, now purchases services from public hospitals and through contracted private hospitals. Other examples include the Adult Migrant English Program, various employment programs, ambulance services and urban transport in Victoria.

This shift to contestable provision has been motivated by a view that such contestability — competition *for the market* — can improve the cost-effectiveness (including quality) of services that governments fund.

As well as facilitating better tailoring of available funding support to the needs of specific communities, these sorts of approaches could have other advantages. In particular, vesting control over service delivery in a single entity able to take a whole-of-workforce perspective, would minimise the risk of overlaps, duplication and conflicts in individual programs. It could also increase accountability for outcomes achieved.

In addition, at least in principle, the competitive tender approach would:

- make it incumbent on governments to be explicit about minimum levels of access and service quality that must be met in rural and remote areas, and to provide funding commensurate with achieving those care levels. At present, access and quality levels are effectively the outcome of a funding process with much less tightly defined objectives;
- by introducing competition to 'supply the market', effectively extend competition to the delivery of some specific services currently supplied by monopoly providers. This in turn could be expected to drive efficiencies that would reduce the costs of delivering any particular level of service access and care quality; and
- encourage innovation in the delivery of health workforce services in rural and remote areas, including through facilitating:
  - further development of multidisciplinary care models; and

– exploration of ways to make it more attractive for health workers to practise outside the major population centres, including mechanisms to reduce the lock-in problem.

However, the competitive tendering model, in particular, would give rise to a range of costs and practical difficulties. It could be extremely difficult to get governments to be explicit about floor levels of access and quality in rural and remote areas, let alone directly tie funding appropriations to those levels. Also, large scale introduction of a purchaser provider model for delivering rural and remote health care would represent a very major change which would need to be widely debated, especially given the ramifications for the health care system as a whole.

And even if introduced on more limited scale:

- Decisions would be required on the geographical delineation of tenders, the range of services they covered, and the duration of tenders. The associated contracting process could be complex, with scope for 'bureaucratic failure'.
- The pooling of funds for primary and acute care necessary to operate the tender process would raise questions about which level of government would control the process.
- Given the essential nature of health care services, governments would inevitably have to remain as the default provider in the event that a successful tenderer was subsequently unable to meet its contract obligations. This of itself could dilute the inherent efficiency advantages in such an approach.

Moreover, it is far from clear that, in many rural and remote areas, there would be several entities competing for the right to coordinate and supply a full range of primary and less complex acute care services. In these circumstances, the only practical block funding model would have an entity — appointed by government — organising and oversighting the service delivery function.

Here too, implementation would be far from straightforward. For example, in advocating a pooled funding approach, the Western Australian Government (sub. 179, p. 18) suggested that the 'Commonwealth could negotiate with States individually on the best way to use the funds allocated for that State'. But, past experiences would suggest that this could be a difficult and protracted process. Synthesising this range of issues, the National Rural Health Alliance pointed to 'the complexity of the number and type of service providers that would be involved', and raised questions about:

> … the ability of most of the types of organisations suggested to manage such diversity, including quality, safety and indemnity issues; whether the true, higher cost of service delivery in rural and remote locations as compared to metropolitan can be clearly enough calculated so that contracts could safely be determined by the 'lowest level of

subsidy' … and whether the level of cost savings would be significant … (sub. PP295, pp. 5–6)

Box 10.8 **Coordinated care trials**

Nine coordinated care trials were run in six States and Territories, from June 1997 to December 1999. Trials were run on either a randomised or geographically controlled basis, and were measured against control groups.

The trials were found to have several flaws, including their short time frame preventing any real impacts on complex illnesses, poor choice of individuals to participate in the trials and the application of the same intervention to all patients, regardless of the severity of their condition.

Overall, the results from the trials were seen as disappointing:

> Intervention groups did not perform better than control groups for either [general measures of health status] … or reductions in hospitalisation, readmission, or length of stay for those hospitalised. Trials were unable to fund coordinated care out of savings from reduced hospitalisation. (Esterman and Ben-Tovim 2002, p. 469)

However, they did reveal that coordinated care may not be the answer if cost containment is a primary objective:

> The possibility remains, however, that the essential premise that better coordination reduces hospitalisation is misguided. It may be that lack of coordination in a complex care system operates as a functioning rationing system, so that better care coordination reveals unmet needs rather than resolving them. … the government has given priority to increased service coordination, vertical integration and cost containment. … [it] might well be that the objectives are mutually exclusive and that improved coordination comes at a cost. (Esterman and Ben-Tovim 2002, p. 470)

Indigenous coordinated care trials

In addition to the general trials, four trials were run in Indigenous communities between 1997 and 1999. These were viewed as more successful than the general trials:

> … [the Indigenous] trials showed enhanced service access, progress in infrastructure development, and improved individual and community empowerment. Funds pooling was successful in providing greater flexibility in resource allocation. (Esterman and Ben-Tovim 2002, p. 469)

A second round

A second round of general trials began in late 2002, with arrangements altered to reflect some of the lessons learnt from the first trials — notably the trial duration is longer, at three years, and the targeting of interventions and measurement of outcomes have been improved.

Source: Esterman and Ben-Tovim (2002).

Further, the Commission notes that previous experiences with pooled funding arrangements within the so-called 'coordinated care trials' (see box 10.8) were not

generally viewed as successful, at least in terms of reducing the cost of care provision.

That said, some have suggested that this outcome at least partly reflected the fact that the lack of coordination in current arrangements acts as a de facto rationing mechanism. The implication is that the benefits of more coordinated care under these trials may have been manifest in the provision of additional and higher quality services, rather than through cost savings. Trials in Indigenous communities were assessed as giving better results.

Moreover, during visits the Commission was informed about the Primary Health Care Access Program (PHCAP), a 'block funding' model for the provision of primary health care for Indigenous people. This model has been used with some success in the Northern Territory, where State and Territory and Australian Government funds have been pooled to provide block funding (in the form of a grant for the population of the service provider's 'catchment area'), as well as access to Medicare fee-for-service payments. Regarding its operation in the Northern Territory, the Aboriginal Medical Services Alliance Northern Territory commented that:

> … the model of Aboriginal community controlled primary health care has major advantages over the traditional private practice model and our model can deliver better access, better quality, better health outcomes, better recruitment and retention of health professionals and other advantages … [PHCAP] is an important existing funding model … that potentially has broader implications, especially in rural and remote areas. (sub. PP 244, p. 2)

The Commission similarly considers that PHCAP exhibits a number of attributes that any block funding model should embody. (More detail on the model is provided in chapter 11.)

In sum, the preceding discussion highlights the challenges of ensuring that funding available to support better health workforce outcomes in rural and remote Australia is used to best advantage. While current arrangements clearly have some significant shortcomings, the scope to address these through innovations such as block funding remains open to question. But this is precisely why experimentation with block funding — an approach which has a number of in-principle attractions — seems warranted.

As discussed below, the Commission is advocating a major cross-program evaluation of the effectiveness of the various broad approaches for improving health workforce outcomes in rural and remote areas. In this context, block funding trials could help to shed light on the practicality of the approach (in mainstream as well as rural and remote settings), and provide hitherto lacking quantification of the costs of

meeting access and quality objectives outside the major population centres through subsidisation of service provision. Moreover, even if the trials themselves prove unsuccessful, the models of service provision adopted may have relevance within existing funding approaches.

In the Commission's view, it would be most appropriate to start with trials where responsibility for the coordination and oversight of the delivery of services is vested in a suitably skilled entity, appointed by the Australian and State and Territory Governments. If these prove successful, trials involving competitive tenders to allocate responsibility for service delivery could then be initiated. The Commission would envisage that its proposed health workforce improvement agency would have an input to the configuration and evaluation of the trial arrangements.

RECOMMENDATION 10.2

To provide input to the proposed cross program evaluation of rural and remote health workforce policies (see recommendation 10.3), and to help assess the general applicability of block funding models, the Australian Health Ministers' Conference should initiate further trials of these models in rural and remote areas. Specifically these trials should involve:

- ***pooling of government funding available to support primary and acute care services in the trial areas;***
- ***allocation of responsibility for distributing that funding and oversighting service delivery to an agreed entity; and***
- ***establishment of evaluation protocols, involving as appropriate the proposed health workforce improvement agency.***

Regional development

Beyond the health workforce policy environment, the general economic wellbeing of rural and remote communities is likely to play a pivotal role in their capacity to attract and retain health workers. Accordingly, some participants pointed to the important complementary role of regional development policy:

> Family factors … and community resource factors are significant contributors to poor retention indicating that in addition to revised service delivery models community development action is also required. (QRMSA 2004, p. 2)
>
> The best medium-term program for the recruitment and retention of workers to country areas would be successful rural development. (National Rural Health Alliance and College of Medicine and Health Services, ANU, sub. 126, p. 11)

Amongst other things, regional development can help to make communities more attractive places for health professionals to live and work in. Moreover, regional

development and better transport and communications links with major centres — that would facilitate easier access to services in those centres and greater use of telemedicine — often go hand in hand.

However, regional development policy, and government support for such policies, is well beyond the remit of this study.

Better program evaluation is essential

The preceding discussion illustrates that the menu of approaches to deliver better health workforce outcomes in rural and remote Australia is very large. Amongst the measures that the Commission considers show most promise are education and training initiatives in general, and further emphasis on rural and remote clinical placements in particular, as well as block funding models of the sort in place in the PHCAP model.

Moreover, the potential menu of programs is likely to grow as innovation in the rural and remote health workforce continues apace. Indeed, in its visits to a number of rural and remote centres, the Commission saw for itself the many health workforce innovations in these areas.

Evaluation of such innovations can provide the basis for their wider application. For example, the Northern Territory Government referred to the evaluation and subsequent territory-wide roll-out of *The Pathways to Professional Practice Program for Remote Area Nurses* (RANs):

> The evaluation … found that the Program considerably improved RAN recruitment and that there [is] also some evidence of improved retention. Based on the evaluation the Program has now been rolled out across the NT with education units undertaken being accredited through the Centre for Remote Health (Alice Springs) so that RANs who complete the required number of units … may be awarded a Graduate Certificate in Remote Practice. (sub. PP182, p. 22)

However, provision for evaluation of programs has often been lacking. Thus, in regard to education and training initiatives in rural and remote areas, the Committee of Deans of Australian Medical Schools (CDAMS) noted:

> Currently there … [is] no mechanism to understand … whether initiatives such as the Commonwealth-funded rural incentives to medical schools or the bonded medical student programs will produce the desired outcomes. There was no planning for such long-term evaluation mechanisms when these programs were initiated.
>
> … With the assistance of the Department of Health and Ageing (DHA), CDAMS is now engaged in a project involving all medical schools to produce a uniform data source relating to all entrants to and graduates from Australia's medical schools, the Medical Schools Outcomes Database (MSOD) project …(sub. 49, p. 9)

Moreover, when evaluation does occur, it is usually limited to an assessment of whether a particular program has led to an improvement in targeted workforce outcomes, and does not consider whether it is more or less effective than other approaches for pursuing these outcomes.

Such a focus is not unreasonable. Cross program evaluation can be both costly and conceptually difficult. Hence, especially for smaller scale programs, comparative performance assessment may not constitute a good investment of resources.

Yet the lack of rigorous cross program evaluation means that there is still considerable uncertainty about which *broad* approaches are the most efficient and effective for improving health workforce outcomes in rural and remote areas. And, where jurisdictions have undertaken such evaluation, the results have not always been disseminated to others. Commenting on these matters, the Australian Health Ministers' Advisory Council said that:

> 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. (sub. 166, p. 18)

Without effective cross program evaluation and dissemination across jurisdictions, it is also more difficult to identify overlaps in, and conflicts between, individual support mechanisms.

In light of this, the Victorian Government recommended that:

> … the Commonwealth, States and Territories agree to a common approach to program evaluation and sharing of learnings to inform future national and jurisdictional policy and program development in rural recruitment and retention. (sub. 155, p. 32)

And echoing this call, the Tasmanian Government advocated:

> Adoption of common evaluation methods for policy and programs, particularly in relation to recruitment and retention in areas of shortage. … Common evaluation methods will enable systematic identification of successful policy and programs, and enable their wider deployment and adaptation for broader benefit and better consumer outcomes. (sub. PP180, p. 17)

However, cross-program evaluation needs to address not only recruitment and retention initiatives, but also:

- the provision of financial incentives through the MBS rebate structure as compared to practice grants that are unrelated to servicing volumes, or other expenditure alternatives such as additional FBT and superannuation concessions;
- financial incentives versus coercive mechanisms; and

- the longer term effectiveness of providing regionally-based education and training opportunities relative to other broad approaches (see box 10.9).

As alluded to above, such evaluation is likely to be both complex and quite costly in absolute terms — though not in relation to the large amount of support available to improve access to, and the quality of, health workforce services in rural and remote Australia. It will also require effective cooperation and coordination between the Australian Government — which is responsible for many of the major policy settings that influence outcomes in rural and remote areas — and State and Territory Governments.

Box 10.9 **Incentives versus coercive approaches**

As well as the provision of financial incentives, governments also employ some more coercive approaches to boost workforce supply in rural and remote areas. Examples include:

- making some subsidised medical places at universities conditional on students agreeing to work in regional areas for up to 6 years; and
- requiring overseas trained doctors to practise in 'districts of workforce shortage' in order to be eligible for Medicare Provider numbers.

Some, such as the New South Wales Government (sub. 178, p. 6), have suggested that the latter approach be extended more generally, through administratively allocated geographic provider numbers. And, as noted above, the Joint State and Territory Health CEOs (sub. PP332, p. 34) have advocated mandatory rural rotations as a part of clinical training.

However, several participants pointed to downsides of using coercion in an effort to boost workforce supply in the bush. Thus, the Doctors in Rural and Remote Training Association has previously observed:

> To insist that doctors remain in an area of need may translate to a reduction in the quality of service that they provide. While this satisfies the basic requirement of having a medical practitioner in town, … [h]aving unmotivated and frustrated doctors will do nothing to improve their retention. (DIRRTA 2001, p. 1)

And, in relation to the use of geographic provider numbers, the AMA said that it:

> … opposes geographic provider numbers as a means of regulation. Locking in younger doctors to a career in certain areas tends to discourage rather than promote participation. (sub. 119, p. 15)

Some also expressed concern about the implications for continuity of care, if most of those 'conscripted' to work in rural and remote areas leave as soon as their period of bonding is over.

Accordingly, the Commission proposes that a cross-program evaluation exercise be initiated and oversighted by the Australian Health Ministers' Conference through

the Australian Health Ministers' Advisory Council. As well as providing for a national and coordinated assessment of the comparative effectiveness of the different rural and remote health workforce programs, this approach would afford individual States and Territories the opportunity to feed in considerations specific to their particular jurisdictions. It could also draw on experiences with different approaches in other countries — though it is important to recognise that, in an area like health care, experience does not always readily translate across countries.

The Commission also emphasises that this exercise would not be expected to indicate that particular approaches are likely to be most beneficial in every situation. As stated earlier, rural and remote areas are not homogenous and, as such, one solution will not necessarily 'fit all'. This in turn points to the importance of effective mechanisms to share experiences with different models. As the Department of Health and Ageing commented:

> … improving capacity to share the learning on models that have worked or not worked well in different areas would be helpful. (sub. PP293, p. 6)

However, the proposed evaluation process would be expected to shed light on where the overall emphasis in government support should lie, and circumstances where different approaches are likely to be called for.

The Commission further emphasises that it is important that the results of this evaluation are carried forward into policy settings — a point also made by the Queensland Government (sub. PP325, p. 21). Thus, the Commission envisages that the proposed assessment of the NHWSF (see recommendation 3.3) would provide a vehicle for ensuring that appropriate policy responses ensue from this evaluation.

RECOMMENDATION 10.3

The Australian Health Ministers' Conference should initiate a cross program evaluation exercise designed to ascertain which workforce policies, or mix of policies, are likely to be most cost-effective in improving the sustainability, quality and accessibility of health services in rural and remote Australia. Amongst other things, it should compare and/or examine:

- ***the provision of financial incentives through the MBS rebate structure versus other means such as practice grants and FBT and superannuation concessions;***
- ***'incentive-driven' approaches versus 'coercive' mechanisms such as requirements for particular health workers to practise in rural and remote areas; and***

- ***whether the current and planned level of investment in regionally-based education and training is sufficient, relative to investment in other policy initiatives.***

While this recommendation is focused on evaluation of rural and remote health workforce policies, rigorous program evaluation is clearly a prerequisite for effective reform across the full range of health workforce arrangements (see chapter 13).

A whole-of-workforce perspective in policy formulation

Finally, whatever particular policy settings are adopted to enhance health workforce outcomes in rural and remote areas and elsewhere, it is very important that a 'whole-of-workforce' perspective is bought to bear. To date, rural and remote policies have focused heavily on the medical workforce. While medical practitioners are integral to the provision of quality care in rural and remote areas, some participants suggested that nursing and allied health have often been the 'poor cousin' in policy deliberations. For example, the Association for Australian Rural Nurses said that:

> Any incentive program aimed at supporting the rural and remote workforce needs to be *equitable.* Nurses and allied health professionals are equally deserving of incentive schemes. Currently these programs favour medical practitioners. We urge that incentive programs be applied across the spectrum of service providers, inclusive of nurses and allied health workers. (sub. PP204, p. 2)

And, in relation to education and training, the Centre for Remote Health noted that, although there is a variety of rural undergraduate support schemes for both medical and allied health students:

> Because responsibility for different professional groups lies with different levels of government, some students receive higher levels of support with, for example, student placement programs than others. (sub. PP212, p. 3)

While support policies will sometimes appropriately differentiate across professional groupings, excessive compartmentalisation is likely to hinder further evolution in scopes of practice and the development of multidisciplinary care in rural and remote areas. And even where such differentiation is ultimately judged to be warranted, it is important that such outcomes are not 'pre-determined' by an overly narrow professional focus in policy formulation. Additionally, it is important that, where such differentiation exists, it is open to review — as care models and thus the required mix of providers can vary over time.

Accordingly, the Commission considers that Australian Health Ministers should ensure that future policies implemented in their jurisdictions to promote better

health workforce outcomes in rural and remote areas are developed within a whole-of-workforce framework, rather than on a profession-by-profession basis.

11 Addressing special needs

Key points

- As well as catering for 'mainstream' needs in both the cities and regional areas, an effective health workforce system must address the particular requirements of a range of groups with special needs.
  - Broader institutional frameworks should provide for explicit consideration of these needs to help ensure complementarity between system-wide and specific policy responses.
- Improving Indigenous health outcomes will require action on a variety of fronts extending well beyond the health arena, including to: further enhance educational attainment; increase capacity for self-driven economic and social development; and continue to improve community and health workforce governance structures.
- Workforce-specific Indigenous reform directions that warrant close attention include:
  - encouraging a further widening of scopes of practice for workers providing health services to Indigenous people;
  - giving greater recognition to prior learning and on-the-job training in Indigenous workforce areas;
  - providing increased health workforce education and training opportunities for Indigenous students in, or adjacent to, their communities;
  - ensuring that training wages provide appropriate incentives for Indigenous participation in health workforce education and training; and
  - making greater use of innovative health care funding mechanisms that have been found to be effective in meeting the needs of Indigenous people.
- The provision of aged care, disability and mental health services accounts for a growing share of overall health care expenditure.
  - This reflects the increased incidence of (reported) mental illness and recognised disabilities, and Australia's ageing population profile.
- The shift in the provision of services from institutional to community-based settings has had implications for the types of health workers required in these areas.
- A common set of workforce issues confront policy makers in each of these areas, including the need to:
  - overcome current and looming workforce shortages and maldistribution;
  - ensure that particular workforce needs in these areas are reflected in education and training arrangements, job design, and career pathways; and
  - address particular workplace environment and remuneration factors that currently make recruitment, retention and re-entry more difficult.

11.1 General approach

As well as catering for 'mainstream' needs in both the cities and regional areas, an effective health workforce system must address the requirements of a range of groups with special needs.

Most obviously, Indigenous Australians suffer particular disadvantage, and require access to, amongst other things, culturally sensitive health workforce services. Various other groups in the community also face particular problems and have some specific workforce needs. Examples include those who require mental health care, disability services and aged care (in both institutional and community settings).

As is the case in the provision of workforce services in rural and remote areas, the system-wide institutional, procedural and funding changes proposed by the Commission would help to underpin better outcomes for groups with special needs. But more specific initiatives will also be required.

Moreover, it is very important that the broader institutional frameworks in the health workforce system provide for explicit consideration of special needs issues, as embodiment within those broader frameworks will help to promote complementarity between policies for these groups and generally applicable health workforce arrangements. It will also help to guard against marginalisation of special needs issues.

In this context, the proposed health workforce improvement agency (chapter 4) should be required to have regard to any particular workforce requirements of specific special needs groups. Indeed, changes to scopes of practice and job design may well prove to be key drivers of future improvements in these areas. Similarly, the terms of reference for the advisory health workforce education and training council (chapter 5) should include an explicit requirement to address any particular education and training issues applicable to these groups, while the secretariat responsible for numerical workforce projections (chapter 9) should investigate the consequences for workforce numbers and composition of the broad demand trends that will underpin the health workforce needs of these groups. That said, the Commission emphasises that the underlying principle must be applied across the board to existing as well as new health workforce institutions.

This approach received considerable support from participants, including from the Joint State and Territory Health CEOs, who advocated that:

> States and Territories as primary employers should identify priority areas for the work of any newly established agencies having regard to special needs groups identified by the Commission. (sub. PP332, p. 31)

RECOMMENDATION 11.1

The Australian Health Ministers' Conference should ensure that all broad institutional health workforce frameworks make explicit provision to consider the particular workforce requirements of groups with special needs, including: Indigenous Australians; people with mental health illnesses; people with disabilities; and those requiring aged care. Progress in achieving this objective should be monitored as part of the proposed regular evaluations of the National Health Workforce Strategic Framework (see recommendation 3.3).

Some participants expressed concern that other important groups with special needs had not been given explicit recognition in the Position Paper (see box 11.1). Another concern was that the Commission had not extensively examined the workforce issues relevant to each of the groups it had identified, although participants generally recognised the difficulty of doing so in a study of this breadth and duration.

The Commission acknowledges these concerns. It also accepts the view, expressed by some participants, that there can be no clear or straightforward delineation of 'special needs'. And it sees merit in the argument put by some that the health care and workforce issues facing these groups should, to the greatest extent possible, be treated as 'mainstream' health care issues, and not compartmentalised. Indeed, the Commission's focus on integrating the workforce requirements of such groups into all broad institutional health workforce frameworks (recommendation 11.1) reflects this view.

The remainder of this chapter highlights some workforce issues that are important in these areas to four groups of people with special needs, namely, Indigenous Australians, people with mental health illnesses, people with disabilities, and those requiring aged care. Large numbers of Australians fall within these groups, and in each case, health workforce shortages have been shown to exist.

However, the depth of this discussion is limited, particularly in the mental health, disability and aged care areas. This is not because the issues are unimportant. It simply reflects that the focus of the Commission's work has been on framework issues and mechanisms, rather than on the complexities that arise in particular key health workforce areas.

Box 11.1 **Participants' comments on other groups with special needs**

Some participants identified other groups that face special health care problems. For example, refugee and asylum seekers may have no access to Medicare because of their visa status, and may face a range of specific health difficulties that are compounded by cultural and language difficulties. This raises particular health workforce, as well as health care, issues. The issue has been recognised by, among others, the Royal Australian College of General Practitioners, which provides extensive information to guide medical practitioners in the delivery of health care to asylum seekers and refugees. The College also provides support for GPs in dealing with other groups with special needs, such as people on low incomes. It advised that it has:

> … been working on improvements to the structures of the MBS for people with an intellectual disability and Aboriginal and Torres Strait Islander people … (sub. PP329, p. 12)

Another example was raised by Professor Allan Carmichael, who suggested that:

> … children may also be considered as a special population group for which the health workforce dealing with them requires specific attributes. (sub. PP208, p. 5)

The College of Nursing said that people with a variety of development and sensory disabilities are still not adequately catered for:

> Education programmes rarely include courses on how to deal with those with deafness or blindness for example and so they are alienated and left frightened in our hospitals. (sub. PP292, p. 4)

And Alzheimer's Australia expressed disappointment that dementia received no mention in its own right as a special need for consideration. In its view, because the incidence and prevalence of dementia is expected to rise exponentially over the coming years, it is:

> … one of the most significant issues which will impact on the health workforce. … the health workforce will need to focus more strongly on prevention, early intervention and health, incorporate multiple models of service and actively pursue revision of responsibilities in the light of changing technologies and workforce training/up skilling. (sub. PP216, pp. 3, 7)

11.2 Indigenous health workforce issues

The current state of play

The parlous state of Indigenous health has been extensively documented (see box 11.2). Put simply, Indigenous Australians are likely to die at a considerably younger age and suffer more extensive health-related disability than their non-Indigenous counterparts.

In response to this large and longstanding gap in outcomes, there are many targeted health and health workforce programs in place. In very aggregate terms, it can be

claimed that per capita spending on Indigenous health care is considerably higher than for the rest of the population. As the James Cook University Faculty of Medicine, Health and Molecular Sciences cautions, however, compared to spending on those in the broader Australian population that have a similar socioeconomic profile — even before taking account of the higher burden of disease among Indigenous people and the difficulties of geographical remoteness — per capita spending is, in fact, lower:

> Reputable estimates (such as that performed for the Australian Medical Association by Access Economics) put the underspend on primary health care for Aboriginal populations at around $450M per year. (sub. PP303, p. 7)

Box 11.2 **Indigenous health**

The health status of Indigenous Australians is significantly below that of the Australian population as a whole. This discrepancy has been long-standing and sits alongside a number of other social disadvantages in the Indigenous community.

- Compared to the total Australian population, infant mortality is almost double and Indigenous life expectancy is around 17 years lower.
- Indigenous people have a higher rate of environment and trauma-related disabilities. Factors that heighten the risk of non-genetic disabilities for Indigenous people include diabetes, some infectious diseases, accidents and violence, mental health problems, and substance abuse.
- Hospitalisations from kidney-related complications of diabetes are some thirteen times higher for Indigenous than non-Indigenous people.
- The rate of hospitalisation of Indigenous children aged four years and under for infectious diseases is more than double that for non-Indigenous children.

A host of factors underlie these outcomes. At a broad level, economic and social disadvantage and lower rates of educational attainment play a key role. More specifically, poor dietary practices, unsanitary living conditions and difficulty in accessing health services are major contributors. In regard to the latter, for example, a 2001 survey of people living in discrete Indigenous communities revealed:

- over 50 per cent lived at least 100 kilometres from the nearest hospital (with 12 per cent of this group having no access to a medical emergency air service); and
- around 45 per cent lived in communities that had no community health centre, with 3 per cent located 100 kilometres or more from the nearest centre.

Sources: SCRGSP (2005a); Access Economics (2004); AHMC (2004b).

The pattern of spending on Indigenous health is also different to that for non-Indigenous Australians. Access Economics found that:

> Indigenous people are making much more extensive use of non-admitted patient services in public hospitals and community & public health services, while having

much less access to other types of primary care services. In part, this reflects the care options that are available. In some remote communities, for example, the hospital may be the only place where health care services are accessed. But it also reflects the needs that are being met and, by implication, the needs that are not being meet. (Access Economics 2004, p. 38)

Apart from funding for primary health care that is provided by Aboriginal Community Controlled Health Services, the Australian and State and Territory Governments provide support for programs to:

- make better use of the workforce available to provide care to Indigenous Australians;
- facilitate job redesign; and
- encourage more Indigenous people to train as health workers (see box 11.3).

Some workforce issues

Despite such programs, workforce problems can be particularly acute. In part, this is due to the difficulties of service delivery in remote areas (particularly in greater extremes of climate or geography where, for example, wet season wash-out of unsealed roads necessitates flying in). The Nganampa Health Council, which provides health care to Indigenous communities through nine clinics and an aged care facility in the Anangu Pitjantjtajara Lands in the remote northwest of South Australia, emphasised that:

> Workforce issues are extremely difficult in remote indigenous communities. … they are the single most significant management challenge. (sub. PP188, p. 1)

The Council said that these issues are exacerbated by: limited access to Medicare because there are so few GPs (discussed below); IT networks that are 'extremely fragile' and of limited bandwidth, thereby precluding the development of Patient Information Recall Systems; and insufficient funds to assist with the transport of patients (sub. PP188, p. 2).

Aboriginal Medical Services Alliance Northern Territory highlighted the lack of nurses available to work in remote areas, adding that:

> … the current largely unregulated manner in which recently graduated nurses can go and begin practise in remote Aboriginal communities as 'Remote Area Nurses' is unsafe and needs to be phased out as soon as possible. Unfortunately, in spite of the important work that they do, Remote Area Nurses still have poorly defined legal and professional status. … Whether generalist nurse practitioners can simply be up skilled to work in remote areas or whether they need a completely separate training and registration process to work in remote areas as 'Remote Area Nurses' is not entirely clear … (sub. PP244, pp. 4–5)

Box 11.3 **Indigenous health programs**

Beyond general funding for primary health care and the delivery of public hospital services, governments also support the provision of primary health care by Aboriginal Community Controlled Health Services.

In addition, governments provide support for specific programs to: make better use of the workforce available to treat Indigenous people; improve access to particular types of health workers; facilitate job redesign; and encourage more Indigenous people to train as health workers (at present, Indigenous people make up 2.4 per cent of the population, but only 0.9 per cent of the health workforce). Some examples include:

- Australian Government funding for the 'Pathways into Health — Workplace Learning' initiatives for Aboriginal and Torres Strait Islander school students;
- support for the development of clinical protocols relating to Indigenous health;
- the development of nurse practitioner roles for remote area clinics;
- scholarship schemes to encourage Indigenous students to study in health related fields, such as the Office of Aboriginal Health Scholarship in Western Australia;
- the provision of financial and peer support for Indigenous people training to become mental health workers;
- the provision of allied health and specialist medical outreach services; and
- initiatives to 'encourage' OTDs to work in or adjacent to Indigenous communities.

Overall, government support for health care for Indigenous Australians is considerably higher than the average for the community as a whole — more than $3600 per person compared to a little over $2200 per person in 2001-02 (the latest data available), notwithstanding that per capita usage of the MBS and the PBS is considerably lower. But as discussed earlier, such higher expenditure levels are unsurprising, given the poor status of Indigenous health, and the fact that a significant proportion of the Indigenous population live in remote areas. Indeed, as the Rural Health Education Foundation noted, remoteness and poorer health outcomes for Indigenous people are strongly correlated:

> [T]he health outcomes of Aboriginal Australians declines as their 'remote-ness' increases, so that health outcomes consistently decline from 'metropolitan' to 'inner regional/rural' to 'outer regional/rural' to 'remote' to 'very remote'. (sub. 84, p. 5)

Additionally, some of this expenditure is through specific programs. This effectively substitutes for spending on mainstream health services, which on a per capita basis, is much lower for Indigenous than for non-Indigenous Australians.

Sources: AIHW (2004a); SCRGSP (2005b); State health departments.

Various issues that affect recruitment and retention in remote areas have been discussed in chapter 10. Important considerations in an Indigenous context include remuneration; training, professional support and workplace back-up arrangements; the suitability of housing and other facilities; effective family support; and leave

arrangements. (For influences on GP recruitment and retention, see, for example, General Practice and Primary Health Care Northern Territory, sub. PP324, pp. 3–4.) However, several participants said that, even with an attractive package of measures in place, they have difficulties in finding sufficient suitable staff. This can also put added pressure on remaining staff, and may lead to subsequent departures.

Often, primary health care in remote areas caters for a wide range of Indigenous and non-Indigenous patients, which places a premium on cross-sectoral health workforce arrangements. For example, the Northern Territory Government's health department and the Aboriginal Community Controlled Health Services both provide a range of primary health care services to remote communities. Consequently:

> Remote area health services workforce planning and support needs to take into consideration both sectors, given the relatively small pool of staff, their mobility (including between the sectors) and economies of scale for workforce development initiatives. (sub. 182, p. 7)

The Northern Territory Government added that:

> The importance of Australian Government practical support for these cross sectoral workforce activities is critical, and may need to be made more explicit than articulated in existing funding models and agreements … (sub. 182, p. 7)

The DoHA observed that, with a range of specific Indigenous health programs existing alongside 'mainstream' health and health workforce programs, care must be taken to ensure that their interaction does not lead to overlaps, duplication, or distortion in service provision:

> One of the key issues for primary health care models in urban and regional areas is the extent to which Aboriginal and Torres Strait Islander peoples are using *both* [Aboriginal Community Controlled Health Services] and mainstream primary care services such as private general practice. While this may be a small proportion of total utilization, it may be important to consider the need to develop coordination activities that link primary care and related community services. (DoHA 2005b, p. 321)

What more can be done to address the problems?

While some improvement has been evident, the gap in health status with other Australians remains unacceptable. Consequently, governments, communities and professional organisations are devoting considerable attention to what more can be done.

Multifaceted responses are required

It is widely recognised that improving Indigenous health outcomes will require action on a variety of fronts extending well beyond the health arena. James Cook University Faculty of Medicine, Health and Molecular Sciences emphasised that poor outcomes in Indigenous health have their origins in 'fundamental structural determinants' such as:

> … overcrowding, educational and employment opportunity, unaffordable or unavailable healthy food, economic exclusion and social inequality. (sub. PP303, p. 7)

Hence, as the Australian Medical Association has observed:

> No single intervention can solve the crisis in Aboriginal and Torres Strait Islander health. (AMA 2004b, p. 1)

Of particular importance at a broader level is the need to achieve further improvements in the educational attainment of Indigenous Australians, and in particular, improvements in basic literacy and numeracy. Greater education would have a direct impact on health outcomes through improving health awareness and dietary practices, and through increasing the willingness and capacity to seek appropriate medical treatment. It would also help facilitate higher standards of living in Indigenous communities, with consequent health benefits.

Improved educational attainment is also likely to encourage increased Indigenous participation in the health workforce — itself a contributor to better health outcomes. As well as being readily accessible and able to provide culturally sensitive care, Indigenous health workers typically play an important leadership role on health care matters within their communities. The Australian Medical Association, amongst others, drew attention to the beneficial linkages between Indigenous participation levels and improved health outcomes observed in other countries:

> The USA, Canada and New Zealand all have more [Indigenous] health professionals and, despite continuing disparities, have made greater improvements in health for their Indigenous populations. (AMA 2004b, p. 3)

Moreover, increased participation by Indigenous people in the health workforce would have a range of other benefits beyond the direct impact on service delivery. The Australian Indigenous Doctors' Association, which in October 2005 released a report, entitled *Healthy Futures: Defining best practice in the recruitment and retention of Indigenous medical students*, said that the positive effects of Indigenous doctors for the physical, emotional and cultural wellbeing of Indigenous people have long been recognised, and include:

- their ability to empathise and understand the social/cultural context (such as knowing enough to ask the right questions, and understanding the priorities of patients and extended family obligations);
- the better flow of personal information that often results from their understanding of family groups;
- being seen as leaders and advocates by the community;
- their ability to interpret western medicine into Indigenous understanding;
- their ability to bring Indigenous understanding of holistic concepts and spiritual attributes of health to enrich the medical community/profession; and
- fulfilling the role of mentors and role models for Indigenous children. (sub. PP356, pp. 3–4)

It also said that the recruitment, training and graduation of Indigenous health professionals addresses many of the social and economic determinants of health:

> Achievement in education and successful attainment of health qualifications leads to employment — a transition from welfare to participating in the real economy. In particular, the health (as well as the education) sector is a significant employer of Indigenous peoples and may be the major employer in smaller Aboriginal and Torres Strait Islander communities. (sub. PP356, p. 3)

Indeed, programs aimed at building capacity for self-driven economic and social development (see box 11.4) will be important — not only in terms of the health benefits that come from higher standards of living, but also through reinforcing incentives for participation in education. Thus, the South Australian Government observed that:

> In SA, experience has shown that in order to bring more Indigenous people into employment, education and training, a significant investment has to be made in community capacity building and in healing the community before more people are ready and able to take up new opportunities. (sub. 82, p. 15)

In a similar vein, Noel Pearson, reporting on recent work by the Cape York Institute assessing the economic viability of Cape York Indigenous communities, said that engagement with the real economy is a necessary requirement to build and sustain acceptable capabilities:

> ... proximity to a real economy is not enough ... In our modelling, economically viable scenarios required policies and attitudes that actively promoted economic development. … the capability of employment is central to wellbeing … common themes … are that people must be mobile and enhance their capabilities; policies and attitudes must enable engagement in the real economy; and people must be engaged in both local and non-local productive activities. (Pearson 2005)

And James Cook University Faculty of Medicine, Health and Molecular Sciences observed that:

> The power of economic uplift and opportunities on Indigenous populations is already being seen in provincial centres, but this is not shared by Indigenous communities in many inner urban or remote areas. (sub. PP303, p. 7)

Box 11.4 **Indigenous Enterprise Partnerships**

The Indigenous Enterprise Partnerships (IEP) program is designed to build capacity for self-driven development in Indigenous communities. IEP is a not-for-profit organisation, which aims to foster long-term economic and social development by facilitating partnerships between Indigenous and corporate and philanthropic groups.

This program has been operating, on a pilot basis, in Cape York since 2001, though its principles are intended to have broader application. The pilot program has delivered a number of direct benefits including the installation of new building and telecommunications infrastructure, the provision of training and personnel development support, and assistance for the establishment of businesses to provide commercial employment opportunities in Indigenous communities. But it has also provided less tangible, though equally important, broader economic and social benefits:

> … such as improved commercial literacy and Indigenous motivation to participate in business or employment … [and] personal development and empowerment gains. Other benefits include building the capacity of Indigenous organisations through factors such as organisational development plans or direct training.

Source: SCRGSP (2005a, p. 11.19).

Less commonly raised in the context of improving health and health workforce outcomes, but still important, is the need to continue to improve community and health service governance structures. Poor governance structures and practices can lead to a variety of problems, including:

- inefficient use of funds available to improve access to health workforce services;
- discouragement for practitioners to work in Indigenous communities and for Indigenous people to train as health workers; and
- reduced incentives for economic development and participation in education, thereby constraining improvements in standards of living and the health benefits that follow from them.

As the circumstances of individual communities vary considerably, governance structures will similarly need to vary. In a health workforce context, community-driven care — to provide 'ownership' of services and to facilitate tailoring of governance structures to particular circumstances — will continue to be a key foundation in most cases. However, 'community-driven' care need not always

translate to ‘community-managed’ care. As for other economic and human services, contracting out of service delivery may sometimes be efficient. Indeed, in common with other aspects of health workforce reform, a willingness to look beyond current models is likely to be helpful in achieving better outcomes.

What health workforce-specific directions look most promising?

Submissions to this study have put forward a wide range of possible initiatives to improve the access of Indigenous Australians to health workers, and the effectiveness of the services provided. Many of these were directed at immediately increasing the numbers of health workers available to treat Indigenous Australians not only in communities, but also in the cities. However, others were variously directed at:

- making better use of available resources — for example, through changes to scopes of practice or greater use of telemedicine;
- facilitating greater Indigenous participation in the health workforce through changes to training delivery, career pathways and remuneration structures;
- enhancing service quality through a greater emphasis on culturally appropriate models and methods of delivery in training programs (see box 11.5);
- improving the coordination of service provision through, for example, reducing barriers to cross-jurisdictional practice; and
- increasing the emphasis on preventive health.

Indeed, some new initiatives are already in train to improve Indigenous participation in the health workforce, guided by the Aboriginal and Torres Strait Islander Health Workforce Strategic Framework (box 11.6).

In the Commission’s view, a greater emphasis on preventive health strategies will be especially important — though the specific requirements to give effect to this lie well outside a study into the health workforce. Beyond that, it considers that the following reform areas warrant particular policy attention in an Indigenous context.

Wider scopes of practice and greater recognition of prior learning

As is the case for rural and remote service provision more generally, the often acute shortages of health workers available to treat Indigenous people have resulted in more flexible scopes of practice than in the major population centres.

Two examples are the development of nurse practitioner roles in remote area clinics and expanded roles for Aboriginal Health Workers (AHWs) who, apart from their clinical role:

> … play a key role in cultural brokerage between Western medical systems and Indigenous communities. (General Practice and Primary Health Care Northern Territory, sub. 132, p. 6)

Box 11.5 **Cultural training**

Indigenous people are more likely to understand, respect and use services that are provided in a culturally appropriate fashion. Accordingly, the principle of culturally appropriate service provision is enshrined in the Aboriginal and Torres Strait Islander Health Workforce Strategic Framework.

To promote the delivery of culturally appropriate services, several participants emphasised the need for training programs for non-Indigenous health professionals providing services to Indigenous people, to include a significant cultural component. Apart from enabling them to provide effective services to Indigenous people, a good grounding in Indigenous culture can assist non-Indigenous health professionals to:

- convey broader health awareness and disease prevention messages to patients and communities; and
- understand the role of Aboriginal Health Workers and to make best use of their skills.

In commenting on some of these roles, the National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan Steering Group suggested that:

> … non-Indigenous staff be required to undertake a cultural awareness program that highlights the role of Indigenous Health Workers. We also strongly recommend an appropriate mentorship program for the mentoring of non-Indigenous staff by Indigenous staff on areas such as cultural issues and localised cultural conduct. This could also be seen as two way 'skills exchange'. (sub. 74, p. 1)

Others also suggested that a greater emphasis on cultural training might increase Indigenous usage of health services in metropolitan areas where, despite better access to health workers, the health status of Indigenous people still lags that of other Australians.

The Northern Territory Government noted, however, that while there is a significant body of knowledge around Aboriginal cultural awareness, security and respect and the impact that this has on the effective delivery of services to Aboriginal people living in remote communities:

> ... there is a 'two-way' cultural awareness required to facilitate optimal health outcomes. It is also recognised that cultural obligations and expectations may intersect with the practice of remote area Aboriginal health workforce, particularly [Aboriginal Health Workers]. (sub. PP182, p. 6)

Box 11.6 The Aboriginal and Torres Strait Islander Health Workforce Strategic Framework

This framework, which was endorsed by the Australian Health Ministers' Advisory Committee in 2002, aims to build:

> … 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.

It is based on nine principles seen as necessary for sustained improvement in Aboriginal and Torres Strait Islander health. These principles also form part of the National Strategic Framework for Aboriginal and Torres Strait Islander Health (endorsed by the Australian Health Ministers' Conference in 2003) and are consistent with the National Aboriginal Health Strategy (1989). They are:

- cultural respect;
- a holistic approach;
- health sector responsibility;
- community control of primary health care services;
- working together;
- localised decision making;
- promoting good health;
- building the capacity of health services and communities; and
- accountability for health outcomes.

The objectives of the Framework are to:

- increase the number of Aboriginal and Torres Strait Islander people working in all the health professions;
- improve the clarity of roles, regulation and recognition of Aboriginal and Torres Strait Islander Health Workers, and improve VET sector support for their training;
- address the role and development needs of other health workforce groups that contribute to Aboriginal and Torres Strait Islander health;
- improve the effectiveness of training, recruitment and retention measures for Indigenous and non-Indigenous staff working within Aboriginal health services; and
- 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 framework is now embodied within the broader National Health Workforce Strategic Framework (see chapter 3).

Source: AHMAC (2002), AHMC (2004b).

However, the Western Australian Government said there was a 'lack of appreciation of the capabilities' of AHWs, and said that efforts are being made to develop a set of up-to-date national competencies for Aboriginal health work. It noted that 'mainstream cultural misunderstanding' and the need for 'role clarity and support' are key issues (sub. 179, pp. 27, 29).

James Cook University Faculty of Medicine, Health and Molecular Sciences said that there has been 'considerable confusion' on the policy direction for AHWs. It said that expanded clinical roles for AHWs have existed for many years, particularly in northern Australia and in the Aboriginal Community Controlled Health Service sector.

> There are already examples where AHWs are providing advanced functions in emerging areas of need such as haemodialysis as well as advanced roles in community midwifery. However, established clinical roles for AHWs have been under pressure from public-sector employers who have become increasingly preoccupied with clinical credentialing and protocol as well as from organised nursing in some instances. The exclusion of AHWs from the recent 'practice nurse' Medicare item numbers (that apply only to RNs and ENs in spite of the fact that doctors can employ AHWs with 'practice nurse' incentives funding) is regrettable ... (sub. PP303, p. 2)

While the Commission is not in a position to assess these claims, it was advised that, with fairly modest additional training, AHWs could take responsibility for a wider range of tasks, such as performing injections, conducting renal dialysis and midwifery functions. Moreover, the Northern Territory Government said that Indigenous people can play important roles in the wider health workforce in addition to work as AHWs:

> Aboriginal co-workers (allied health therapy assistants) are essential in the implementation of community based rehabilitation. These can provide opportunities for new career pathways for Aboriginal people and articulation into graduate allied health courses. (sub. PP182, p. 19)

One example of expanded roles is the development of Aboriginal Environmental Health Workers in the Northern Territory, a qualification currently under review for potential national adoption by the National Training Quality Council (see sub. PP182, p. 23)

Also, the Centre for Midwifery and Family Health said that one objective of the development of the Bachelor of Midwifery was to attract Indigenous women into the profession, and that:

> In NSW, four places [are provided] for Aboriginal women. These women have all been working as Aboriginal Health Workers as part of the NSW Aboriginal Maternal and Infant Health Strategy and have completed a 12 month Maternal and Infant Preparatory Course … (sub. 41, p. 4)

The development of wider scopes of practice would, in turn, be facilitated by further development of clinical protocols to support appropriate task delegation in Aboriginal Community Controlled Health Services. It would also be assisted by greater recognition of prior and on-the-job learning in registration and credentialing arrangements.

Moreover, wider scopes of practice and greater recognition of prior learning in accreditation arrangements for training courses would enhance career pathways for Indigenous health workers, allowing AHWs, for example, to more easily progress to nursing and other professions. This in turn would encourage Indigenous participation in the health workforce, not only by providing a more accessible career pathway, but also by improving the standing of Indigenous health workers in their communities.

Though necessity will continue to drive further broadening in scopes of practice, and possibly greater recognition of prior learning and on-the-job training, that impetus must be reinforced by broader institutional arrangements impacting on job design and education and training regimes. It is precisely for this reason that the Commission is proposing that those broader frameworks make explicit provision to consider the particular workforce requirements of groups with special needs, including Indigenous Australians (see recommendation 11.1). Consistent with the thrust of this recommendation, DoHA said:

> Widening the scope of practice for Aboriginal Health Workers could be considered early in the life of the proposed health workforce improvement agency. (sub. PP293, p. 7)

An emphasis on increasing participation in education and training

The Commission supports a strong focus on Indigenous education and training initiatives, as well as for regional and remote areas more generally (chapter 10). In particular, the provision of locally-based training options can increase incentives for Indigenous participation in the health workforce. Those who contemplate joining the health workforce are often important members of the community, and may be heavily involved in day-to-day community life. As such, they may be reluctant to travel long distances, or spend a long time away from their communities, for training purposes. Moreover, training provided in larger centres — especially for AHWs — may not pay sufficient regard to cultural and other issues pertaining to specific Indigenous communities.

The importance of such initiatives is reinforced by the fact that it is becoming increasingly difficult to recruit new AHWs as the existing workforce ages. For

example, there are few young AHWs in the Northern Territory Department of Health and Community Services:

> … with only 9% aged 20–29 years, 70% aged 30–49 years and 21% aged 50 years and over. While the ageing of the health workforce is an NT as well as national concern, specific factors such as changes to the NT AHW career structure, training provider capacity, the process of selection of AHWs and alternative career choices for Aboriginal people may have reduced the number of younger people entering the AHW workforce. (sub. PP182, p. 14)

This concern about the difficulty of recruiting younger Indigenous people was raised with the Commission on several occasions by AHWs working in a range of health care settings and in different jurisdictions.

The New South Wales Government put forward a range of strategies to boost the involvement of Aboriginal people in the health workforce:

- provide target programs for Aboriginal students to easily articulate from school through VET to higher education;
- identify the current skills, knowledge and experience of AHWs as a basis for ongoing training and career development plans;
- establish ongoing training plans and support for AHWs in chronic conditions management; and
- develop prototypes for clinical protocols and health assessment tools for the early detection and management of chronic conditions in Aboriginal people and develop and implement appropriate training to support the implementation of the protocols across the wider health workforce (sub. 178, p. 32).

Such approaches may well have merit, although it is not possible to evaluate them in the current study.

Appropriate remuneration arrangements

Indigenous participation in the health workforce will obviously be influenced by remuneration levels, not only in relation to other occupations, but also compared with community development program payments and forms of income support. While it appears that remuneration for those who have completed training provides reasonable incentives to pursue a career in the health workforce, the level of payments for those in training seems more problematic. Such training wages must of course be considered in the context of other support available to students. However, in this regard, the South Australian Government noted that, because Indigenous people seeking employment in the health sector are typically of mature age:

> … they are ineligible for Commonwealth Cadetship monies for 17 – 28 yr olds. … Many have financial commitments that require a full-time salary to cover their cost of living, often coupled with family responsibilities that may extend to a number of family members. For example, an individual may wish to become a qualified Health professional, but cannot afford to live on Abstudy because of financial responsibilities and the future impact of a HECS debt. Individuals are also often required to forfeit their Abstudy allowance if they are recipients of scholarships. (sub. 82, p. 15)

Given the inter-relationships between training wages (generally the responsibility of the States and Territories) and income support and training support payments (mainly an Australian Government responsibility), such remuneration issues would need to be addressed at an intergovernmental level. In the Commission's view, they are issues that appear to warrant greater policy attention.

Funding mechanisms

In response to the Position Paper, some participants highlighted the role of particular features of funding arrangements for the provision of health care services to Indigenous Australians (see also chapter 8).

Many pointed to the shortcomings of Medicare in meeting the health needs of Indigenous people living in regional and remote areas, because of insufficient access to GPs. For example, the Nganampa Health Council said that:

> Medicare access is limited for remote organisations because it is dependent on the GP actually seeing the patient. In our organisation 2.5 FTE doctors provide care for all residents of the [Anangu Pitjantjtajara] Lands. This is an area of over 100,000 square kms. Necessarily over half their consultations are held by phone with Community Health Nurses at the particular remote worksite. None of these phone consults can be billed under the HIC's current Medicare arrangements. (sub. PP188, p. 2)

Similarly, General Practice and Primary Health Care Northern Territory said that:

> The Fee For Service, private practice model under the MBS has failed to deliver equitable access to general practice services and quality care for Aboriginal people throughout Australia (and for other disadvantaged groups) and there is a need for alternative models. In Aboriginal health, these models are based on salaried health professionals working as part of multidisciplinary teams in organisations that are large enough to deliver consistent access and quality care. (sub. PP324, p. 3)

Some changes have been made to the MBS arrangements to make them more accessible to Indigenous people. For example, Medicare rebates may be paid for services provided in 114 Indigenous primary health care services and in agreed State and Territory run remote health services in Queensland and the Northern Territory. Moreover:

> Access to Medicare also allows access to other mainstream funding programs such as the Practice Incentives Program and the General Practice Immunisation Incentives Program, that use Medicare activity in the calculation of payments. (DoHA 2005a, p. 176)

(In addition, the supply of pharmaceuticals covered by the PBS to clients of remote area Indigenous primary health care services is facilitated by special arrangements under Section 100 of the *National Health Act 1953*.)

In looking at the scope for further innovation in the funding area, the Primary Health Care Access Program (PHCAP) is of particular relevance. The program is intended to facilitate access to primary care health services for Indigenous people by funding the expansion of primary health care services in the areas of clinical care, illness prevention, early intervention activities and management support systems. The objectives of PHCAP are to increase the availability of primary health care services, better meet the health care needs of Indigenous people, and empower people to take better care of their own health.

PHCAP provides funding for new services in areas identified as having the highest relative need and the community capacity to manage funding and service delivery. Essential elements of the funding framework are pooling of Australian Government and State or Territory Government funding and a preference for community controlled models. Sites for expanding services are identified through consultation in regional health forums (which comprise Australian, State and Territory Governments and peak bodies representing the Aboriginal Community Controlled Health Services). These forums also help to identify regional needs and plan services.

There are several features of the PHCAP model, as it is used in the Northern Territory, that are seen by those involved as providing an opportunity for Aboriginal people to gain access to properly resourced comprehensive primary health care services.

- Agreement on pooled funding between the Australian and Northern Territory Governments avoids problems that often arise where combined Australian and State or Territory funding arrangements are involved.
- The mixture of funding mechanisms preserves flexibility in the overall program. Specifically, the program provides for:
  - a block funding component, based on the size of the client population and the benchmark of national per capita usage of Medicare, weighted for remoteness and morbidity; together with

  - access to MBS income, payable to the service provider, for medical services provided, thereby giving the capacity to respond to visitor needs and to unexpected increased morbidity in the client population.
- The service is operated by Aboriginal Community Controlled Health Services.

Some participants' comments on the PHCAP program are provided in box 11.7.

In the Commission's view, the PHCAP has some features that could potentially be employed more generally to deliver health care packages in some parts of rural and remote Australia (chapter 10).

It also has some wider benefits in an Indigenous context. For example, the Aboriginal Medical Services Alliance Northern Territory said:

> In addition to the innovative funding model the PHCAP is also about supporting the development of Aboriginal community controlled health services as the appropriate organisational structure for the delivery of primary health care to Aboriginal people. (sub. PP244, p. 2)

Box 11.7 **Participants' comments on the PHCAP program**

The Aboriginal Medical Services Alliance Northern Territory and the Central Australian Aboriginal Congress referred to the PHCAP model, as it is used in the Northern Territory, as:

> … the best possible way to fund comprehensive [primary health care] at the present time … (Rosewarne and Boffa 2004, p. 1)

General Practice and Primary Health Care Northern Territory similarly saw PHCAP as having a valuable role in developing Aboriginal primary health care services. It added that the program also has benefits in respect of Aboriginal health workforce levels and capacity. While it said that PHCAP funding from the Australian Government has slowed down in the past 12 months:

> … the program remains the most logical means of expanding the Aboriginal health workforce via funds pooling between the Commonwealth and the States within a community controlled health framework. (sub. PP324, p. 3)

And the Australian Physiotherapy Association said that PHCAP is one specific program that has been effective in developing workforce capacity to provide Indigenous primary health care services:

> The program … has been in operation for five years and has had a positive impact on the Indigenous health workforce in the Mt Isa and Katherine regions. Unfortunately Federal funding is dwindling and the program is under threat. (sub. PP271, p. 8)

The Association argued for greater government commitment to the program.

But the Alliance added that a significant number of Aboriginal community controlled health services do not have in place all of the key elements needed for this model to be successful:

> … and are therefore struggling to deliver accessible, quality services that are able to report on key performance indicators. (sub. PP244, p. 3)

More evaluation is required

In sum, in seeking to improve Indigenous health outcomes through health workforce specific initiatives, the Commission supports the following directions:

- encouraging the further widening of scopes of practice for those providing services to Indigenous people, consistent with maintaining or enhancing quality and safety;
- facilitating Indigenous workforce participation through giving greater recognition to prior learning and on-the-job training;
- providing increased health workforce education and training opportunities for Indigenous students in, or adjacent to, their communities;
- ensuring that training wages, in conjunction with other support mechanisms, provide appropriate incentives for Indigenous participation in health workforce education and training; and
- investigation of the scope for wider application of innovative funding mechanisms such as those employed within the PHCAP.

That said, as in other areas of health workforce policy, there has not been a great deal of evaluation of the effectiveness of the various workforce-related approaches for achieving better Indigenous health outcomes. Hence, better evaluation of existing and proposed programs in this area should also be a high policy priority. Indeed, there would be value in encompassing the evaluation of Indigenous programs within the broader evaluation initiative that the Commission has proposed for rural and remote health workforce policies (recommendation 10.3). And that evaluation could draw on the extensive overseas experience with providing health care services to Indigenous groups — subject to the caveat on the extent to which it is possible to translate such experiences across countries.

11.3 Other key special needs areas

As noted in section 11.1, health workforce arrangements must effectively address the health care requirements of a range of groups with special needs.

While there are many such groups in the community, the remainder of this chapter briefly discusses three areas — mental health, aged care and disability services. In the discussion that follows, the Commission has not sought to develop recommendations or firm bottom lines, but does indicate some ways forward.

Mental health

Mental health disorders are the leading cause of disability burden in Australia, accounting for about 27 per cent of the total years lost to disability. Mental health problems and mental illness will affect more than 20 per cent of the adult population in their lifetime and between 10 and 15 per cent of young people in any one year. Indeed, because of this, the Royal Australian and New Zealand College of Psychiatrists argued that mental health should be considered a mainstream health issue and not an area of 'special need' (sub. PP245, p. 1).

Prevalent mental health disorders include:

- affective disorders (such as depression, mania and bipolar affective disorder);
- anxiety disorders (such as panic disorder, agoraphobia, social phobia, obsessive compulsive disorder and post-traumatic stress disorder); and
- substance abuse disorders.

The Australian Medical Association said that mental health disorders are on the rise in Australia, such that:

- by 2013, over 100 000 people will be affected by bipolar disorder (up 6 per cent);
- by 2011, the number of people with schizophrenia will rise to 41 000 (up 10 per cent);
- by 2050, about 730 000 Australians will be affected by dementia. (AMA 2005a).

The Royal Australian and New Zealand College of Psychiatrists said that, while most mental illness is treatable, people with mental illness often face stigma and discrimination. For a proportion of patients, it is chronic, disabling, and affects all aspects of life. Moreover, sufferers may require significant assistance in relation to work, family and accommodation, and for related matters such as drug and alcohol problems (sub. 79, pp. 1–3). Reflecting this, mental health problems have significant social, individual and economic costs (DoHA 2005d).

Mental health services are delivered in a variety of settings, including in general practice, and by private psychiatrists, private and public psychiatric and general hospitals, and community mental health services. Total spending on these services

in 2001-02 was around $3.1 billion, an increase of about 65 per cent since 1992-93. Funding responsibility is essentially shared between the Australian (37 per cent of the total in 2001-02) and State and Territory Governments (58 per cent), though there is a small contribution from private heath insurance funds (around 5 per cent) (sub. 79, p. 3).

Over the last decade, there have been significant changes to the delivery of mental health care that have led to the deinstitutionalisation and mainstreaming of mental health services into general health services. These changes have been guided by the National Mental Health Strategy — a reform framework endorsed by all jurisdictions in 1992, and updated since (box 11.8). A central element of the Strategy has been an expansion of treatment and support services in community-based settings. As a result, the share of funds allocated to community-based mental health services increased from 29 per cent of the total in 1992-93 to 51 per cent in 2001-02.

However, the Australian Medical Association has argued that, while the National Mental Health Strategy was a worthwhile initiative:

> … it is now becoming clear that some of the directions set early in the piece were quite inappropriate. The AMA applauds the steps that have been taken to improve policy directions and urges more. The main challenge now is to address the failures in the implementation of the policy. A decade or so after the deinstitutionalisation of mental health, it is now obvious that governments did not ensure enough resources for the new community-based care structures to operate effectively. (AMA 2005b, p. 1)

It also expressed concern that mental health remains one of the 'weakest links' in the health care system — services get low funding priority, workforce shortages are increasing, access to hospital services is 'increasingly problematic', access and equity has not been achieved, existing resources are not used as well as they could or should be, and:

> Stigma and discrimination remain as major obstacles to improving outcomes for those who suffer from mental health conditions. (p. 1)

The Royal Australian and New Zealand College of Psychiatrists also claimed there are inadequacies in funding of mental health care. It said that:

> … it is the underfunding of the mental health care system, along with the low status of mental health care as a specialty area, that is a major contributor to the problems of mental health workforce recruitment and retention. (sub. PP245, p. 1)

Within the broad framework of the National Mental Health Plans, a range of specific policy initiatives has been introduced in the mental health area, including initiatives to support GPs in primary mental health care, in recognition that most people seeking help for a mental disorder generally approach their GP, rather than a

specialist mental health professional. For example, the *Better Outcomes in Mental Health Care* initiative provides for education and training for GPs to treat patients in primary care settings, financial incentives, allowing MBS rebates for the services of some allied health professionals (such as psychologists and social workers) where referred by a GP, and more support for psychiatrists (Australian Government 2001).

Box 11.8 **The National Mental Health Strategy**

In 1992, Health Ministers agreed to a National Mental Health Policy, to be implemented under a five-year National Mental Health Plan, to coordinate mental health care reform nationally. It focused on State and Territory public sector services and specialist mental health services, and provided for decreased reliance on stand-alone psychiatric hospitals, 'mainstreaming' of acute beds into general hospitals and increased emphasis on community-based services, including residential accommodation.

Whereas the first plan focused on severe and disabling low-prevalence illnesses, particularly psychoses, the second (1998) was broadened to encompass high-prevalence illnesses, such as depression and anxiety disorders. It also added a focus on mental health promotion and mental illness prevention, and on how the public mental health sector could best dovetail with other areas such as private psychiatrists, general practitioners, the general health sector, emergency services and non-government organisations.

The third plan — the National Mental Health Plan 2003–2008 — builds on the work of the two previous plans, and provides an ongoing agenda for mental health services. Its broad aims are to:

- promote the mental health of the Australian community;
- prevent, where possible, the development of mental disorder;
- reduce the impact of mental disorder on individuals, families and the community; and
- assure the rights of people with mental disorder.

Source: DoHA (2005d).

However, the Royal Australian and New Zealand College of Psychiatrists argued that the main barrier to the provision of effective treatment to those requiring specialist interventions is their inability to access services appropriate to their needs, or in a timely manner:

> We currently have services that are significantly under-funded for the needs of the community, with service components that are significantly disintegrated, and … workforce shortages with inadequate strategies to meet workforce needs in terms of both numbers and skills. (sub. 79, p. 2)

The Mental Health Council of Australia went further, saying that 'countless reviews and reports' have identified a 'crisis' in mental health care in Australia (sub. 162, p. 2). Reinforcing this view, it released a major study in October 2005, reporting the experiences of people who had sought primary or specialist mental health services. The report noted that:

> The great majority of written and verbal submissions focused on deficits in key aspects of mental health care services. While a wider range of community and other welfare, housing and custodial services were the subject of individual or group submissions, the fundamental issue of inadequate access to quality health services for persons with mental illness dominated the discourse. (MHCA 2005, p. 14)

It added that:

> The contrast between experiences of care when presenting with a physical illness as compared to presenting with a mental illness was profound. (MHCA 2005, p. 14)

In March 2005, a Senate Select Committee commenced an inquiry into how mental health policies and care could be improved. Among other things, it is examining the extent to which the National Mental Health Strategy has achieved its aims and objectives. The Committee is to report by March 2006.

Mental health workforce

The wide-ranging changes in the financing and structure of mental health services are reflected in the composition, size and distribution of the workforce. The main professional disciplines (other than general practice) that make up the bulk of the mental health workforce are psychiatry, nursing (including a mental health specialty), psychology, social work, occupational therapy, other allied health occupations and Aboriginal and Torres Strait Islander Mental Health Workers. In 2002, there were just under 3000 practising psychiatrists (80 per cent of the total) and psychiatrists-in-training (20 per cent) in Australia. This represented an increase of about 16 per cent since 1998 (AIHW 2005c, pp. 193–195). There were also around 12 000 specialist mental health nurses in 2001 and approximately 7600 clinical psychologists, an increase of 44 per cent since 1996 (AIHW 2005c, pp. 199–200).

Since the commencement of the National Mental Health Strategy, the size of the public sector clinical workforce (medical, nursing and allied health) has risen by 25 per cent, with expansion of ambulatory and residential services accounting for the entire increase. There has also been a shift in staffing mix, with medical and allied occupations increasing their workforce share from 26 to 34 per cent in the decade to 2001-02. Reflecting the shift from hospital to community-based practice, the

nursing share of the workforce (the bulk of which comprises registered nurses) has declined to around 63 per cent.

Mental health workforce issues

The main workforce-specific issues in mental health relate to shortages, geographic distribution and ageing. For example, a 1999 AMWAC study into the psychiatry profession noted that the overall supply of psychiatrists was inadequate and that shortages existed in all geographic areas other than capital cities. (In 2002, 85 per cent of psychiatrists worked in a major city.) The study also cited evidence suggesting that access to both private and public sector psychiatrists was inadequate in both urban and rural locations. It noted that future supply would be affected by the cohort of psychiatrists aged 55 years and over proceeding to retirement and the comparatively large and increasing representation of female psychiatrists working on a part-time basis (AMWAC 1999, p. 7).

The Australian Medical Association said that workforce shortages in mental health are increasingly apparent and are producing sub optimal outcomes for patients:

> The Government must ensure there is a well trained and highly motivated psychiatrist workforce and needs to address such issues as unfilled Registrar training positions, unattractive working environments, poor remuneration etc. Psychiatrists are among the poorest paid of all medical specialties and it is not attracting sufficient new entrants which will show up in serious workforce shortages in later years (AMA 2005b, p. 2).

Shortages of mental health nurses and some allied health professions have also been identified (see, for example, SCAC 2002, p. xiii and AHWAC 2003, p. 8). AHWAC attributed difficulties in recruiting and retaining qualified and experienced mental health nurses to a range of issues including:

- lack of awareness and negative views of the mental health sector;
- shortcomings in education programs (for example, removal of direct entry psychiatric nursing programs leading to a decline in new entrants to mental health nursing);
- workplace issues (including pay and working conditions);
- regulation/accreditation difficulties; and
- the lack of ease and affordability of re-entry (including access to relevant training programs).

More broadly, the Mental Health Council of Australia referred to the need to:

> … address the declining morale and chronic skills shortages now evident in the mental health care workforce … (MHCA 2005, p. 18)

It reported that there are major workforce shortages across all disciplines in mental health, and major difficulties in recruitment and retention, due to, for instance, a lack of support and training, poor working conditions and insufficient career path options.

Similar observations were made by the Health and Community Services Union, which expressed concerns about the future implications of the ageing of the Victorian psychiatric nursing workforce, and the shortages of graduate nurses seeking to specialise in this field (particularly following the end of direct entry specialist psychiatric nursing courses in 1993) (sub. PP217, pp. 3, 9).

And Alzheimer's Australia pointed to the interdependence of the community services and health sector workforces in the context of caring for dementia patients. It also expressed concern that both workforces are often characterised by:

- lack of attractiveness to young people;
- low remuneration and demanding working conditions;
- difficulties in maintaining currency of skills;
- difficulties in obtaining work release to undertake training or retraining; and
- a predominantly female workforce, resulting in breaks from work and part-time work (sub. PP216, p. 6).

It urged that a study be undertaken into health workforce delivery models, taking into account the roles of allied health workers and workers with community services training in other than clinical settings. In its view, increasing demands for aged care in particular (see below), will drive considerations of changes in skill mix.

As the Mental Health Council of Australia observed, a necessary first step in this process would be to better understand the current capacity of the mental health workforce:

> Further research is required to understand the current capacity of the various professions and workers to expand their roles to relieve key pressure points such as those faced by psychiatrists, mental health nurses and general practitioners. (sub. 162, pp. 6, 8)

Indeed, while the current National Mental Health Plan contains several 'workforce key directions', there may be merit in the development of a specific mental health workforce strategy to complement the National Mental Health Strategy, and which might then be incorporated into a future National Mental Health Plan (box 11.8).

Participants' views on solutions to mental health workforce issues

While acknowledging some of the recent initiatives in the mental health area, a few submissions questioned their effectiveness. For example, commenting on the increased support for GPs to treat mental illnesses, the Australian Psychological Society said:

> Although the involvement of GPs in managing mental health disorders has been significantly enhanced by the recent Better Outcomes in Mental Health Care (BOMHC) initiative, funding for this initiative is capped and access to the program is limited to GPs who have undergone training for the program. Of the 32,000 GPs in Australia, only 12 per cent are currently involved in BOMHC. (sub. 118, p. 18)

The Mental Health Council of Australia said that 'deinstitutionalisation' in mental health and the closure of long-term mental health institutions have not been matched by increased funding for community service and support. In its view:

> … chronic under-funding has undermined the success of [the National Mental Health Strategy] process over the last 13 years. … Compounding this problem have been rising prevalence rates, increasing case complexity and rising drug and alcohol use. (sub. 162, p. 2)

It went on to argue that, as a result, deinstitutionalisation had been undermined and this is increasing pressure on the mental health workforce.

> There is an increasing number of clients and a decreasing number of beds and staff (in terms of FTE hours worked). There is a paucity of community-based services and these are often not properly resourced. This leaves them ill-equipped to share the burden with acute care service providers. (sub. 162, p. 2)

As well as increased funding, the Council called for job redesign to allow for the more efficient use of the existing workforce:

> Consideration should be given to where improved role definition (and redefinition) can make better use of the current workforce across both the mental health and community sectors. (sub. 162, p. 6)

The Australian Psychological Society noted that the existing psychology workforce is underutilised in both the public and private sectors and that there is significant scope for task substitution between the relevant professional groups. It suggested that extending the BOMHC program to accredited psychologists (through access to the MBS) would ameliorate both the extent of workforce shortages and maldistribution problems, as the psychology workforce is more geographically dispersed (sub. 118, p. 18).

The Mental Health Council of Australia similarly advocated:

> … better use of and access to the psychology workforce, which is available and skilled, and can reduce pressure on other areas of the workforce … (MHCA 2005, p. 18)

It also argued for training programs to be undertaken in all States and Territories to integrate the drug and alcohol and mental healthcare workforces.

Others focused on the need to address the impacts on access to mental health nurses of changes in education and training arrangements and the shift to community-based care. The New South Wales Mental Health Co-ordinating Council said:

> In NSW the demands for a skilled workforce for the sector have been further complicated by the simultaneous move from institutional to community care, occurring since the mid '80s, with the move from hospital based to university based training for nurses, who were previously the main workforce in mental health. Currently nurses trained at university receive a generic qualification and, with a few exceptions, those wanting to specialise in mental health need to undertake post graduate 'user pays' training. Similar processes have occurred in psychology, social work and occupational therapy. This has led to a shortage of trained mental health workers available for care of people with a mental illness living in the community. (sub. 125, pp. 4–5)

In regard to recruitment, the New South Wales Government said that, following the success of its 'Nursing Re-Connect' program that commenced in 2002, for nurses who have been out of the workforce for some time:

> A Mental Health Nursing Re-Connect was launched in April 2005. The mental health nurse recruitment strategy includes orientation programs; scholarships for further study; flexible rostering, mentoring, clinical skills updates and professional development. (sub. 178, p. 56)

Another issue raised in a recruitment context was the lack of clinical exposure of trainee nurses to specialist nursing environments. The School of Nursing at the University of Melbourne, for example, commented:

> Undergraduate curricula are typically compressed with little flexibility and little choice of clinical places. As a consequence there is a lack of exposure of undergrad nurses to specialised areas such as mental health, operating room and paediatric settings due to rigidity of mandated clinical component in curriculum from regulatory authorities and low availability of clinical places. (sub. 150, p. 2)

Finally, the Royal Australian and New Zealand College of Psychiatrists argued that the negative view of the mental health sector is a major contributor to workforce shortages and called for improvements in the mental health sector generally and changes to funding arrangements specifically (such as increasing the MBS rebate) to provide incentives to enter the specialty:

> Recruitment levels are influenced by the marginalisation of the specialty within medicine and by the stigma associated with the profession and mental illness — these are specific issues facing psychiatry as a discipline, which impact on the status and

> desirability of the profession. Much of this is a direct result of under funding, system dysfunction and chronic workforce shortages, and improvements in the mental health system are necessary to combat psychiatry's unattractiveness as a career. (sub. 79, p. 2)

The College also drew attention to the key role of Aboriginal and Torres Strait Islander Mental Health Workers, noting that their current status and career structure is 'poorly defined', and that there needs to be a more effective career structure for this group (sub. 79, att. 2, p. 2).

Aged care

Aged care services play a central role in the delivery of health care services in Australia. Aged care covers a number of services ranging from those provided in residential aged care facilities and acute hospitals, through to community health services such as home and community aged care programs (eg home-help, home nursing services, and home and centre-based respite care). In recent years, various policy initiatives have resulted in a marked shift in the balance between these alternative care streams toward the delivery of services in community-based settings. In 2002-03, around 218 000 people received either permanent or respite residential care, while 731 000 received care through home and community care programs.

Arrangements for the provision of aged care are complex and varied with all tiers of government involved either as regulators, providers or both. Providers comprise private sector entities, local and state governments and a range of not-for-profit groups such as charitable and religious organisations. The total cost of supplying formal aged care services (residential care services, community care packages and Home and Community Care) was $7.8 billion in 2002-03 (two-thirds of which was accounted for by labour costs). This represented a little over 1 per cent of GDP. Reflecting Australia's ageing population profile, this share is expected to double over the next four decades (Hogan 2004, p. 131).

Aged care workforce

The aged care sector is a major employer in the Australian economy with approximately 131 000 people (or 1.3 per cent of the workforce) employed in the aged care industry in June 2000 (the latest available ABS data), as well as 33 000 volunteers (Hogan 2004, p. 219). The bulk of the paid workforce is made up of personal care workers. In addition, in 2003, there were estimated to be some 2.6 million carers (some of whom have access to a carers allowance), who provided help for those needing assistance due to age or disability (ABS 2004b).

The employed aged care workforce has undergone considerable adjustment over the last decade in response to government policy initiatives, industry growth, a changing consumer profile and the dynamics of the nursing workforce. For example, the number of employees in the residential aged care sector (which accounts for 20 per cent of total industry employment) fell by around 5 per cent in the five years to June 2000. Over the same period, the share of employment accounted for by registered and enrolled nurses also declined, while the use of personal care assistants increased significantly (Hogan 2004).

Current workforce issues

There have been longstanding concerns about the size, skill mix and availability of aged care workers — particularly in regard to nursing staff. A number of recent reports have reinforced these concerns. For example, the Senate Community Affairs Committee Inquiry into Nursing identified aged care as the area of nursing in greatest crisis, with the acute shortage of nurses having led to increased use of unregulated workers, to the detriment of quality of care (SCAC 2002, ch. 4). Also, submissions to the House of Representatives Standing Committee inquiry on *Future Ageing* from aged care providers referred to difficulties in obtaining regular and reliable GP and allied health services in residential care homes (HRSCOHA 2005, p. 167).

The Hogan Report similarly noted that:

> … [the] residential care sector faces significant workforce issues that need to be addressed in the near future if the quality of care in residential care services is to be maintained. (Hogan 2004, p. 221)

According to that report, these include:

- the general shortage of trained nursing staff, which is greater in the residential care sector than in other areas of the health system;
- specific barriers to recruitment, retention and re-entry to the aged care workforce (including pay structures, working conditions, lack of career opportunities and poor sector image);
- the ageing of the aged care sector's nursing workforce;
- differences between the States and Territories in the regulatory frameworks governing training, medication management and employment conditions; and
- the changing profile of consumers of residential aged care services, with implications for the nature and extent of the demand for future services and the composition and skills mix of the workforce.

In its response to that report, the Australian Government announced a package of measures under the *Investing in Australia's Aged Care: More Places, Better Care* program (Bishop 2004a). This provides additional funding over four years to support a range of workforce measures, including increased education places for registered and enrolled nurses and community/personal care workers, skill upgrading for existing aged care workers and higher payments to aged care providers to reduce pay discrepancies between aged care and other health services.

A National Aged Care Workforce Strategy (DoHA 2005c) has also been developed (focusing on the residential aged care sector) to address many of these issues through a range of specific strategies covering workforce supply, workforce education, training and recruitment, and workforce retention — while also aiming to enhance the safety and desirability of the aged care sector as a place to work.

Participants' views on problems and solutions to aged care workforce issues

While acknowledging the recent policy initiatives in the aged care workforce area, a number of participants questioned their ability to fully overcome current problems. Accordingly, many proposed additional measures to build on these recent changes. The COTA National Seniors Partnership, for example, said:

> Through the package *Investing in Australia's Aged Care: More Places, Better Care*, the Government has allocated funding to increase nursing places in universities and other education and training facilities. There will be 1203 aged care nursing places to universities by 2008, commencing with 440 from next year. The question is — will this be sufficient to meet the demand for nurses in aged care? (sub. 123, p. 12)

It saw an increased reliance on unpaid carers as inevitable and called for additional government financial assistance to support this shift:

> With increased pressure and need for unpaid carers due to the rapid growth in the number of people needing care and the fact that the health and aged care system is not meeting existing demand, it is obvious that appropriate and encouraging government policy needs to be in place to provide assistance and incentives to unpaid carers so as to maximise the resource that this group are currently injecting into the economy and community. (sub. 123, p. 10)

The Aged Care Association of Australia contended that workforce shortages across medical, nursing and allied health professionals are the result of both the poor image of aged care work and inappropriate remuneration arrangements. While acknowledging recent initiatives to support GPs and allied health professionals working in aged care, it suggested workforce problems could be further ameliorated by, for example: funding salary-based (as opposed to Medicare-based) GP services to the aged care industry; expanding roles for enrolled nurses and personal care

assistants; and designating aged care as an 'area of need' to promote the development of nurse practitioners in the industry.

Aged and Community Services Australia focused on nursing shortages and the need to reduce wage differentials with nurses operating in hospital-based settings. It argued that current funding for aged care 'does not enable this wages gap to be closed' (sub. 64, p. 2). It also called for attention to be given to skills mix issues in the specific context of aged care to address the inadequacy of nurse availability under current models of care.

The Migrant Resource Centre North-West expressed concern about what it sees as a serious lack of bilingual, aged care qualified direct care workers (that is, personal carers, home carers and respite carers):

> … to serve the large and growing population of culturally and linguistically diverse … elderly persons, who need practical home and community care services to prevent them from being admitted to residential care and, in many other cases, occupying beds in the hospital sector. (sub. 3, p. 1)

It said that, while programs such as Home and Community Care Services and Community Aged Care Packages are critical elements in the health and aged care service system for culturally and linguistically diverse elderly people:

> To be fully effective … these services must be staffed by persons who are not only qualified in personal and community care competencies, but also by persons who can clearly and effectively communicate with their clients in their own languages. Services, however, often fail on both counts. (sub. 3, p. 1)

Several participants referred to the difficulties that people in residential aged care have in gaining access to medical practitioners. Resthaven noted that doctors earn less for successive consultations during a visit to a residential aged care facility and are not paid for travel time. It expressed concern about the impact on residents, as it:

> … raises the risk that financially disadvantaged residents are subject to non bulk bill charges to ensure access to doctors. There is also concern that the current few 'champion' doctors who take on heavy workloads in aged care facilities are ageing and it is not clear how their work in aged care will be replaced when they retire in the future. (sub. PP186, p. 6)

It further noted that difficulties in accessing the services of medical practitioners in turn makes it more difficult for staff to obtain timely advice on the care and treatment of the residents.

To help address these and other workforce problems, Resthaven saw the need to consider the scope for job redesign in aged care. It referred to the 'great potential' of nurse practitioners working in collaboration with GPs in the aged care area. And it also suggested that some traditional nursing tasks (such as administration of

medication) could be handled by enrolled nurses and care workers, freeing up RNs to focus their expertise in areas of 'clinical outcomes and leadership' (sub. PP186, p. 8).

People with disabilities

Around 20 per cent of the Australian population suffered some form of recognised disability in 2003 — up from 15 per cent two decades earlier (ABS 1999, 2004b). The main disabilities are attributable to intellectual, psychiatric, sensory, physical or neurological impairment or acquired brain injury, or some combination of these. People with a disability receive specialist support services ranging across accommodation services (in hostels, group homes and institutions), community support and access programs (including case management and counselling), disability-specific employment services and advocacy support, together with informal care and assistance from family and friends in home-based environments.

The third Commonwealth State/Territory Disability Agreement (CSTDA) — which operates over five years to 2006-07 and currently involves a total financial commitment of $16.7 billion — provides the national framework for the delivery, funding and development of specialist services for people with disabilities (FaCS 2005a). Under the three agreements signed so far (the first in 1991):

- the Australian Government has responsibility for the planning, policy setting and management of specialised employment assistance;
- State and Territory Governments have similar responsibilities for accommodation support, community support, community access and respite; and
- there is shared responsibility for support for advocacy and print disability.

In 2003-04, disability support services provided under the CSTDA accounted for some $3.3 billion in government expenditure and provided assistance to around 188 000 people. More than half of this amount was spent funding accommodation services (Australian Healthcare Associates 2005, pp. 9, 53, 58).

Over the last two decades, there has been a significant increase in the share of accommodation services provided in community-based as opposed to institution-based settings. Accordingly, the States and Territories now provide the bulk of direct funding for specialist disability support services (just over 70 per cent of the total in 2003-04). Based on data for the period January to June 2003, around 53 per cent of users of CSTDA services had an intellectual disability and 47 per cent had an intellectual disability as a primary disability (SCRGSP 2005b, p. 13.9).

A statement of principles that guide government policy is contained in the Commonwealth Disability Strategy, a strategic framework intended to ensure that people with disabilities can participate in government policies, programs and services (box 11.9).

Box 11.9 **The Commonwealth Disability Strategy**

This strategy was launched in 1994 to provide a ten-year planning framework to help Australian Government agencies ensure that their services, programs and employment opportunities are accessible to people with disabilities. This is intended to:

- promote acceptance that people with disabilities have the same rights as others in the community;
- identify and remove barriers in program development and delivery;
- eliminate discriminatory practices in employment and program administration; and
- facilitate the development of plans, strategies and actions to ensure planning and service delivery takes account of the needs of people with disabilities.

The Strategy is based on the following principles:

Equity — people with disabilities have the right to participate in all aspects of the community, including the opportunity to contribute to its social, political, economic and cultural life.

Inclusion — all mainstream Australian Government programs, services and facilities should be available to people with disabilities. The requirements of people with disabilities should be taken into account at all stages in the development and delivery of these programs and services.

Participation — people with disabilities have the right to participate on an equal basis in all decision-making processes that affect their lives.

Access — people with disabilities should have access to information in appropriate formats about the programs and services they use.

Accountability — all areas of Australian Government organisations should be clearly accountable for the provision of access to their programs, facilities and services for people with disabilities. This includes specifying the outcomes to be achieved, establishing performance indicators and linking reporting on outcomes of the Strategy to mainstream reporting mechanisms.

The Strategy was revised in 1999, and is currently being further evaluated to assess its effectiveness and the progress that has been made in removing barriers for people with disabilities.

Source: FACS (2005b).

However, this Strategy is not intended to deal with broader matters such as disability workforce issues. The National Health Workforce Strategic Framework

fulfils that role for the health workforce generally (chapter 3). Nevertheless, the Commission considers there may be merit in the development of a specific disability workforce strategy, which could subsequently be incorporated into the National Health Workforce Strategic Framework.

Disability workforce

The provision of disability services requires a mix of practitioners from the health and community services sectors, and also relies heavily on volunteer carers. A number of medical practitioners and allied health professionals may be involved in the treatment of people with disabilities, including specialists in rehabilitation medicine, general practitioners, nurses, dietitians, speech pathologists, neurologists, psychiatrists and home-care workers. As noted earlier, in 2003 there were estimated to be some 2.6 million carers (some of whom have access to a carers allowance) who provided help for those needing assistance due to age or disability (ABS 2004b).

Disability workforce issues

To the extent that many people with disabilities are treated in the general health system, shortages in the numbers of general practitioners, nurses and allied health professionals will impact on their treatment. Shortages have specifically been reported in the number of rehabilitation specialists (although this is based on 1997 data).

Approximately 40 per cent of people with intellectual disabilities also have mental health conditions. Accordingly, the shortage of psychiatrists and other mental health professionals (mentioned earlier) has an impact on many people with disabilities.

The National Disability Administrators — the key national representative body for those government agencies in all jurisdictions that provide services to people with disabilities — is undertaking research to gain a comprehensive understanding of disability workforce issues. Based on a preliminary scoping exercise, an initial understanding has now been reached.

> Some of the most important issues identified from this study include: a forecast increase in the client base for both the disability and aged care sectors, … a need for a consistent standard of quality of care for clients in the disability sector; inconsistent use of high volume recruitment strategies across jurisdictions; a lack of understanding of the potential impact of an ageing workforce; difficulty in recruiting and retaining certain sub-groups of the workforce; and a current undertaking for levels of training to become consistent across jurisdictions and across the sector. (NDA 2005)

Further research is now proposed to:

- analyse the impact of an ageing workforce on the sector;
- develop a strategic, sector-wide approach to recruitment into the future, by making government-funded disability services an 'employer of choice', and disability an 'industry of choice';
- examine recruitment practices, with a focus on developing best-practice strategies for recruiting high quality applicants; and
- assess training strategies, with a focus on improving standards industry-wide.

Participants' views on problems and solutions to disability workforce issues

Participants commenting on disability workforce issues concentrated on workforce shortages, problems with education and training arrangements and inappropriate payment mechanisms for service providers. While many comments related to the specific area of intellectual disability, it was noted that the arguments had equal relevance to other groups with disabilities.

The Australian Association of Developmental Disability Medicine said that current education and training programs do not provide the necessary skills required to effectively treat people with developmental disabilities and that a medical speciality in intellectual disability is required (as has occurred in some other countries), as well as specialist skills for allied health workers and nursing staff. It said:

> While inroads have been made in the education of medical students in some medical schools with the establishment of centres (Centre for Developmental Disability Health Victoria, Queensland Centre for Intellectual and Developmental Disability, the Centre for Developmental Disability Studies in NSW and more recently the Centre for Intellectual Disability Health in South Australia) there is a need to have more input into the undergraduate programs in the other states and territories and there remain real gaps in post graduate training. Two important groups in the delivery of health services to adults with intellectual disability; General Practitioners … and Psychiatrists … while indicating that they would like to better service the needs of this group have acknowledged gaps in their own training. (sub. 114, p. 2)

It went on to comment on the adverse impact of fee-for-service funding arrangements for GPs on those requiring care services, saying:

> … medical practitioners are concerned if they demonstrate an interest they will be overwhelmed by a group with complex health needs and support structures that demand more time and would therefore be severely financially disadvantaged in a system that rewards more frequent and shorter consultations. (sub. 114, p. 3)

The NSW Council for Intellectual Disability referred to shortages in the availability of specialist services for the intellectually disabled, citing research showing there

were only 5 to 6 full time equivalent psychiatrists specialising in this area in 2002. It said there needs to be:

> … an enhanced availability of psychiatrists and other mental health professionals with particular expertise in intellectual disability. (sub. 73, p. 5)

The Council also commented that:

> … there is currently very limited education at a tertiary level on the health needs of people with intellectual disabilities. (sub. 73, p. 3)

It noted that specialist psychiatric and mental retardation nursing courses previously offered in New South Wales had been merged into general nursing courses.

Concluding comments

While several submissions provided much useful information on the special needs areas covered in this chapter, the Commission has not had time to examine in detail the specific health workforce issues that arise in mental health, disability and aged care, in institutional and community settings.

However, it is conscious that people requiring these services face particular health problems and that there are important health workforce issues that need examining. Moreover, there are some common themes in each of the above areas of special need, including: the typically poor health status of many in these groups; the need for more flexible job design and perhaps wider scopes of practice; and a corresponding requirement for enhanced education and training arrangements and better career paths for some health workers.

Addressing some concerns of participants, particularly those that relate to funding levels, would have significant implications for the broader health system and are outside of the scope of this workforce-oriented study. However, the recommendations made in this report for higher level changes to institutional and procedural arrangements, and funding and payment mechanisms, should move workforce arrangements in these areas at least partly in the direction that some participants have been suggesting. This should help to underpin better future outcomes from whatever overall levels of funding are available.

To facilitate this, the Commission has made a specific recommendation (11.1) for the explicit consideration of special needs issues within broader health workforce frameworks. As noted, this should, to some extent, help guard against the potential marginalisation of these groups, and to promote complementarity between policies directed to their needs and more generally applicable health workforce arrangements.

12 After hours GP services and other matters

Key points

- There has been a range of initiatives to improve access to after hours primary health care services — including the establishment of GP clinics in or adjacent to hospitals.
  - However, there is still considerable doubt about which approaches are most efficient and effective. Accordingly, there should be continued experimentation with, and evaluation of, alternative delivery models.
- For a variety of reasons, including the absence of a user charge, some patients will continue to use emergency departments for some of their after hours and other primary care needs.
  - However, the appropriate relationship between after hours services provided by GPs in or near hospitals and acute care can only be properly addressed within a broader review of health funding arrangements.
- There is significant scope for greater benefits to be derived from E-Health, particularly in the areas of service delivery, patient management, administration and education. Realising gains from the technologies will, however, be contingent on effective assessment, trialling and coordination of future investments in these areas.
- Policy settings in a range of other areas — including medical indemnity, general labour market arrangements, migration, taxation and superannuation — will influence the efficiency and effectiveness of future health workforce arrangements. And reforms to enhance the efficiency of Australia's transport and communications infrastructure will help improve access to health services in rural and regional Australia.

12.1 After hours GP services

In the past, after hours primary care was typically provided by GPs through home visits, rostered after hours services and locum services.

But that care model is changing, with many GPs becoming increasingly reluctant to provide 'own-practice' after hours care. For example, a greater emphasis has been

placed on deputising services, with nearly 60 per cent of after hours primary care in inner metropolitan areas now provided this way (DOHA 2002).[1]

This shift has been attributed largely to the general trend towards reduced working hours, reinforced by the ageing and feminisation of the GP workforce (chapter 2). In metropolitan areas in particular, concerns about safety and limited access to locums are also dissuading GPs from providing these services (Victorian Government, sub. 155, p. 55).

The request in the Commission's terms of reference in regard to after hours care is narrow — to provide advice on the issue of GPs in or near hospitals after hours, including the relationship of services provided by GPs and acute care. There appear to be two considerations underpinning this request:

- The reduced availability of after hours GP services in some parts of Australia, including outer metropolitan areas, may be contributing to increased low acuity presentations at emergency hospital departments. There are concerns that such added pressure on emergency departments has been to the detriment of patients in need of acute care.
- And there are intergovernmental fiscal implications associated with changes in the distribution of primary care services provided in community and public hospital settings.

Evidence to support the contention that high acuity patients presenting at emergency departments are being disadvantaged is far from conclusive. Triaging protocols have been well developed, such that those with serious complaints almost always receive priority over those requiring less urgent primary care. Indeed, several participants argued that the major treatment 'blocker' for more seriously ill admitted patients in emergency departments is a shortage of public hospital beds to which they can have access (box 12.1).

That said, although the magnitude of the issue varies across regions, it is clear that increased presentations at emergency departments for often relatively minor primary care needs add to the already considerable pressures on these departments and those waiting in them. And whatever the precise impact on emergency departments and their patients, there is the underlying need to ensure the availability of adequate and cost-effective after hours primary care services and their provision in appropriate settings.

[1] Deputising services are generally defined as after hours and related services that are provided by doctors as their sole function. In contrast, locum work involves filling a temporary vacancy in the absence of a doctor, and performing their normal duties, both during and out of normal working hours.

Box 12.1 **Impacts on emergency hospital departments**

Several State Governments commented on the increased presentations at emergency departments for after hours primary care. For example, the Victorian Government said:

> In many areas, particularly in the outer metropolitan suburbs, there are large numbers of patients attending hospital emergency departments who could be managed by a GP. These hospitals lie within recognised areas of GP shortage. Presentations are most noticeable in the out of hours periods and on week ends. (sub. 155, p. 55)

The New South Wales Government stated also:

> … public hospitals are increasingly wearing the brunt of decreased bulk billing rates and lack of access to general practitioners in the community. This reduces the ability to achieve efficient coordination of primary care for patients with chronic and complex conditions. (sub. 20, p. 6)

However, Family Care Medical Services, the largest provider of after hours services in Australia, said that in its experience in southern Queensland, there is no evidence that public hospital departments are overburdened by patients seeking GP-like services. While over 90 per cent of its after hours services are bulk billed, it experiences low patient demand during the week and only moderate demand on weekends (sub. 28, pp. 1–2).

Moreover, the significance of the impact of such presentations at emergency departments on waiting times and the treatment of those with more serious complaints was questioned. For example, the Australasian College for Emergency Medicine said that most emergency department overcrowding is due to:

> … 'access block', which relates to the inability of admitted patients to access inpatient beds in a timely manner. (sub. 76, p. 8)

Similarly, Family Care Medical Services, said:

> … seriously ill patients (category 1, 2 and 3) are trapped in Emergency Departments awaiting the availability of a bed within the main public hospital and … these beds are taken up by chronically ill patients. … significant under funding and poor productivity in State hospitals blocks patients leaving the ED and accessing a State hospital bed. (sub. 28, p. 2)

What has been done to improve access to after hours services?

A range of initiatives has been introduced by governments and health service providers to improve after hours care in the community. Examples include new after hours clinics and the development of other cooperative arrangements amongst GPs. There are also specialist management companies providing fee-for-service administrative support to groups of practitioners delivering deputising GP and related services. And triaging arrangements by hospitals have been supplemented by use of telephone help lines, staffed by nurses, to help ensure that people do not unnecessarily access after hours services. However, despite these policy initiatives,

after hours primary care arrangements and the availability of such services are far from uniform across Australia.

For its part, the Australian Government has sought to facilitate better access to after hours care through increased financial support. For example, the Practice Incentive Program provides additional remuneration to GPs, or groups of GPs, providing own-practice after hours services (with remuneration tiered to reflect the level of own-practice involvement). The MBS schedule has also been amended to provide a loading to rebates for after hours GP attendances (eg the Round the Clock Medicare initiative).

As well, the Australian Government has provided funding for experimental services, including through the After Hours Primary Medical Care Program (box 12.2). This is designed to test the effectiveness of alternative approaches for providing after hours care and has financed trials of different care models, in a variety of locations — including GP services in or adjacent to hospitals (see below).

Box 12.2 **The After Hours Primary Medical Care Program**

This program was introduced in 2001-02 with initial funding for $43 million over four years. It was recently announced that the program is to be extended to 30 June 2006.

A range of after hours care models have been funded under the program, including:

- triaging services;
- GP after hours clinics;
- home visits; and
- patient transport arrangements.

These trials have generated some information on the efficiency and cost effectiveness of different approaches. For instance, an evaluation during the program's initial year of operation suggested that the most appropriate model depends very much on local circumstances, including the characteristics and attitudes of particular GPs and other relevant local service providers. However, that early stage evaluation was unable to shed light on the merits, from an access perspective, of government support for new models of care relative to increases in MBS rebates for after hours services.

Source: DOHA (2002).

After hours GP services in or near hospitals

The provision of after hours primary health services through GP clinics located in or adjacent to hospitals is expanding. For example, the Australian Government, through its 2004-05 budget initiative *GP Services — Improving After Hours Access*,

has provided for case-by-case exemptions from the *Health Insurance Act 1973* to facilitate the establishment of up to 10 after hours co-located GP clinics with assistance from the States. Through the exemptions, the clinics will be able to access Medicare rebates (sub. 159, p. 80). And, as noted above, this model of after hours care has also been subject to a national trialled assessment (box 12.2).

Participants expressed a variety of views about such clinics (box 12.3). Some said they provided tangible benefits for patients, for instance, by reducing waiting times for treatment and possibly allowing hospitals to better manage their acute care patients. Others, however, said that diversion of patients from emergency departments has often been low and there have been difficulties in attracting doctors to work in the clinics.

Further examination is required

The efficiency and effectiveness of these new health care models, including co-located GP clinics, remains unresolved. Some evaluation is already occurring — for example, the Department of Health and Ageing is presently undertaking an external evaluation of after hours care initiatives (sub. 159, p. 50). However, it is important that such evaluation gives appropriate emphasis to the comparative analysis of options, especially the merits of support for co-located GP clinics relative to changes to MBS arrangements for after hours services provided in community settings.

How would changes in general funding arrangements help?

As noted above, the requirement for the Commission to provide advice regarding after hours care is seemingly in part to do with the intergovernmental fiscal implications associated with changes in the distribution of primary care services provided in community and public hospital settings.

Under the current delineation of funding responsibilities, the Australian Government subsidises the costs of care provided by GPs, whereas the States and Territories provide a primary care service through the emergency departments of their public hospitals (subject to the operation of the Australian Health Care Agreements).

The Australian Government's initiatives in relation to co-located GP clinics give effect to the principle, endorsed by CoAG in its recent communiqué (see chapter 1), that funds should follow function — specifically, through the allowance for these clinics to access Medicare rebates, even when they are established with support from the States.

Box 12.3 **Participants' views about co-located GP services**

A range of comments were provided regarding the effectiveness of after hours GP services near hospitals. Family Care Medical Services said that such services can reduce the call on emergency departments (sub. 28, p. 1). This view was also shared by the Australian Healthcare Association, which said that co-located GP clinics in particular:

> … will reduce waiting times for emergency treatment and may take some of the pressure off staff in hospital emergency departments. GPs co-located in hospital emergency departments could also be used to better co-ordinate care between the hospital and the community care setting. (sub. 151, p. 12)

It added that, if implemented with the involvement of all stakeholders, and restricted to providing care after hours:

> … co-located clinics have the potential to provide benefits to both patients and doctors. For example, clinics could support multi-disciplinary care by enabling GPs, emergency staff and nursing staff working together to provide the most appropriate form of care to patients presenting to emergency departments. (sub. 151, p. 12)

The South Australian Government similarly said that there are benefits to emergency departments from the arrangement, including better management of acute care patients (sub. 82, p. 16). Specifically, its trial of co-located GP clinics (as part of the After Hours Primary Medical Care Program), revealed that:

- between 29 and 35 per cent of low triage patients presenting at hospital emergency departments after hours could also be treated by a GP if the services were available;
- outcomes for patients seeing the GP were equivalent to those seen in the emergency departments; and
- waiting times for low priority patients were reduced, and the arrangement allowed for improved management of more acute patients.

While the service was not continued beyond its trial period, the South Australian Government recommended further national development of a sustainable model of after hours GP care in hospitals.

The Tasmanian Government further noted that convenience for consumers — both in location and operating times — is an important factor in the utilisation of such services. In terms of a particular after hours service in Hobart, it indicated that while:

> … not particularly close to the major hospitals, [the service] has been able to treat a range of cases which would otherwise contribute to workload in Departments of Emergency Medicine. ... The processes used, including screening arrangements, are estimated to have decreased the out of hours work of subscribing General Practitioners by 80 per cent, and contributed to the lower rates of usage increase for Hobart Emergency Medicine facilities than is the case in other jurisdictions. (sub. PP180, p. 9)

(Continued next page)

Box 12.3 (continued)

Others, however, pointed to shortcomings in the approach or raised questions about its effectiveness, particularly in terms of taking pressure off emergency departments.

For instance, the chairman of the NSW State Committee of the Royal Australasian College of Surgeons stated:

> In my own hospital, the concept of having a General Practice Unit within the Casualty Department was trialled some years ago and was an unmitigated disaster. However, I think the concept of providing incentives for groups of GPs to set up offices close to hospitals is a good idea. I think with adequate planning this could significantly improve the efficiency of the system with little cost. (sub. PP231, pp. 5–6)

And, while noting some diversion of emergency presentations to a new co-located GP clinic at the Northern Hospital — established under the Australian Government's recent expansion initiative — the Victorian Government said that recruitment of sufficient GPs has been an issue in establishing other clinics (sub. 155, p. 56).

The Australasian College for Emergency Medicine also raised the recruitment issue, alongside some other problems with the co-located service model:

> a. The numbers of patients diverted from EDs are low (often only 1-2 patients per hour maximum), often at a high marginal cost.
>
> b. Difficulties finding experienced staff, who are often paid at a premium (often 2-3x the cost of ED staff, with a lot less responsibility and skills).
>
> c. A proportion of patients will still need to be referred to the ED, reducing the efficiency. (sub. 76, p. 9)

And the Department of Health and Ageing similarly questioned the value of co-located GP clinics in taking pressure off emergency departments:

> Early evidence suggests that while these clinics can provide a practical model for after hours services, they are not having a significant impact on easing ED pressure. Depending on how they are established, there is also the potential for negative impacts on the existing GP after-hours workforce and it is therefore important they are set up in cooperation rather than competition with existing providers. Given that this model represents only one of a number of models currently being examined, the Department does not consider there to be a strong case for specific initiatives to encourage more co-located clinics at this time. (sub. 159, p. 50)

However, these initiatives will not be sufficient to deliver a fully efficient distribution of primary health care across public hospitals and community settings. People choose where to seek such care based on a variety of factors, including the range of available services and convenience of location. Hence, use of public hospitals will sometimes reflect ready access to X-rays and other diagnostic tests, as well as better public transport accessibility.

Cost is another significant influence and some patients will elect to use public hospital services largely or solely on the basis that services are provided free of

charge. In contrast, in a community setting, unless those services are bulk-billed, a charge will be incurred.

The precise impact of such factors on the distribution of primary care services provided across different settings is unclear. However, resolution of the associated intergovernmental fiscal implications of those choices, and pursuit of an efficient and effective distribution of services across community and hospital settings more generally, can only be properly addressed within reform of broader health funding arrangements.

12.2 E-Health

In recent years, there has been increasing use of E-Health technologies by many health care providers. These technologies, which broadly encompass specific health sector applications of information and computer technology (ICT), can involve data and information management — such as the storage, retrieval and linkage of medical records — as well as telehealth and telemedicine, and remote based education activities.

A number of participants commented on the potential for E-Health to play a greater role in the delivery of health services and facilitate improved workforce efficiency (some particular E-Health initiatives are outlined in box 12.4). Indeed, as discussed in chapter 10, the Commission was told by some that expansion of telemedicine could be a particularly effective means to improve access to services in rural and remote areas.

In its recent study, *Impacts of Advances in Medical Technology in Australia* (PC 2005d), the Commission similarly reported that there is significant scope for the health sector to derive greater benefits through E-Health. In addition to potential improvements to service access, the benefits identified by the Commission included administrative cost savings, lower transportation costs, diagnostic efficiencies and improvements to patient care — for example, through fewer errors, reduced adverse events and side-effects from drug interactions.

Many of these potential benefits derive from the capacity of E-Health to improve the efficiency and effectiveness of the health workforce — through, among other things, facilitating, greater workforce flexibility and better utilisation of different skill mixes. On the clinical side, for instance, telemedicine allows more complex health services to be accessed in the direct presence of less specialised health workers with advice provided by off-site practitioners via telecommunication links. The wider adoption of E-Health opportunities will, therefore, have obvious implications for the health workforce.

Box 12.4 **Some E-Health initiatives**

National initiatives

- National E-Health Transition Authority — an agency, jointly funded by all Australian jurisdictions — was established in 2005 with an initial three year program. Reporting to AHMAC, the role of the authority is to facilitate the establishment of national public E-Health foundations, by developing the specifications, standards and infrastructure necessary for an interconnected health sector.
- HealthConnect — a joint initiative of the Australian and State/Territory Governments — is to trial the gathering and sharing of patient health records and other related information through a dedicated network. The program will also incorporate a national electronic medication record system, MediConnect, which aims to improve medication management and reduce adverse events.
- The Australian Government also provides financial support to encourage broadband uptake — for example, to GPs (through its Practice Incentive Program), pharmacists and Aboriginal Health Services.

Telemedicine initiatives

The number of telemedicine facilities in Australia has increased markedly over recent years, funded largely by State and Territory Governments. For example, in NSW, the number of facilities increased from 16 in 1996 to over 200 by 2003 (PC 2005d, p. 508). Current telemedicine applications being used or trialled in Australia include:

- Telepsychiatry — the provision of psychiatric consultations using videoconferencing has become relatively widespread, mainly in State health systems. In 2002, telepsychiatry was included in the MBS schedule for rural and remote patients.
- Teleradiology — the transmission of digital radiography images between locations is being used at various sites to allow off-site radiologists to interpret images and report on these faster. Victoria has, for example, developed a microwave network to allow diagnostic images to be sent across the State. Potential future applications include mobile teleradiology mammography units.
- Telepaediatrics and teleobstetrics — a number of major metropolitan hospitals, for example the Brisbane Royal Children's Hospital, are providing specialist paediatric and obstetric services such as video-based consultations and teleultrasound programs in partnership with smaller regional hospitals.

Telehealth initiatives

Telenursing is a relatively new area of nursing practice involving the provision of nursing services by telephone, such as nurse triage, chronic disease management programs and mental health triage and case management. State and Territory health departments, the Department of Veterans' Affairs and health insurers are major users.

Sources: Professor Peter Brooks (subs. 51, 194); Chris Lewis (sub. PP202); McKesson Asia Pacific (sub. PP288) and PC (2005d).

In citing the potential future advantages of E-Health, the Commission observed that not only have ICT developments in general dramatically changed many other industries, but that the complexity and diversity of the health sector can make it particularly receptive to advances in these technologies. It further noted that Australia's current ICT spending in health, estimated at between 1 and 3 per cent of total healthcare costs, is proportionally lower than in many countries like the United States and the United Kingdom, where ICT expenditure comprises around 4 to 5 per cent of healthcare costs (PC 2005d).

Greater uptake of E-Health will, however, require that a number of impediments be overcome. For example, the technology can require considerable supporting infrastructure like broadband communication networks that enable video conferencing and high-speed data transfer. Health workers may also need to undergo extensive training to effectively use the technology. In addition, the implications of technology changes for professional regulation, medical indemnity, clinical protocols and privacy will need to be addressed.

To date, quantifying the overall benefits and costs of E-Health has proven difficult. One reason is that many E-Health applications are still in relatively early stages of development and, accordingly, more information is available on their upfront costs than on their recurrent expenditures and longer term (and often intangible) benefits. To some extent, this reflects the fact that previous E-Health activities have tended to be implemented in a 'localised, uncoordinated and fragmented manner' (PC 2005d, p. 484).

The latter observation highlights the importance of effective assessment procedures, trials and coordination in rolling out new investments in E-Health, especially if gains from the technology are to be fully realised. Indeed, this was a specific conclusion of the Commission's 2005 study on the impacts of medical technology:

> ICT developments have significant capacity to improve health outcomes in their own right, or by providing architecture for the development and diffusion of other medical technologies and more efficient and safer delivery of health services through greater connectivity. Realising this potential will require better upfront assessment, planning, coordination and more investment. (PC 2005d, finding 11.3)

Uptake of E-Health technologies will also depend on the degree of government support for this form of service delivery, including through the MBS. Notably, the provision of advice on such matters would be encompassed by the Commission's proposed review committee to assess requests to extend the coverage of the MBS (see chapter 8). And, as noted in chapter 10, the proposed workforce improvement agency would have a role in evaluating and facilitating emerging E-Health technologies — such as telemedicine and telehealth — as a potentially cost-effective means of delivering some health services.

That said, while these measures would undoubtedly assist in 'unlocking' some of the potential for E-Health to enhance service delivery, the technology will not, of itself, be a remedy for many of the problems currently confronting the health sector — such as widespread workforce shortages and fragmented work practices. For instance, at least in terms of its direct clinical applications, E-Health will rarely be as ideal as face-to-face consultations with suitably qualified practitioners. In recognising some of these innate limitations, the Centre for Remote Health said:

> We are cautious about recommendations in relation to use of telemedicine and robotic technology in the absence of adequate workforce in remote Australia. In other words, even if the ICT infrastructure were up to speed, these technological advances are welcome as an adjunct to appropriate numbers of appropriately trained health professionals, not as a substitute for them. (sub. PP212, p. 1)

And, in the context of providing some mental health services through telemedicine, the Australian Psychological Society cautioned:

> The potential for 'telemedicine' in the mental health area is limited. It carries the danger of over-reliance on use of prescription drugs as a ready electronic means of providing some help to a mentally disturbed client. … [Telemedicine] should not be seen as a means of replacing the human service deliverer but may be a very useful supportive aid. However they do not save money: they require development and tailoring to specific uses … [and require] significant start-up and ongoing expense. (sub. 118, p. 62)

But while E-Health does not represent a cure-all for the problems facing the health sector, it does form part of the menu of options for improving health care outcomes and making better use of the workforce across all parts of Australia.

12.3 The influence of policies in other areas

While this study is focusing on health workforce reform, policy settings in a range of other areas will have an influence on the efficiency and effectiveness of future workforce arrangements. Such areas include arrangements for medical indemnity, migration, taxation and superannuation.

Medical indemnity arrangements

Medical indemnity arrangements are an important influence on the health workforce — for example, affecting career choices and the distribution of health workers across the public and private systems.

They also affect workplace practices, such as servicing levels and substitution of clinical responsibilities across professional boundaries, as well as the delegation of

tasks to other suitably qualified health workers. As such, they may be an impediment to the emergence of new innovative models of care, especially those involving greater use of non-medical health workers.

Cost and availability concerns have been largely addressed

In response to concerns regarding the costs of, and ready access to, appropriate indemnity insurance for medical practitioners, there have been a number of recent policy measures. Some of these measures, primarily introduced by the Australian Government, have been designed to improve the availability and affordability of insurance, and security of coverage (box 12.5). Others, such as State and Territory tort law reforms, have sought to reduce the number and cost of claims through, for example, changes to caps and thresholds on damages, limitations periods and practitioner standards of care.

Box 12.5 **Medical indemnity policy initiatives**

Recent medical indemnity policy measures introduced by the Australian Government include:

- *Premium Support Scheme* — funds 80 per cent of eligible doctors' medical indemnity costs if these exceed 7.5 per cent of their gross income. Doctors eligible under the scheme are those in 'high-risk' specialties such as neurosurgeons, obstetricians and procedural GPs.

  For procedural GPs working in rural areas, the scheme funds 75 per cent of the difference between their premiums and the premiums for non-procedural GPs working in similar circumstances. (Some States also provide additional subsidies for premiums for higher risk specialties, particularly in rural areas.)
- *High Cost Claims Scheme* — funds medical indemnity insurers for 50 per cent of all insurance payouts that exceed $300 000, up to the limit of the practitioner's cover.
- *Exceptional Claims Scheme* — covers doctors for claims that exceed their level of insurance. From July 2003, doctors must have cover of at least $20 million for the scheme to apply.
- *Run-off Cover Scheme* — a reinsurance scheme backed by the Australian Government that provides cover for eligible doctors who have ceased practice, either permanently or on maternity leave. The scheme is funded by a charge on medical indemnity insurers, which is then passed on to doctors through insurance premiums.

Sources: MIIAA (sub. 62); DOHA (sub. 159); Victorian Government (sub. 155).

There is a widely held view that these reforms have largely fixed problems with the availability and affordability of insurance for doctors. For example, the Victorian Government said:

> In Victoria, concern over medical indemnity has been greatly diminished through a number of initiatives introduced by both the Commonwealth and State governments. Indemnity is now less likely be a major factor in preventing practice, particularly for those practitioners working in rural locations. (sub. 155, p. 35)

In addition, the MIIAA commented:

> … the industry is sustainable, collecting enough capital to satisfy all future claims on a vigorous actuarial model.

It also noted, in relation to the costs of insurance, that:

> Premiums for medical indemnity cover have risen on average 245 per cent over the nine years to June 2004. In the last two years, since the majority of reforms, premiums have decreased. (sub. 62, p. 11)

Improved sustainability of medical indemnity insurance arrangements was further indicated in a March 2005 review of the competitive neutrality of government assistance to those providing such insurance (Rogers 2005). The review concluded:

> In March 2005, it is clear that the sum total of all the initiatives introduced by both state and federal governments, the oversight of the regulators, APRA and the Australian Competition and Consumer Commission (ACCC) and, most importantly, by the medical indemnity industry itself, has brought the industry back to a state of health surprisingly quickly. (Rogers 2005, p. 5)

But other problems remain

However, there are concerns that indemnity arrangements are presenting problems in other areas of the health workforce. For instance, the Australian College of Midwives said that affordability pressures are restricting the effective utilisation of private midwives in hospital settings:

> Without access to medical indemnity (since a market failure in mid 2001) private midwives have been unable to gain visiting access to hospitals, so when they make the decision to transfer one of their clients to a hospital, they cease to be able to provide professional care to the women once they enter the hospital. Given that private midwives in Australia (currently numbering less than 2% of the midwifery workforce) are often among our most experienced and capable health professionals, with robust records of safe practice, this situation is undesirable for consumers and inefficient. (sub. 99, p. 29)

Moreover, recent policy attention and reforms do not directly tackle the issue of 'defensive medicine'. Not only can the practise of defensive medicine generate

workforce inefficiencies and wasteful service provision, but it can be counterproductive to an open evaluative culture within the health care sector — possibly hindering an openness to determine whether clinical errors occurred and why. Furthermore, the perceived need to engage in defensive medicine may still be playing a role in distorting career choices and aggravating shortages in certain disciplines.

As well, arrangements for medical indemnity may be adversely impacting on clinical training. A particular concern is that current arrangements are restricting the provision of clinical training in private hospitals and other private health care settings (see chapter 5).

The Medical Indemnity Industry Association of Australia (MIIAA), however, downplayed this particular concern, stating:

> Medical indemnity insurers in Australia have generally recognised the issues of indemnity for training both in terms of coverage and cost and addressed them, and offer policies which are readily available and cost effective to support training provision in the private sector. (sub. 62, p. 6)

Nevertheless, the Department of Education, Science and Training said that:

> … in a number of States the cost and availability of indemnity insurance for students and supervisors is emerging as an issue contributing to skills shortages in the health workforce. (sub. PP181, p. 11)

The Commission is not aware of information establishing the scale of such problems or the significance of their associated costs — through, for example, encouraging wasteful practices or constraining workforce productivity. Further evaluation of these issues is therefore required. In this regard, there could be value in the Australian Government commissioning an independent review of broader medical indemnity arrangements, including the benefits and costs of extending coverage of government indemnity insurance schemes.

Immigration arrangements

In view of the increasingly global environment for health workers, overseas trained health professionals are likely to continue to play an important role in Australia's health workforce. While concerns exist about over-reliance, appropriate use of such workers can have significant benefits, including through the transfer of valuable skills and experience (chapter 3).

Hence, there is a requirement for policy settings that facilitate the timely immigration and cost-effective deployment of overseas trained health workers. This

is particularly important for rural and remote areas where there is a greater reliance on these workers.

There have been a number of recent initiatives to facilitate the timely intake of overseas health professionals. These include:

- addition of many health professions to the Skilled Occupations List, allowing permanent entry through the General Skilled Migration Scheme (see box 12.6);
- permitting overseas medical students to remain in Australia as interns and to seek permanent residency; and
- for medical practitioners, streamlined examination arrangements through the Australian Medical Council (sub. 178, pp. 41–42).

It has, however, been argued by some that entry procedures for overseas health professionals are complex and could be simplified. For example, the NSW Government said:

> … there are many challenges identified with the process of recruiting and using overseas trained doctors including dealing with government departments and recruitment agencies, helping overseas trained doctors adapt and learn about the Australian health system and dealing with variations in skill levels and supervision requirements. In order to better meet the needs of health services and individuals reliant on overseas trained staff, a number of enhancements need to be made. (sub. 178, p. 42)

Also, the Department of Immigration and Multicultural and Indigenous Affairs (DIMIA) commented:

> It is possible that the hurdles and complexity presented by [Australia's] accreditation system may prove discouraging to many applicants. (sub. 11, p. 3)

The Commission is not in a position in this study to assess such claims and what, if any, specific response might be required. However, the proposed reforms to accreditation and registration arrangements, discussed in chapters 6 and 7, could help to address the concerns raised by DIMIA. Specifically, the Commission is proposing that an overarching national accreditation board be established which would have responsibility for developing a national approach for assessing the education and training qualifications of overseas trained health workers. It has also recommended the creation of a single national registration board that would lock in national standards based on requirements established by the accreditation agency, and simplify the registration requirements for health professionals practising across different States and Territories.

Box 12.6 **Visa categories for health professionals**

Overseas health professionals can access a range of visas to gain entry into Australia on either a permanent or temporary basis. The main categories include:

- Permanent skilled migration — available through the General Skilled Migration Scheme or programs requiring sponsorship from employers (for example, the Employer Nomination Scheme and Regional Sponsored Migration Scheme).
- Temporary migration — under the Temporary Business Entry (Long Stay) or Temporary Medical Practitioner visa programs.

Health workers applying to migrate through the skilled migration stream need to satisfy, as part of a broad points based system, professional skill requirements and work experience. These are typically assessed by relevant accreditation or registration bodies such as, for medical practitioners, the Australian Medical Council, and for nursing, the Australian Nursing and Midwifery Council. There are also entry requirements covering age and English language proficiency.

Certain categories of sponsored migration, however, may have somewhat different requirements, such as those for temporary resident doctors (see box 6.5).

Source: DIMIA (sub. 11, pp. 1–2 and www.dimmi.gov.au).

Other relevant policy settings

Other policy arrangements likely to have a significant impact on the health workforce include general labour market arrangements, such as those relating to industrial relations, which may variously help or hinder some specific health workforce reforms.

And, further to these, taxation policies will have an influence on the recruitment, participation and retention of health workers, as they do on the broader workforce. Of particular relevance are Fringe Benefits Tax exemptions available to health professionals in the public system. As discussed in chapter 10, some State Governments sought an extension to these arrangements to promote the recruitment and retention of health workers in rural and remote areas.

In conjunction with taxation arrangements, policies for superannuation will similarly affect participation incentives — influencing the timing of exits from the health workforce, as well as the opportunities for older health workers to continue to contribute in a part-time capacity.

And finally, in a broader sense, reforms to enhance the efficiency of Australia's transport and communications infrastructure will help to improve access to health services in rural and regional Australia in particular.

13 Our proposals in practice

Key points

- The Commission has mapped out an integrated and coherent reform plan premised on a need to:
  - maintain the provision of high quality and safe health care;
  - adopt a whole-of-workforce perspective;
  - recognise the interdependencies between the different elements of the health workforce arrangements and ensure that they are properly coordinated;
  - establish effective governance arrangements for institutional and regulatory structures; and
  - ensure that services are delivered by staff with the most cost effective training and qualifications to provide safe, quality care.
- Taken together, the Commission's package would:
  - drive reform to scopes of practice, and job design more broadly, while maintaining safety and quality;
  - deliver a more coordinated and responsive education and training regime for health workers;
  - underpin accreditation and registration arrangements with nationally consolidated and coherent frameworks; and
  - provide the financial incentives to support access to safe and high quality care in a manner that promotes innovation in health workplaces.
- Establishing good governance structures and practices will be crucial to the success of the proposed reforms.
  - Of particular importance is the constitution of boards which, while providing the appropriate expertise, should be small, focused and structured to reflect the broad public interest.
- The proposed new national entities should operate separately — though with strong linkages. However, it is the proposed functions for those entities along with good governance structures, rather than their precise organisational configuration, which are critical to achieving better health workforce outcomes.
- Effective evaluation of policy initiatives will also be a critical part of the reform process, supported by a suitably comprehensive information base.
  - To facilitate such evaluation, the Commission intends to continue its work on developing robust measures of productivity in the health sector.

To address the systemic impediments to a more efficient, effective, sustainable and responsive health workforce, the Commission has mapped out an integrated and coherent reform plan premised on a need to:

- maintain the provision of high quality and safe health care;
- adopt a whole-of-workforce perspective;
- recognise the interdependencies between the different elements of the health workforce arrangements and ensure that they are properly coordinated;
- establish effective governance arrangements for institutional and regulatory structures such that decision making processes are objective, informed by appropriate expert advice, transparent and reflect the public interest; and
- ensure that services are delivered by staff with the most cost effective training and qualifications to provide safe, quality care.

Its proposals encompass all of the linked sequential health workforce processes and arrangements, namely:

- workplace change and job innovation;
- health education and training;
- accreditation and professional registration;
- funding and payment arrangements; and
- quantitative projections of future workforce requirements.

They involve a mix of financial and other incentives to encourage desirable change and some new institutions and processes that would alter and enhance the way that decision making occurs in key health workforce policy areas. In this latter regard, the Commission has proposed an advisory health workforce improvement agency, an advisory health workforce education and training council, a consolidated national accreditation regime for health workforce education and training, a national registration board covering all registrable health professions, and an independent standing review committee to advise on the coverage of the MBS and related matters.

Detailed policies and programs developed within these new arrangements would directly influence the deployment of both new and existing health professional groups. One aim of this chapter is to illustrate the process by which this would occur. Using an example — the introduction of a new type of health practitioner — the key processes and decision points affected by the Commission's proposals are highlighted and contrasted with current arrangements. The chapter also discusses some important facilitators of successful reform and some requirements for the effective evaluation of policy initiatives.

13.1 Processes influencing workforce deployment

Figure 4.1 earlier depicted a number of processes that influence the deployment of health professionals, including design of education and training courses, accreditation of courses, registration of professionals and funding and payment of health workers. With the addition of the institutional arrangements associated with each step, figure 13.1 below highlights some of the shortcomings in current health workforce arrangements and the changes to these arrangements that are proposed by the Commission.

13.2 How the proposals would work

Over the course of this study, participants have described a number of specific opportunities for job innovation (see chapter 4). Some submissions suggested the introduction of new types of health practitioners. For example, the Northern Rivers University Department of Rural Health identified a need for a 'rural primary health care worker' who would focus on disease prevention and health promotion:

> A clearly defined training pathway could stream people after core training into a variety of workforce models such as a General Practice PHC worker, or a health educator community development type worker, through modules including health screening, health promotion, population health, community development, and basic triage. (sub. 152, p. 13)

The Australian Council of Deans of Health Sciences argued that:

> Developing generic training pathway and credentialing options for a broad range of Australian health graduates to function as an Australian equivalent of the Physician Assistant ('Clinical Associate') has a number of attractions…'. (sub. 67, p. 8)

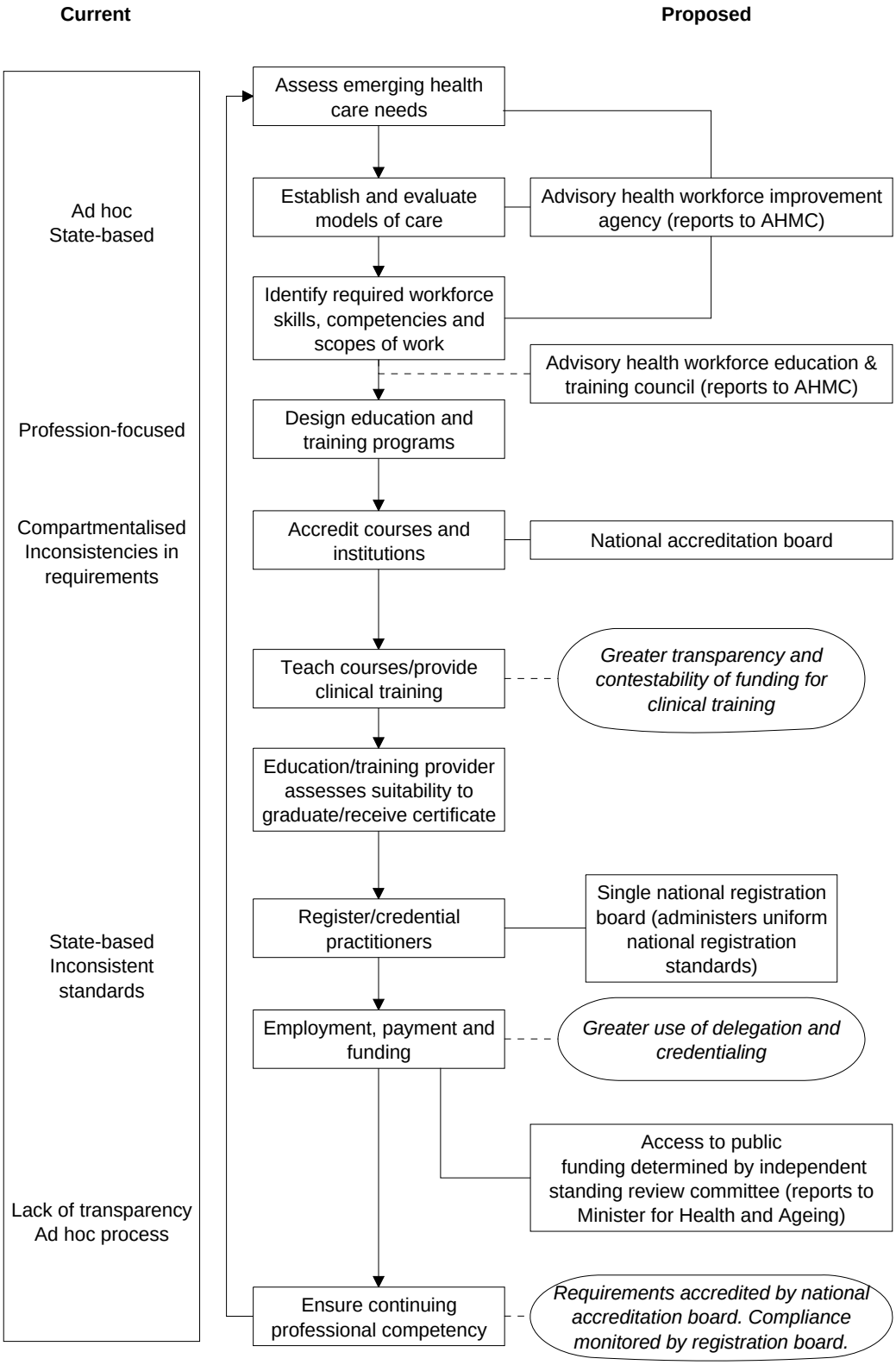
And the recent Queensland Health Systems Review suggested the possible development of radiographer practitioners, following the nurse practitioner model (QHRS 2005, p. xxxvi).

Several submissions also canvassed the potential for extensions to the scope of practice of existing professional groups. For instance, the Australian Physiotherapy Association recommended that enhanced scope physiotherapy practitioner roles be formalised:

> These roles facilitate workforce substitution and allow physiotherapists to fully employ their clinical reasoning abilities. They reduce the pressure on the specialist doctor workforce, reduce the number of consultations a patient has before receiving an intervention, and provide career paths …
>
> These roles are being trialled in some Australian hospitals, which is a positive step, but there are some barriers to the wide-scale development of these roles. (sub. 65, p. 6)

Figure 13.1 **Workforce deployment**

Current issues and proposed institutional arrangements



And the Pharmacy Guild of Australia noted the potential for an increased role for pharmacists in medication management:

> A study currently being undertaken and nearing finalisation … explored a number of models by which pharmacists could be involved in medication continuance programs …
>
> … current Australian prescribing arrangements do not fully meet the needs of the community in terms of timely, cost effective and convenient access to prescription medicines.
>
> The draft report … sees efficiency gains that can be achieved through a better use of pharmacist and medical practitioner time and a more streamlined approach to medication management. (sub. 165, pp. 14–15)

While the Commission is not in a position to endorse any of these specific suggestions, they are fertile ground for the proposed workforce improvement agency, in exploring ways to facilitate workforce innovation.

For the purposes of this discussion, it is instructive to look at the roll-out of nurse practitioners, the best recent example of a recent 'new practitioner' in Australia. As outlined in chapter 4, nurse practitioners are nurses with advanced educational preparation who may prescribe medications, initiate diagnostic investigations and refer patients in accordance with clinical guidelines. The concept was originally aimed at augmenting the rural health workforce, although over time the range of clinical settings open to nurse practitioners has increased. Table 13.1 compares the process under the new regime proposed by the Commission with the process that actually took place.

The table illustrates several areas where the Commission's proposals would have made an important difference to the process of implementing nurse practitioners in Australia. The first relates to the speed and coordination with which the concept was investigated and adopted. While the State-based reviews produced a variety of evaluative material relating to different nurse practitioner roles, this material could have been better used and roles implemented earlier, had there been a greater level of coordination and a core body providing impetus to the task. The second area of difference is that the accreditation of education and training, and registration of nurse practitioners, would be undertaken nationally, avoiding the fragmentation evident today. A third difference relates to nurse practitioners' scope of practice — under the Commission's proposals, a more transparent process would have taken place to assess the appropriate level of access for nurse practitioners to the MBS and PBS.

Table 13.1 **Differences at a glance: the case of nurse practitioners**

Roll-out under current and proposed arrangements

Process	*Current*	*Proposed*
Evaluation	Undertaken on a jurisdictional basis over an extended period of time. No transparent, objective, national assessment.	AHMAC would consider the concept and the improvement agency would undertake a benefit-cost assessment, focusing on the potential for it to increase the efficiency and effectiveness of the health workforce.
Assessment	Decisions about roll-out are undertaken independently by each jurisdiction. Process not transparent.	Based on the agency's public report, AHMC would decide whether to facilitate the roll-out on a national basis.
Designing education and training	Curricula are designed by individual education providers in each jurisdiction, in consultation with the peak nursing bodies and relevant nursing board. Course development is profession-focused.	Curricula design would remain the responsibility of universities etc. The advisory health workforce education and training council may provide input, particularly in relation to the potential for any interdisciplinary training.
Accreditation	Education programs for nurse practitioners are accredited by Nurses Boards in each jurisdiction.	The national accreditation board would be responsible for accreditation of courses and institutions based on a uniform set of requirements for the delivery of nurse practitioner courses (but not uniformity in courses), and a nationally consistent level of competency required by graduates.
Regulation	Nurse practitioners are registered on a jurisdictional basis. Each jurisdiction formulates its own description of the core role of the nurse practitioner and the core competency standards required.	The national registration board would automatically accept qualifications accredited by the national accreditation agency, and assess applicants on character, experience and completion of professional development requirements.
Scope of practice	The scope of practice within a designated area or position is governed by position-specific clinical protocols (credentialing).	Codes of practice and guidelines might be drawn up by the nurses' professional panel of the registration board to help define appropriate scopes of work. Credentialing would continue.
Accessing the MBS and PBS	Nurse practitioners are not able to access the MBS or the PBS. The processes for reviewing this status, and the criteria that would need to be met, are not transparent.	Drawing on the recommendations of the workforce improvement agency, the independent standing review committee would assess the benefits and costs of allowing nurse practitioners access to the MBS and prescribing rights under the PBS. It would provide recommendations to the Minister for Health and Ageing, and its report would be made public.
CPD	CPD requirements are the responsibility of the relevant registration board. However, the ANMC may develop national requirements.	CPD requirements would be accredited by the accreditation agency, with the national registration board ensuring compliance.

13.3 The benefits would be considerable

The preceding discussion illustrates the benefits that are likely to arise from a coordinated, whole-of-workforce approach to health workforce policy making, that is supported by rigorous, transparent and independent evaluation of policy alternatives. Such characteristics are at the heart of the new set of arrangements that the Commission is proposing.

Accordingly, the Commission expects that its package of proposals would considerably enhance the efficiency and effectiveness of health workforce arrangements in Australia and facilitate adjustment to the significant demand and supply pressures that will emerge in the years ahead. In particular, the Commission sees its package as:

- driving reform to scopes of practice, and job design more broadly, while maintaining safety and quality;
- delivering a more coordinated and responsive education and training regime for health workers;
- underpinning the accreditation of health workforce courses and providers and the registration of health professionals with nationally consolidated and coherent frameworks; and
- providing the financial incentives to support access to safe and high quality care in a manner that promotes, rather than hinders, innovation in health workplaces.

13.4 Facilitating the reform process

The proposals put forward by the Commission entail some major changes to the institutional framework for the health workforce. Care needs to be taken to ensure that the potential benefits of these changes are not diluted or lost through poor implementation. Some important ingredients of a successful reform effort are outlined below.

Governance

The reforms proposed by the Commission will not be successful unless accompanied by good governance structures. In their absence, the institutions created could become blockers rather than facilitators of reform, and could introduce further barriers to improved efficiency and effectiveness in the health workforce.

In essence, good governance is the exercise of authority with transparency, accountability, and integrity. As part of this, governance structures must also have legitimacy and possess the power to drive change.

There are a number of good governance practices that can help reduce the risk that reform progress will be frustrated by particular interest groups or by the unwillingness of the architects of previous arrangements to address mistakes. These include:

- a degree of separation between policy making and policy administration;
- a degree of separation between policy making and the responsibility for monitoring the implementation and impacts of major policy changes;
- a core management group with the necessary range of expertise to effectively undertake the functions involved, and of a size that allows for effective decision making;
- the engagement of interest groups and use of their expertise, but within a context where those groups do not generally have a predominant role in determining broad policy settings;
- rigorous processes for the appointment of board/panel members;
- clear lines of accountability and transparent processes for monitoring and measuring outcomes;
- public disclosure of key decisions and supporting analysis; and
- effective evaluation (see section 13.5).

Following the release of the Commission's Position Paper, several participants emphasised the importance of establishing good governance structures for the proposed institutions and supported a strong degree of independence from political pressures and vested interests (box 13.1). Some participants suggested that governance structures similar to that of the Productivity Commission would provide the appropriate separation from government and professional influences.

The constitution of boards for the new bodies proposed by the Commission was considered to be of particular importance. A number of participants agreed that membership should be on the basis of expertise, rather than representation of a particular profession or group. Under such an arrangement, board members would be appointed for their qualifications and experience in such areas as health, finance, management and education, with the mix and range varying across the bodies according to their functions and tasks. Importantly, there would not be explicit representation of any or every professional/educational interest. While many groups indicated in their submissions that they would seek specific representation for their

members, the Commission considers that expertise-based boards would be preferable and does not support profession-based membership.

Box 13.1 **Views on governance**

The Queensland Government noted the importance of governance arrangements as a facilitator of change. It commented:

> Key to the success of [the Commission's proposals] will be the capacity of all stakeholders to set aside vested interests and act in the public interest in formulating governance arrangements. (sub. PP325, p. 6)

Similarly, the NSW Government said the internal governance of the proposed agencies:

> … will also need to provide for engagement of professional organisations and specialty colleges in a way that supports innovation over professional protectionism. (sub. PP352, p. 5)

And a joint submission from State and Territory Health CEOs considered that:

> … overriding principles about the governance of any new bodies created at a national level should include:
>
> - membership representative of all jurisdictions (and community interests where relevant)
> - actions implemented through an identified national decision making forum
> - support provided by an independent secretariat with adequate resources
> - a clear focus of effort on areas where national cooperation is required
> - the priorities of the participating jurisdictions are to be reflected in work and directions
> - new governance bodies only being established after considering opportunities to abolish or amalgamate any relevant existing bodies
> - meaningful engagement with health occupational groups to support innovation and a future sustainable, quality health workforce. (sub. PP332, p. 5)

Jurisdictional representation on the boards of the proposed bodies should follow a similar expertise-based selection process. While the interests of jurisdictions should be reflected, two or three representatives, selected on the basis of their expertise and grasp of jurisdictional issues, should be adequate.

Effective engagement of consumers was mentioned by a number of participants as vital for the success of reforms. On the one hand, the activities of the proposed bodies need to be well informed about patient needs and concerns. Equally, greater understanding by consumers and/or their representatives of the limits on the capacity of governments to subsidise health services, the importance of preventive health activities, and the possibilities for a higher level of self-management of conditions, would all help to reduce pressures on the health system and support necessary changes to the way health care is delivered. As such, consumer interests should be reflected within board membership.

In the interests of effective decision making, the overall size of boards needs to be small and focused. For example, in the recent *Review of Future Governance Arrangements for Safety and Quality in Health Care*, it was recommended that the current Australian Council for Safety and Quality in Health Care be succeeded by a smaller body, comprising eight or nine people, led by an independent Chair (Paterson Review 2005, p. x). The Review also considered that board membership should be expertise-based:

> ... It must incorporate a mix of skills which will allow it to translate expert knowledge on safety and quality across the continuum of care into feasible recommendations to Health Ministers. The size of the body must be small enough to focus its energy on key outcomes and support timely decision-making. …
>
> The essential features of the new safety and quality body … are:
>
> - a small body of 8 or 9 members with skills in health systems improvement and corporate governance …
> - A full-time CEO, capable of engaging government and non-government organisations at a senior level, and an expert office;… (Paterson Review 2005, pp. vi-vii)

It is also important that there are adequate linkages between the proposed bodies, to ensure that their collective activities mesh well together in improving the efficiency and effectiveness of the health workforce. The establishment of formal information exchange networks, and the proposed reporting requirements, should help to reinforce such a coordinated and cohesive approach to health workforce issues.

Of course, one size 'does not fit all', and governance arrangements will need to be tailored to particular circumstances. However, the broad principles outlined here will set a robust foundation for any institution. With good governance arrangements in place, the Commission's suite of proposals should enhance the current institutional frameworks and processes, rather than adding new layers of bureaucracy. To be most effective, the Commission considers that the new national entities should operate separately — though with strong linkages. That said, it is the proposed functions for those entities along with good governance structures, rather than their precise organisational configuration, which are critical to achieving better health workforce outcomes.

Other important facilitators of successful reform

Australia's two decades of successful microeconomic reform provide important insights into broad factors that can help to both progress reform and ensure that the reforms are in the best interests of the community as a whole. Though the health care sector is very different from many other parts of the economy that have

undergone reform programs, several of the lessons learned are nonetheless applicable. Indeed, given the diverse range of entities involved across the health workforce arrangements, and the pervasive nature of government intervention, some of these facilitators will arguably be more important than in less complex areas.

Clear objectives

Successful policy reform requires agreement among key stakeholders on: the problems with the current arrangements that must be addressed; the objectives of the reform program; the strategies to be implemented; and a pre-agreed evaluative framework to assess the level of success and any need for strategy modification.

Collaboration, cooperation and leadership

As National Competition Policy has highlighted, where more than one level of government is involved in an area, a collaborative and coordinated approach will often deliver much better outcomes than can be achieved through individual governments acting independently. So too will collaborative effort between different areas of government involved in a particular policy area. As outlined above, facilitation of such collaboration and cooperation is one of the advantages of the more 'active' approach to reform which the Commission is proposing in a number of areas.

Effective consultation and engagement with those directly affected by a reform process is also important in engendering support for reform, or at least reducing resistance to change, as well as in developing consensus on specific reform directions.

Finally, while collaboration and cooperation are crucial there must also be strong leadership of the reform process, especially at government level. As John Menadue remarked in his submission:

> I am sure that workforce reform requires, most of all, courage by health ministers, governments and senior officials to face down the powerful vested interests that oppose reform of the workforce and want to protect their privileged positions. Ministers, governments and officials must win the case for change and drive the process. (sub. 149, p. 3)

Good regulatory practice

As the work of the Office of Regulation Review has shown, it is important that the need for regulation, and the nature of that regulation, is determined within a framework that fully assesses costs as well as benefits (see box 13.2).

Box 13.2 **Good regulatory principles**

Some costs are unavoidable if regulation is to meet its objectives. However, these costs are likely to be kept to a minimum if governments follow good regulatory principles (PC 2003c, 2004):

- The need for regulation should be clearly established and linked to particular objectives that government is seeking to pursue.
- Regulation should only be employed where less intrusive means of pursuing those objectives are unlikely to be successful.
- Regulation should only be introduced after a rigorous assessment of its benefits and costs and those of alternative approaches.
- Where regulation is employed, it should be designed to achieve its goals effectively and at least cost. It should also minimise the risk of unwanted side effects.
- Regulation should be clearly communicated.
- Regulation should be enforceable and consistent with other laws.
- Existing regulations and policy programs should be periodically reviewed in a transparent fashion to ensure that they continue to achieve their objectives in an efficient manner.

Red-tape reduction

As part of a drive to reduce the burden of regulatory activity, the Australian Government recently appointed a taskforce to undertake a 'red tape review'. The taskforce is to:

- identify specific areas of Commonwealth Government regulation which are unnecessarily burdensome, complex, redundant or duplicate regulations in other jurisdictions;
- indicate those areas in which regulation should be removed or significantly reduced as a matter of priority;
- examine non-regulatory options (including business self-regulation) for achieving desired outcomes and how best to reduce duplication and increase harmonisation within existing regulatory frameworks; and
- provide practical options for alleviating the Commonwealth's 'red tape' burden on business, including family-run and other small businesses (Howard and Costello 2005).

With its broad remit, the findings and recommendations of this review are likely to be no less relevant in the health workforce area than in other sectors of the economy. The taskforce will report by 31 January 2006.

Harnessing competition and market disciplines

The characteristics of health care, including extensive government intervention in the sector (see chapter 1) constrain the scope to give competitive market forces free rein, relative to markets for most other goods and services. But there are opportunities for competition or market-style instruments to play a greater role in facilitating cost-effective health service delivery — even where those services continue to be heavily subsidised by governments.

Reducing resistance to change

Even reform programs that offer the prospect of major benefits for the wider community will inevitably impose costs on some. Managing and reducing the resultant resistance to reform will be particularly important in the health workforce area, given the potential ramifications of reform for the status, incomes and workloads of some health professionals, and the power of particular regulatory bodies, for example. As well as engaging effectively with the health workforce and the wider community about the need for and nature of reform, governments can also reduce opposition to change by dealing with transitional issues up front, and, as far as feasible, pursuing reform on a broad front.

In considering the case for change, it will therefore be important to undertake sound, evidence-based evaluation of the costs and benefits of alternatives to current arrangements. Such evaluation will necessarily include the impacts, if any, of reform options on the safety and quality of health services. While safety and quality issues are obviously of paramount importance in the health area, effective evaluation will ensure that they are not used inappropriately as a shield to protect existing interests.

A supportive workplace culture

The benefits of changes to institutional structures and regulations can be negated if customs and practices within the workplace are not supportive of the changes and the outcomes they yield. For example, relaxing traditional role delineations, where this is required for more effective and efficient use of the health workforce, may be difficult if workplace cultures continue to support a compartmentalised style of working. Indeed, the Northern Territory Government stated:

> Workplace culture underpins this delineation of roles that impedes the development of interdisciplinary education, training and practice and the development of new models of care. (sub. PP182, p. 21)

The Queensland Government similarly noted the importance of an organisational culture that facilitates effective service provision in the health system, suggesting that government policy can have a positive impact in transforming a dysfunctional workplace culture, through:

> … the recruitment, development and professional support of effective workplace leaders; focused team building in an atmosphere of trust and cooperation; the promotion of an atmosphere of trust between staff and managers; a fair and effective grievance process; ongoing monitoring of organisational culture; and an emphasis on accountability. (sub. PP325, p. 8)

And in commenting on the importance of workplace culture in the reform process, the Western Australian Government said that one of the 'levers' for developing a sustainable workforce is:

> … the development of a workplace culture that has: a system wide focus on promoting better health and good health care; an environment of transparency, value, trust and learning through value-based leadership and creativity; a collaborative, friendly and supportive environment based on mutual respect. (sub. 179, p. 19)

13.5 Facilitating effective evaluation

As emphasised at various junctures in this report, effective evaluation of current and future initiatives in the health workforce area will be a critical part of the reform process. Amongst other things, sound, evidence-based evaluation of the costs and benefits of current arrangements and alternatives to them will:

- provide the basis for identifying what new specific approaches that have been successful at a local level (or in other countries) are most likely to improve the efficiency, effectiveness, safety and quality of Australia's health workforce arrangements as a whole;
- shed light on changes or augmentations to these approaches which could further increase the benefits for the community; and
- point to traditional approaches which have become less relevant or effective as the health system and the role of the health workforce has evolved.

Moreover, effective evaluation can potentially be a powerful tool for reducing the scope for interest groups to use uncertainty about the precise impacts of mooted change as a means of frustrating worthwhile initiatives.

However, despite its importance to good policy making, and its role in lending impetus to reform, soundly-based evaluation of policies and programs has not generally been a hallmark of this sector.

Not surprisingly, therefore, more effective evaluation was seen by most participants to be a key component of the governance regime for future health workforce arrangements. The Melbourne Institute and University of Melbourne Department of Economics said:

> The strengthening of the evidence-base is fundamental in ensuring that the most cost-effective policies are implemented and value for money obtained. …
>
> [Better data] would provide:
>
> - a valuable resource for government to monitor and evaluate key policy changes,
> - strengthen the knowledge on which policy and practice are developed, and
> - lead to demonstrated improvements in the efficiency and equity of the health care system. (sub. PP278, pp. 1–2)

Several of the Commission's proposals have a strong evaluation component to them. For example:

- Evaluation of better ways of doing things is at the core of the roles of the proposed workforce improvement agency, the health education and training council and the committee to advise on possible extensions of access to the MBS.
- The Commission has proposed a major cross-program evaluation exercise to establish which approaches for boosting access to health workers in rural and remote Australia are likely to provide best value for money.

More broadly, it has also emphasised the need for better data and research to support the evaluation process (see section 9.3).

Measuring productivity in the health sector

In this latter context, the Commission has been particularly cognisant of the lack of good data on the productivity of Australia's health workforce and in the health system more generally. In other sectors of the economy, access to such productivity data has provided the platform for much of the identification and subsequent evaluation of reform initiatives. Moreover, it has also offered a means of illustrating the magnitude of the gains that reform can bring and thereby helped to garner support for necessary change within the community. In recognition of these roles, AHMAC (sub. 166, p. 11) emphasised the need to collect the information required to support both productivity analysis within the health sector and comparisons between the sector and other parts of the economy.

To this end, as an input to both this study and its wider work program, the Commission has been examining what would be involved in developing robust

measures of productivity in the health sector and what data and information would be required to support such measurement. That analysis has been informed by consultations with key practitioners in the area, including the Australian Institute of Health and Welfare (AIHW), the Department of Health and Ageing and the ABS. A summary of what has emerged from this analysis follows, with a more detailed progress report provided in appendix C.

Key themes and findings from the Commission's work

Measuring current productivity levels in the Australian health sector, how productivity is growing over time, and the contribution of the health workforce to that growth, raises a number of significant conceptual and practical challenges. These are over and above the usual difficulties encountered in separating out the range of influences on the value of a sector's output, properly accounting for quality change, or attributing productivity growth across labour, material and capital inputs.

First, the economic framework underpinning conventional productivity analysis has been developed for situations where the goods and services involved are marketed on a commercial basis. Hence, through reference to market prices, the value of these goods and services can be established independently of the value of inputs.

In contrast, many health services are provided at heavily subsidised rates or even free of charge, with quantities consumed heavily influenced by deemed medical need rather than willingness to pay, as well as by various rationing devices to contain the budgetary costs for government and to guard against over servicing.

In the absence of price-based measures of the value of health services, proxy measures must be used, typically linked to service provision costs. But this in turn means that changes in unit costs will have a direct and potentially proportional impact on the value of output, making it difficult to separate genuine productivity improvement from increases in unit costs.

Second, though there is a large body of information available on health sector outputs, the health workforce and health care expenditures, that information is disparate and far from comprehensive. Indeed, the comments made by the AIHW in relation to the suitability of data available to project future workforce requirements are similarly germane in a productivity measurement context:

> The inventory of data sources … provides information on many [relevant] features. But the information base is far from ideal:

- it must be patched together from a variety of sources, which are not based on consistent concepts — so judgment or synthetic methods must be invoked to construct the data needed for policy design and evaluation;

- some key segments of the workforce are unmeasured or poorly measured or suffer from significant problems of data quality;
- some data that are important for policy design and evaluation are available only with a long time lag. (sub. 58, p. 4)

More specifically, current data sets do not provide the sort of integrated measures of health sector outputs and inputs needed to support robust measurement of sectoral productivity or the productivity of the health workforce. Factors that limit the usefulness of current information for this purpose include:

- the quantification of health sector outputs in ways that emphasise processes and process costs (such as expenditure on diagnostic and clinical procedures and 'separations');
- the resulting absence of measures that indicate how the quality of output is changing over time and how valuable the outputs are from the point of view of the consumer; and
- the absence of comprehensive information on the inputs, appropriately classified to items of a similar character (labour, materials, capital etc) and types of health-service activity.

Reliance on these imperfect data sets could lead to quite misleading assessments of trends in health sector productivity. For example, technological change has seen the treatment of cataracts transformed from a procedure requiring hospitalisation with frequent complications, to one routinely performed in outpatient settings, with fewer complications and improved post-operative visual quality (Shapiro, Shapiro and Wilcox 2001). But the use of simple incidence-based indicators of output — such as numbers of patients treated for cataracts — would fail to capture this significant increase in quality-adjusted output levels.

Against this backdrop, and as a first step in developing robust and 'cost-effective' productivity measures in the health workforce area and the health sector more generally, the Commission has developed a set of measurement 'design principles'. These principles, which draw on a recent UK study into the measurement of productivity in the government services area (Atkinson 2005), would also provide the basis for developing the supporting data collections.

Specifically, the Commission considers that measures to support the quantification and evaluation of the productive contribution of the health sector to national output and the wellbeing of the community should:

- be based on independent measures of outputs from, and inputs to, the health sector;
- allow for quality differences between outputs and inputs and the incremental contribution of changes in quality to outputs and inputs;

- be comprehensive and inclusive of preventive, curative and management health services;
- be measurable and capable of being applied consistently across different health sector activities and aggregated to broad sectoral indicators of performance;
- maintain an output focus and avoid concentrating on component care processes, procedures and ancillary services;
- avoid creating adverse incentives for health workers, or for administrative or ancillary staff;
- be capable of evolving over time as medical technology, ways of working and outputs change;
- avoid unnecessary compliance costs for service providers and governments; and
- be compiled in a clear and transparent manner according to methods that are made available for evaluation.

Some specific uses for future productivity estimates

The Commission will continue to work with the AIHW, the Department of Health and Ageing, the ABS and other key stakeholders with a view to collecting the data and information necessary to translate these principles into concrete productivity estimates for the health sector and its workforce. Amongst other things, the availability of such measures would:

- facilitate independent evaluation of the outcomes from implementing the NHWSF in the broad (see recommendation 3.3) and of specific initiatives ensuing from the 'systemic' changes proposed in this study;
- strengthen ongoing analysis of the performance of the health care sector as a whole, including that analysis undertaken under the auspices of the Steering Committee for the Review of Government Service Provision; and
- provide a valuable resource that could be drawn on by a range of other researchers and by various government agencies involved in health care policy formulation, implementation and evaluation.

The Commission intends to report on how this stream of work is progressing.

APPENDICES

A Inquiry processes and consultation

The Commission has sought to facilitate public participation in this study, to the maximum extent possible.

- An initial circular, in March 2005, invited submissions from interested parties. To help in the preparation of submissions, the circular included a brief overview of relevant issues and some specific questions for interested parties to consider.
- A more detailed Issues Paper was published in early June 2005. Its purpose was to serve as a progress report to CoAG, while providing further guidance to participants in the preparation of their submissions by building on the topics and questions outlined in the initial circular.
- In September 2005, to provide for more targeted feedback, the Commission released a Position Paper outlining its preliminary analysis and reform proposals.
- The Commission has consulted extensively with a wide cross section of interested parties in all States and Territories and visited a number of rural and remote centres and Indigenous communities. Following release of the Position Paper, roundtables were held in Sydney, Melbourne, Brisbane, Canberra and Alice Springs in order to obtain feedback and comment on the preliminary proposals. A listing of these visits and informal discussions is provided below.
- The Commission received almost 180 submissions prior to the release of the Position Paper and around 190 following its release. These submissions are also listed below. All public submissions may be read on the Commission's website.

The Commission thanks all those who contributed to the study.

Visits and informal discussions with interested parties

New South Wales

National Health Workforce Secretariat

Centre for Health Economics Research and Evaluation, University of Technology, Sydney

College of Health Sciences, University of Sydney

Clinical Research Unit for Anxiety and Depression

Community Services and Health Industry Skills Council

New South Wales Government — various departments

Victoria

Affinity Health

Australian Dental Council

Australian Physiotherapy Association

Borland, Professor Jeff

Duckett, Professor Stephen

Health Services Advisory Committee

Melbourne Institute of Applied Economic and Social Research

Monash University Department of Epidemiology and Preventive Medicine

Optometrists Association Australia

Victorian Government — various departments

Queensland

Australian College of Rural and Remote Medicine

Australian Rural Health Research Centre

Family Care Medical Services

Queensland Government — various departments

Rockhampton Health Service District

University of Queensland Medical School

Woorabinda Indigenous Community

Wronski, Professor Ian

Western Australia

Australasian Association of Clinical Biochemists

Kimberley Aboriginal Medical Services Council

Port Hedland Hospital (with video links to Tom Price, Mt Newman, Karratha, Paraburdoo and Carnarvon hospitals)

South Western Health Services

Tjalku Wara Aboriginal Community

WA Country Health Service

Western Australian Government — various departments

South Australia

Australian Research Centre for Population Oral Health

Kearney, Professor Brendon

National Centre for Vocational Education Research

Nurses Board of South Australia

South Australian Government — various departments

Tasmania

Alexander, Dr Graeme

Calvary Private Hospital

Ramsey, Mr John — Australian Health Workforce Officials' Committee

Tasmanian Government — various departments

University of Tasmania School of Medicine

Australian Capital Territory

Access Economics

ACT Government — various departments

Australian Competition and Consumer Commission

Australian Council of Physiotherapy Regulating Authorities

Australian Government — Education, Science and Training; Health and Ageing; Prime Minister and Cabinet

Australian Institute of Health and Welfare

Australian Medical Association

Australian Medical Council

Australian Nursing Federation

Catholic Health Australia

Consumers' Health Forum of Australia

Council of the Ageing / National Seniors

General Practice Education and Training

National Rural Health Alliance

Pharmaceutical Society of Australia

Pharmacy Guild of Australia

Royal College of Nursing Australia

Rural Doctors Association of Australia

Northern Territory

Alice Springs Hospital

Central Australian Aboriginal Congress Clinic

Hermansburg/Ntaria

Menzies Health Research Institute

Northern Territory Government (by video conference and at Alice Springs roundtable) — various departments

Tiwi Islands Indigenous Community

Roundtables

Allied health professionals roundtable, Melbourne (18 May 2005)

This roundtable was held with the Health Professions Council of Australia and its member organisations, namely:

Audiological Society of Australia

Australian Association of Social Workers

Australian Institute of Radiography

Australian Physiotherapy Association

Australian Psychological Society

Australasian Podiatry Council

Dieticians Association of Australia

Orthoptic Association of Australia

OT Australia

Society of Hospital Pharmacists of Australia

Speech Pathology Australia

Professional colleges roundtable, Sydney (18 May 2005)

This roundtable was held with the Committee of Presidents of Medical Colleges and its member Colleges, which are:

Australian and New Zealand College of Anaesthetists

Royal Australasian College of Surgeons

The Australasian College of Dermatologists

The Australasian College for Emergency Medicine

The Royal Australian College of General Practitioners

The Royal Australasian College of Medical Administrators

The Royal Australian and New Zealand College of Obstetricians & Gynaecologists

The Royal Australian and New Zealand College of Ophthalmologists

The Royal College of Pathologists of Australasia

The Royal Australasian College of Physicians

The Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Radiologists

Roundtable on Position Paper, Campbelltown (25 October 2005)

Allied Health Professions Council

Australian Medical Association

Australian Salaried Medical Officers' Federation

Committee of Presidents of Medical Colleges

Medical Training and Education Council of NSW

National Health Workforce Secretariat

New South Wales Government

New South Wales Nurses' Association

Royal Australian College of Medical Administrators

Rural Doctors Association

Rural Doctors Network of NSW

South West Sydney Area Health Service

Brooks, Professor Peter

Roundtable on Position Paper, Melbourne (26 October 2005)

Allied Health Professions Council
Australian and New Zealand College of Anaesthetists
Australian Dental Council
Australian Medical Council
Australian Nursing Federation
Brotherhood of St Laurence
Duckett, Professor Stephen
Postgraduate Medical Council of Victoria
Victorian Government

Roundtable on Position Paper, Brisbane (31 October 2005)

Allied Health Professions Council
Australian Council of Deans of Health Sciences
Brisbane North Division of General Practice
College of Rural and Remote Medicine
Committee of Deans of Medical Schools
Council of Deans of Nursing and Midwifery
Ellis, Professor Niki
Gibbon, Professor Wayne
Queensland Government
Queensland Nurses Union
Royal Australian and New Zealand College of Radiologists

Roundtable on Position Paper, Canberra (1 November 2005)

Allied Health Professions Council
Alzheimers Australia
Australian Capital Territory Government
Australian College for Emergency Medicine
Australian Council of Physiotherapy Regulating Authorities
Australian Institute of Health and Welfare
Australian Medical Association

Australian Nursing and Midwifery Council

Australian Nursing Federation

College of Midwives

Community Service and Health Industry Skills Council

Department of Education, Science and Training

Department of Health and Ageing

General Practice Education and Training

Pharmacy Guild of Australia

Royal College of Nursing

Services for Australian Rural and Remote Allied Health

Roundtable on Position Paper, Alice Springs (2 November 2005)

Alice Springs Hospital

Central Australian Aboriginal Congress

Central Australian Division of Primary Health Care

Central Australian Remote Health Development Service

Centre for Remote Health

Council for Remote Area Health Nurses

Ngampa Health Council

Northern Territory Government

List of submissions

'PP' indicates submission received after the Position Paper was finalised.

Participant	*Submission number*
Aboriginal Medical Services Alliance Northern Territory	PP244
ACT Health	18
ACT Government	177, PP336
Aged and Community Services Australia	64, PP230
Aged Care Association Australia	115, PP285
Alexander, Dr Graeme	23
Alzheimers Australia	PP216
Anderson, Moya	100
Association for Australian Rural Nurses	PP204

Submissions (continued)

Participant	*Submission number*
Australasian Association of Clinical Biochemists Inc	35
Australasian College of Cosmetic Surgery	PP358
Australasian College for Emergency Medicine	76, PP228
Australasian College of Dermatologists	104, PP241
Australasian College of Physical Scientists and Engineers in Medicine	157, PP275
Australasian College of Podiatric Surgeons	131, PP290
Australasian Podiatry Council	88, PP281
Australasian Society of Cardio-Vascular Perfusionists	37, PP269
Australian and New Zealand Association of Physicians in Nuclear Medicine	168
Australian and New Zealand College of Anaesthetists	38, PP236
Australian and New Zealand Intensive Care Society	PP364
Australian Association for Exercise and Sports Science	PP262
Australian Association of Developmental Disability Medicine	114
Australian Association of Pathology Practices	111
Australian Association of Social Workers	116, PP326
Australian Association of the Deaf	75
Australian College of Ambulance Professionals	PP258
Australian College of Ambulance Professionals, Tasmania Branch	145
Australian College of Critical Care Nurses	PP279
Australian College of Midwives	99
Australian College of Non VR General Practitioners	128, PP211
Australian College of Operating Room Nurses	PP335
Australian College of Rural and Remote Medicine	72
Australian Council of Deans of Health Sciences	67, PP302
Australian Council of Physiotherapy Regulating Authorities	PP184, PP252
Australian Dental and Oral Therapists' Association	PP249
Australian Dental Association	103, PP310
Australian Dental Council	32, PP214
Australian Diagnostic Imaging Association	56
Australian Divisions of General Practice	135, PP320
Australian Doctors' Fund	PP192
Australian Doctors Trained Overseas Association	PP277, PP368
Australian Health Information Council	173
Australian Health Ministers' Advisory Council	10, 166

Submissions (continued)

Participant	*Submission number*
Australian Health Policy Institute, University of Sydney	22, 87
Australian Healthcare Association	151
Australian Indigenous Doctors' Association	PP356
Australian Institute of Health and Welfare	58
Australian Institute of Medical Scientists	55, PP213
Australian Institute of Radiography	25, 107, PP264
Australian Local Government Association	172
Australian Medical Association	119, PP315
Australian Medical Association (New South Wales)	PP340
Australian Medical Association (Victoria)	PP220
Australian Medical Council	PP306, PP365
Australian Nurse Practitioner Association	PP347, PP369
Australian Nursing and Midwifery Council	92, PP225
Australian Nursing Federation	137, PP291
Australian Nursing Federation (Victorian Branch)	133, PP287
Australian Orthopaedic Association	PP227
Australian Osteopathic Association	PP331
Australian Pharmacy Examining Council	PP191
Australian Physiotherapy Association	16, 65, PP271
Australian Private Hospitals Association	109, PP316
Australian Psychological Society	19, 118, PP283
Australian Psychology Accreditation Council	PP268
Australian Rheumatology Association, Victorian Branch	17, PP243
Australian Rural and Remote Workforce Agencies Group	136, PP353
Australian Rural Health Education Network	PP255
Australian Rural Health Research Collaboration	34
Australian Society of Anaesthetists	57, PP195
Australian Society for Medical Research	PP274
Australian Sonographers Association	PP286
Australian Vice-Chancellors' Committee	PP354
Bernadette Brennan & Associates	90
Breast Cancer Network Australia	8
Breheny, Dr James E.	29
Brisbane North Division of General Practice	42
Brooks, Professor Peter	13, 51, PP194

Submissions (continued)

Participant	*Submission number*
Brotherhood of St Laurence	45
Cancer Voices NSW	PP224
Capital Region, Area Consultative Committee	PP357
Carmichael, Professor Allan	PP208
Centre for Health Services Management, University of Technology, Sydney	142
Centre for Innovation in Professional Health Education	163
Centre for Midwifery and Family Health	41
Centre for Military and Veterans' Health	PP238
Centre for Psychiatric Nursing Research and Practice, School of Nursing, University of Melbourne	77, PP342
Centre for Remote Health	PP212
Chamber of Commerce and Industry Western Australia	69, PP294
Chiropractors' Association of Australia (National)	PP263
Clinical Oncological Society of Australia and the Cancer Council Australia	156, PP341
College of Nursing	120, PP292
Committee of Deans of Australian Medical Schools	49, PP337
Committee of Presidents of Medical Colleges	47
Community Services and Health Industry Skills Council	7
Confederation of Postgraduate Medical Education Councils of Australia	85, PP298
COTA National Seniors Partnership	123
Council of Deans of Nursing and Midwifery (Australia and New Zealand)	63, PP215
Council of Ambulance Authorities	PP321
Council of Pharmacy Registering Authorities	PP206
Council of Procedural Specialists	PP261
Council of Remote Area Nurses of Australia	134
Council of Social Service of New South Wales	40
Cregan, Dr Patrick	4
Deakin University, Faculty of Health and Behavioural Sciences	PP253
Department of Education, Science and Training	PP181, PP355
Department of Epidemiology & Preventive Medicine, Monash University	138
Department of Health and Ageing	9, 159, PP293
Department of Health, Western Australia	PP333

Submissions (continued)

Participant	*Submission number*
Department of Immigration and Multicultural and Indigenous Affairs	11
Dental and Oral Therapist Association of Queensland	PP305
Dental Hygenists' Association of Australia	PP301
Dental Practice Board of Victoria	PP338
Dietitians Association of Australia	61, PP239
Doig, Stephen	PP189
Duckett, Professor Stephen	PP197
ECH Inc	PP345
Eggert, Marlene	26, PP309
Faculty of Health Sciences, University of Sydney	39
Faculty of Medicine, Dentistry and Health Sciences, University of Melbourne	PP314
Faculty of Medicine, Nursing and Health Sciences, Monash University	PP229
Family Care Medical Services (Australia)	28
Flinders Human Behaviour and Health Research Unit, Flinders University	PP256
Gatenby, Professor Paul	PP209
Geffen, Professor Laurie	PP282
General Practice and Primary Health Care NT	132, PP324
General Practice Education and Training Ltd	129, PP311
General Practice Registrars Australia	PP370
Gibbon, Professor Wayne	48
Glaspole, Dr David W.	PP187
Guide Dogs Association of SA and NT	PP203
Hancock, Dr Heather	PP280
Harford, Dr Elizabeth	PP259
Harris, John	94
Health and Community Services Union	PP217
Health Professions Council of Australia	70, PP267
Health Reform South Australia	PP276
Health Services Union	PP323
Health Workforce Queensland	12, PP296
Heinzle, Dr Erich	174, PP198
Human Genetics Society of Australasia	97
Humphreys, Professor John	96, PP240

Submissions (continued)

Participant	*Submission number*
Industry Skills Council	PP299
I-MED/MIA Network	176
Interprofessional Education Group of the Australian Rural Health Education Network (University Departments of Rural Health)	PP200
James Cook University, Faculty of Medicine, Health and Molecular Sciences	5, 106, PP303
Johnson, Bryan Martin	93
Johnston, Adam	98, PP304
Joint Faculty of Intensive Care Medicine (ANZCA/RACP)	43
Joint Medical Boards Advisory Committee of the Australian Medical Council	PP273
Joint State and Territory Health CEOs	PP332
Lawrence, Lee	PP196
Lewis, Christopher	PP202
Long, Dr Eleanor M.	PP233
Lucas, Dr David	PP219
Massaro, Professor Vin	PP246
McCormack, Dr John	164
McDonell, Andrew and Balon-Rotheram, Auston	PP221
McKesson Asia Pacific	PP288
McLindon, Dr Luke	PP251
McLindon, Dr Luke and Lamont, Dr Amanda	PP344
McMeeken, Professor Joan	15
Medical Indemnity Industry Association of Australia	62
Medical Training and Education Council of NSW	154
Melbourne Institute of Applied Economic and Social Research and the Department of Economics	50, PP278
Melbourne Private Hospital	PP289
Menadue, John, AO	149
Mental Health Council of Australia	162
Migrant Resource Centre	3
Monash University, Faculty of Medicine, Nursing and Health Sciences	89
National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan Steering Group	74
National Heart Foundation of Australia	PP242

Submissions (continued)

Participant	*Submission number*
National Rural Health Alliance	PP295
National Rural Health Alliance and College of Medicine and Health Sciences, ANU	126
National Rural Health Network	PP328
Neurosurgical Society of Australasia	117
New South Wales Council for Intellectual Disability	73
Nganampa Health Council	PP188
Northern Rivers University, Department of Rural Health	152
Northern Territory Government	PP182, PP300
NSW Government	20, 178, PP352
NSW Mental Health Coordinating Council	125
NSW Nurses' Association	139, PP237
NSW Physiotherapists Registration Board	PP257
NSW Rural Doctors Network	110, PP222
Nurses Board of Victoria	PP232
Nurses Board of Western Australia	141
Nursing Board of Tasmania	PP284
O'Connor, Teresa	91
O'Donnell, Carol	1, 27, PP183
Old Linton Medical Practice	36
O'Meara, Dr Peter	160
Optometrists Association Australia	83, PP319
OT Australia	21, 54, PP247
Pathology Associations Committee	105
People's Health Movement Australia	127, PP361
Pharmaceutical Society of Australia	PP190
Pharmacy Guild of Australia	165, PP317
Postgraduate Medical Council of NSW	153
Postgraduate Medical Council of Victoria	81, PP250
Postgraduate Medical Council of WA	PP193
Professions Australia	31, PP346
Public Health Association of Australia	66, PP334
Puls, Kathleen Mary	PP349
Queensland Community Services and Health Industries Training Council	102

Submissions (continued)

Participant	*Submission number*
Queensland Government	171, PP325
Queensland Nurses' Union	2, 80, PP270
Queensland Nursing Council	PP201
Rabach, Jennifer	PP348
Resthaven	PP186
RMIT University	PP308
Royal Australasian College of Medical Administrators	140, PP363
Royal Australasian College of Physicians	108
Royal Australasian College of Surgeons	148, PP231, PP318
Royal Australian and New Zealand College of Obstetricians and Gynaecologists	112, 175, PP272
Royal Australian and New Zealand College of Obstetricians and Gynaecologists Provincial Fellows Committee	113
Royal Australian and New Zealand College of Ophthalmologists	33
Royal Australian and New Zealand College of Psychiatrists	79, PP245
Royal Australian and New Zealand College of Radiologists	78, PP307
Royal Australian College of General Practitioners	143, PP329
Royal College of Nursing, Australia	52, PP266
Royal College of Pathologists of Australasia	44, PP234
Royal College of Pathologists of Australia	122
Royal District Nursing Service	PP235
Royal Rehabilitation Centre	PP248
Rural Ambulance Victoria	PP254
Rural Doctors Association of Australia	46, 161
Rural Doctors Association of Australia and the Australian College of Rural and Remote Medicine	PP313
Rural Health Education Foundation	84
Rural Workforce Agency Victoria	146
St John Ambulance Australia	121
School of Nursing, Faculty of Medicine, Dentistry and Health Science, University of Melbourne	150
School of Pharmacy, University of Queensland	169
School of Physiotherapy, University of Queensland	PP312
Segal, Associate Professor Leonie	144
Services for Australian Rural and Remote Allied Health	71, PP265

Submissions (continued)

Participant	*Submission number*
Short, Leonie M.	124
Smith, Tony	PP226
Society of Hospital Pharmacists of Australia	60, PP207
South Australian Government	82, PP343
Southern Health	PP322
Speech Pathology Australia	53, PP260
Strategic Planning Group for Private Psychiatric Services	147, PP350
Sturmberg, Associate Professor Joachim P.	95
Swanson, Dr Bruce	59, PP327
Sydney South West Area Health Service	30
Tantau, Robyn	PP218
Tasmanian Government	PP180, PP339
Tasmanian School of Medicine and Faculty of Health Science, University of Tasmania	101
Telethon Institute for Child Health Research	PP205
The Maternity Coalition	PP185
Thompson, Dr Barrie G.	167
Urological Society of Australasia	130
University of Adelaide Medical School Curriculum Committee	14
University of Technology, Sydney: Centre for Midwifery and Family Health; Centre for Health Services Management; Faculty of Nursing, Midwifery and Health	PP223
Vanrenen, Dr Bertram	PP199, PP362
Victorian Clinical Genetics Service	PP359
Victorian Government	155, PP297
Vines, Robyn	PP367
Vision Group Pty Ltd	170
Wentworth-Walsh, D.	68
Western Australian Government	179
Western Australian Local Government Association	86

B An overview of the current health workforce

Australia ranks relatively highly for several measurable health indicators, such as life expectancy and infant mortality (see table B.1) with total spending on health care as a percentage of GDP in line with many other (non-USA) OECD countries (see table B.2).

B.1 The health workforce

A snapshot

There were over 450 000 Australians employed in health occupations at the time of the 2001 Census, accounting for around 5 per cent of the total workforce (AIHW 2004a). Of these, some 356 000 or just under 80 per cent were employed in health service industries (including aged and community care) with the remainder employed in other activities such as safety inspection, OH&S and retail pharmacy. In addition, some 200 000 non-health workers, such as clerks and service workers, were employed in the health service industries.

More than half of the health workforce (54 per cent) was employed in nursing occupations, with medical professionals (12 per cent) and the allied health professionals (eg physiotherapists, occupational therapists, podiatrists etc) (9 per cent) being the next most important groupings (see figure B.1).

Health care is also provided by unpaid (informal) carers in community and family settings. Many of those with chronic illnesses or disability are cared for by family members or friends and relatives. There is also a sizeable volunteer workforce providing various community-based care services, such as first aid and support to hospital patients and aged care residents. Such care is often coordinated through St John Ambulance, Red Cross and other charitable organisations.

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

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

Source: AIHW (2004a).

Table B.2 **Health care spending in selected OECD countries**

Country	*Health spending per capita, 2002*	*Health spending as a share of GDP, 2002*	*Real growth in health spending, 1992–2002*
	$A ’000	%	%
Australia	**3.6**	**9.5**	**4.5**
Canada	3.9	9.6	3.2
France	3.7	9.7	2.7
Germany	3.8	10.9	2.3
Japan	2.8	7.8	3.8
Netherlands	3.6	9.1	3.5
New Zealand	2.5	8.5	4.9
Sweden	3.4	9.2	3.6
United Kingdom	2.9	7.7	4.1
United States	7.1	14.6	4.5
OECD-10 mean	3.7	9.7	3.7

Source: AIHW (2004c).

Australia’s (paid) health workforce has been growing considerably faster than the population. Between the 1996 and 2001 Censuses, the health workforce increased by over 11 per cent, nearly double the population growth of around 6 per cent.

However, this growth was not uniform across the workforce. By occupation, the number of enrolled nurses grew more slowly than the population, the numbers of registered nurses and dentists grew at a slightly higher rate, while growth in the allied and complementary health professions was four and five times the growth in population in this period, respectively (see table B.3).

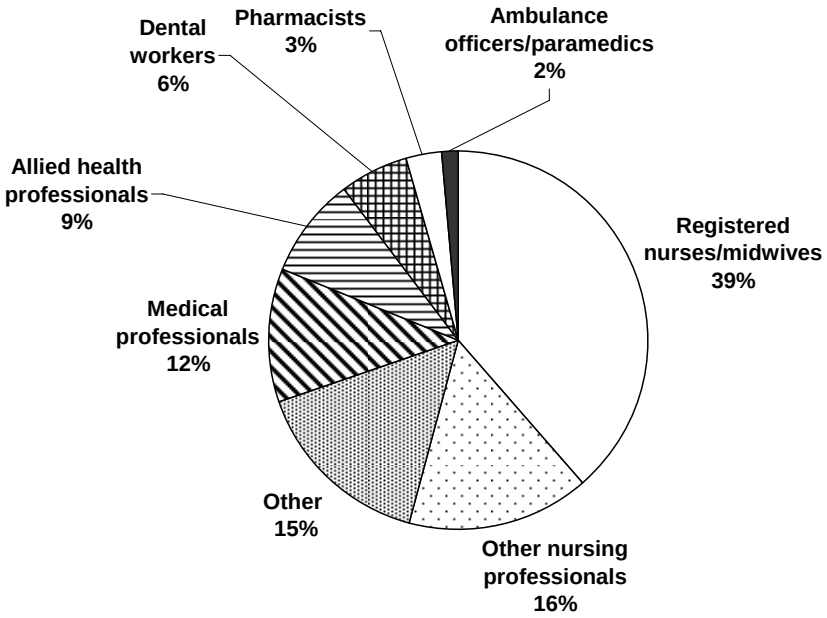
Table B.3 **Health occupations, employed persons and rate of growth**

	2001	*Proportion of health workforce*	*Percentage change between 1996 and 2001*
	’000	per cent	
Registered nurses/midwives	174	38.7	7.3[a]
Enrolled nurses	19	4.3	2.7[a]
Nursing assistants/ personal carers	51	11.2	18.8
Medical professionals	52	11.5	12.6
Dentists	8	1.9	7.9
Dental technicians/assistants	18	3.9	12.5
Pharmacists	14	3.0	13.0
Allied health workers	39	8.6	26.5
Complementary health workers	9	1.9	29.6
Medical imaging workers	8	1.8	25.0
Medical scientists	11	2.6	16.8
Ambulance officers/paramedics	7	1.5	12.5
Other	41	9.1	30.2
Total	451	100	11.6

a Percentage changes between 1997 and 2003.

Sources: AIHW (2003a; 2004a; 2005d).

Figure B.1 **Health occupation shares**



Sources: AIHW (2004a; 2005d).

By location, the health workforce is concentrated in the major cities, with the numbers declining the more rural and remote the location. This concentration is more pronounced amongst the more highly trained health workers. For example, the nurse to population ratio is broadly comparable across regions, whereas the distribution of medical specialists to population is heavily skewed towards major cities (see table B.4 and B.5).

Table B.4 **Geographical location of the health workforce, 2001**
(percentage of the total occupational workforce)

Occupation	*Major cities*	*Inner regional*	*Outer regional*	*Remote*	*Very remote*
General practice	73.0	18.2	7.4	1.0	0.3
Specialist medical	77.4	17.3	4.9	0.4	0.1
Nurses	65.8	21.5	10.3	1.6	0.8
Dental services	74.3	17.5	7.2	0.8	0.2
Optometry & optical dispensing	73.7	19.2	6.6	0.5	0.03
Physiotherapy	74.5	17.9	6.5	0.8	0.2
Distribution of Australian population	***66.3***	***20.7***	***10.4***	***1.7***	***0.9***

Sources: AIHW (2003a; 2003b).

Table B.5 **Employed health professionals per 100 000 population, 2003**
(by remoteness)

Occupation	*Major cities*	*Inner regional*	*Outer regional*	*Remote*	*Very remote*
Primary care practitioners	115	94	85	93	85
Medical specialists	111	52	33	24	8
Nurses	1120	1166	1115	1193	1082

Sources: AIHW (2005b; 2005d).

Key developments and trends

Workforce shortages in a number of areas

Though identifying workforce 'shortages' in the health care sector is not straightforward (see chapter 2 and box B.1), studies undertaken by a range of government agencies, government appointed committees and professional bodies have pointed to significant and growing shortages in many areas of the health workforce. For example, recent quantitative work undertaken by the Australian Medical Workforce Advisory Committee (AMWAC) and the Australian Health Workforce Advisory Committee (AHWAC) pointed to:

- an estimated shortage of between 800 to 1300 GPs in 2002 (or between 4 and 6 per cent of the current GP workforce) (AMWAC 2005); and
- a shortfall of nurses, requiring between 10 000 to 12 000 new graduate nurses in 2006 and between 10 000 and 13 000 in 2010 (which would require at least a doubling of the current graduate completions) (AHWAC 2004a).

Also, following individual AMWAC reviews, the majority of medical specialities have increased their intake of training places in line with the recommendation of the relevant review, although progress has been slow in ear nose and throat surgery, emergency medicine, gastroenterology, obstetrics and gynaecology, orthopaedic surgery, pathology, psychiatry and radiology (AMWAC 2004).

And in other health occupations, the Department of Employment and Workplace Relations (DEWR) has identified shortages of dentists, hospital and retail pharmacists, occupational therapists, physiotherapists, speech pathologists, podiatrists, diagnostic radiographers, radiation therapists, nuclear medicine technologists, pathologists, psychiatrists, registered nurses and sonographers (DIMIA 2005).

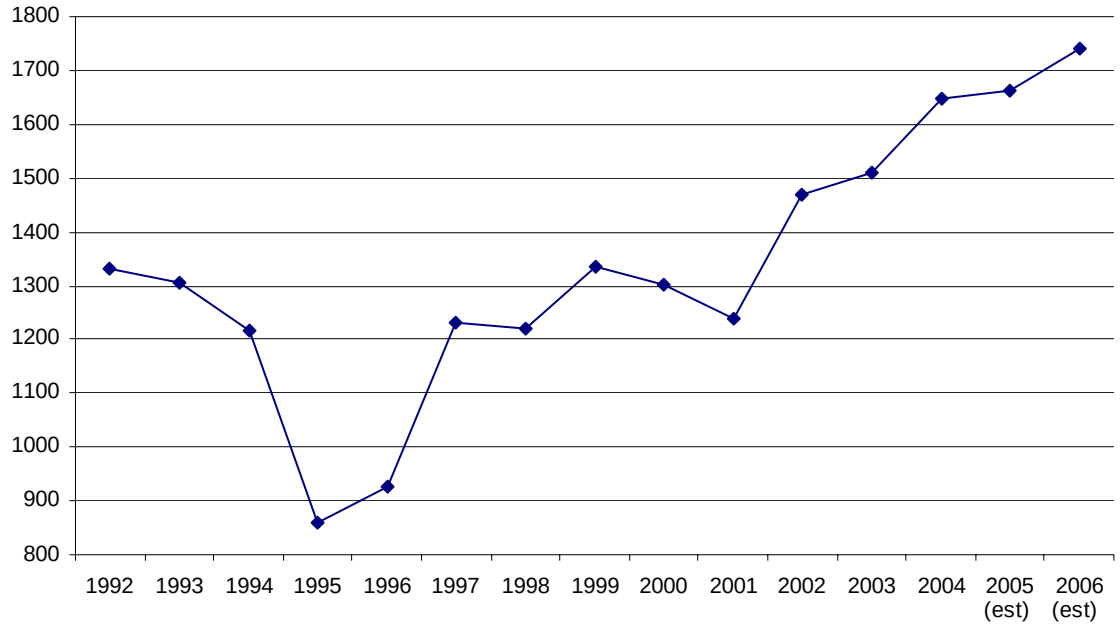
As well as overall shortages, there are even more pronounced shortages in rural and remote areas and in Indigenous communities, reflecting the concentration of many highly trained professionals in major cities (see table B.5). Thus, AMWAC and AHWAC have noted particular concerns in relation to access to GPs and certain medical specialities in rural and remote areas. Submissions from allied health groups to this study also said that shortages of many of these workers are particularly acute in rural and remote areas. For example, OT Australia said, 'OTs [occupational therapists] are underrepresented in rural and remote areas of Australia' (sub. 21, p. 6). The Australian Division of General Practice drew attention to the decline in the number of Aboriginal Health Workers in the Northern Territory (sub. 135).

Some of these shortages are being ameliorated through increased use of overseas trained professionals (see below). More recently, there has also been an increase in the number of education and training places for health workers. For example:

- Medical school commencements of Australian citizens and permanent residents increased by 90 per cent (or nearly 800 places) between 1995 and 2004 (see figure B.2).
- This has flowed through to specialist training where the number of specialists in training similarly increased by around 700 between 2000 and 2003 (a rise of 14 per cent) (see table B.6).
- Nursing school commencements in 2004 were around 8800, some 10 per cent higher than in 2003 (but still below the levels of the mid to late 1990s). Moreover, the Australian Government has identified nursing as a national priority and is to provide an additional 1200 nursing places between 2005 and 2008 (AIHW 2005d, Bishop 2004b).

Also, there have been various initiatives to attract more health professionals to locate in regional areas (see chapter 10).

Figure B.2 **Medical student commencements, Australian citizens and permanent residents, 1992 to 2006**



Source: AMWAC (2004).

Table B.6 **Growth in employed medical practitioners, 2000 to 2003**

Main occupation	*2000*	*2003*	*Percentage change between 2000 and 2003*
	’000	’000	
Clinician	*47*	*51*	*9.4*
Primary care	21	22	4.0
Hospital non-specialist	5	6	15.5
Specialist	16	17	13.0
Specialist-in-training	5	6	14.1
Non-clinician	*4*	*5*	*17.5*
Total	**51**	**56**	**10.0**

Source: AIHW (2005b).

How does Australia compare with other countries?

In comparison to most other OECD countries, Australia does not appear to be significantly undersupplied with health workers. For example, on a doctor to population basis, Australia is not markedly behind in regard to practising medical practitioners — though the distribution of these practitioners between general practice and other specialities is different (see table B.7).

Table B.7 **Practising doctors, general practitioners and specialists per 1000 population, selected OECD countries 2002 and 2003**

	Practising doctors 2003[a]	*General practitioners 2002*	*Practising specialists 2002*
Australia	**2.5**	**1.4**	**1.2**
Canada	2.1	1.0	1.1
France	3.4	1.6	1.7
Germany	3.4	1.1	2.3
Ireland	2.6	0.6	na
New Zealand	2.2	0.7	0.7
Sweden	3.3	0.6	2.3
United Kingdom	2.2	0.6	1.4
United States	2.3	0.8	1.5
OECD average	2.9	0.8	1.7

a France and the United States includes doctors working in industry, research and administration.

Note: These figures are head counts and not FTEs.

Source: OECD (2005).

As to other health professions, Australia compares favourably on a population basis with similar OECD countries in regard to nurses, appears to be slightly behind in dentists and slightly ahead in pharmacists (see table B.8).

Table B.8 **Practising nurses, dentists and pharmacists per 1000 population, selected OECD countries 2003**

	Practising Nurses	*Practising Dentists*	*Practising pharmacists*
Australia	**10.2**	**0.5**	**0.8**
Canada	9.8	0.6	0.7
France	7.3	0.7	1.2
Germany	9.7	0.8	0.6
Ireland	14.8	0.5	0.8
New Zealand	9.1	0.4	0.8
United Kingdom	9.7	0.5	0.6[b]
United States	7.9[a]	0.6	0.7[b]
OECD average	8.2	0.6	0.7

a Data is for 2002. **b** Data is for 2000

Note: These figures are head counts and not FTEs.

Source: OECD (2005).

Of course, such international comparisons must be interpreted carefully. In particular, different models for delivery of care can have a major impact on such ratios. For example, Australia's relatively high number of GPs and low number of specialists reflects the situation in Australia where GPs have a much stronger screening and gate keeping role than in some other countries. Differences in population dispersion will also affect the distribution of these practitioners within any particular country (see box B.1).

An older workforce

Like the wider workforce, the health workforce is ageing. Between 1996 and 2001, the proportion of the health workforce aged over 45 years increased from around 31 per cent to nearly 39 per cent.

The most rapidly ageing occupation was nursing where the proportion of the workforce older than 45 years increased from 29 per cent to 41 per cent over this period. In the medical workforce, the proportion of over 45 year olds increased from 41 per cent to 46 per cent, dentists from 39 per cent to 43 per cent, allied health workers from 27 per cent to 31 per cent and medical imaging workers from 21 per cent to 27 per cent (AIHW 2004a).

Box B.1 **How does Australia measure up on size?**

On a per capita basis, Australia's health workforce in most areas does not appear to be significantly different in size in comparison to other OECD countries. In some areas, it appears Australia has considerably more health professionals on a population basis. As noted in the text, Australia has more GPs and practising nurses per 1000 population than most comparable OECD countries such as New Zealand, Canada, the United Kingdom and the United States and is somewhat above the OECD average. It has similar levels of dentists and pharmacists per 1000 population, but is relatively poorly supplied in regard to medical specialists (see tables B.6 and B.7).

That said, the overall ratio of health workers to population does not take account of the distribution of that workforce in each country. For example, the Australian Divisions of General Practice (sub. 135) noted that in comparison to Australia, there was little variation in the distribution of GP numbers across England which range from around 64 per 100 000 people in North Central London to 51 per 100 000 in South Yorkshire. However, it also noted that while there were just over 23 000 GPs in Australia, England had only around 30 000 GPs for a population approximately two and half times larger (sub. 135). Of course, in Australia this workforce has to provide accessible services to a much more widely distributed population. As a result, even in areas of Australia classified as very remote there are more GPs per 100 000 people (85 per 100 000) than in central London (AIHW 2005b).

Regional distributions in other countries, such as Canada, more closely parallel the distribution of health workers across Australia (see table B.9). For example, in 2004 the distribution of family medicine physicians in Canada ranged from 86 per 100 000 people in the North West Territories, to 121 per 100 000 people in Newfoundland and the number of medical specialists ranged from 19 per 100 000 people in the Yukon Territories to 105 per 100 000 people in Quebec (CIHI 2005).

The distribution of nurses across Canada is heavily skewed towards the less populous regions. For example, there were 1176 nurses per 100 000 people in the North West Territories and only 672 in British Columbia and 650 in Ontario (CIHI 2003). A similar distribution of nurses also occurs in New Zealand. In contrast, nurses in Australia appear to be more evenly distributed. However, the geographic maldistribution of specialists is more pronounced in Australia, with fewer specialists per population in remote areas than in the remote areas of Canada and the less populated areas of New Zealand (see table B.9).

Source: AIHW (2005b), CIHI (2003;2005), NZHIS (2004).

Such ageing is likely to have significant implications for the available pool of health workers in coming years. For example, according to the Australian Rural Health Research Collaboration (sub. 34), if the current large cohort of older or 'baby boomer' nurses retires at the same rate as previous generations, there is likely to be a very rapid attrition of the nursing workforce in the next 15 years. It also found that a similar scenario was facing the medical workforce, though not on the same scale — many doctors will still continue to work beyond the traditional retirement age (Australian Rural Health Research Collaboration, sub. 34).

Table B.9 **Regional distribution of GPs, medical specialists and registered nurses, Australia, New Zealand and Canada**
(per 100 000 people)

	Australia[b]	*New Zealand*[b]	*Canada*
Lowest concentration of GPs to population	85 (very remote)	53 (West Coast Region)	86[a] (NW Territories)
Highest concentration of GPs to population	115 (major cities)	97 (Auckland)	121[a] (Newfoundland)
Lowest concentration of medical specialists to population	8 (very remote)	33 (West Coast Region)	19[a] (Yukon Territories)
Highest concentration of medical specialists to population	115 (major cities)	175 (Auckland)	105[a] (Quebec)
Lowest concentration of nurses to population	1082 (very remote)	772 (Auckland)	650[c] (Ontario)
Highest concentration of nurses to population	1193 (remote)	1013 (West Coast Region)	1176[c] (NW Territories)

a 2004 **b** 2003 **c** 2002

Note: The Australian Standard Geographical Classification of remoteness categorises Australia into major cities, inner regional areas, outer regional, remote and very remote. For example, the remote classification includes Alice Springs, Katherine, Mount Isa, and Broome and very remote includes Cape York, far western Queensland and most of Western Australia, South Australia and the Northern Territory outside the major population centres.

Source: CIHI (2003, 2005); NZHIS (2004); AIHW (2005b, 2005d).

Female dominated

The health workforce has traditionally been predominately female. In all health occupations, apart from medicine and dentistry, females account for the bulk of the workforce. For example, in 2001 females accounted for over two-thirds of the podiatry workforce, around three-quarters of the physiotherapy workforce and over 90 per cent of the occupational therapy and nursing workforces, the latter traditionally having been a female occupation (AIHW 2004a, sub. 21).

However, the traditionally male dominated health occupations of medicine and dentistry are becoming increasingly feminised. Females accounted for nearly 32 per cent of the medical workforce in 2003 up from 27 per cent in 1996. This trend will continue as females have made up around half of the medical school graduates between 1996 and 2001 (AIHW 2004a).

In dentistry, females accounted for just over a quarter of practising dentists in 2001, up from 21 per cent in the mid-1990s. As in medicine, this trend will continue, with females accounting for more than half of dentistry graduates since the late 1990s (AHWAC 2004a).

Some working fewer hours

The health workforce, on average, is more reliant on part-time workers than the wider workforce. For example, in 2001, nearly 40 per cent of the health workforce worked fewer than 35 hours, compared with 33 per cent in the wider workforce and more than half of the nursing workforce was working part time (AIHW 2003a).

More important has been the recent decline in average hours worked by medical practitioners. In 1996, 53 per cent of medical practitioners worked more than 50 hours a week, whereas by 2003 this had fallen to around 44 per cent. For female medical practitioners, who on average work fewer hours than their male counterparts, the average working week declined from around 40 hours to 38 hours over the same period (AIHW 2005b).

This decrease in hours worked means that since the mid 1990s, there has been little change in the full-time equivalent workforce, of around 280 practitioners per 100 000 population, despite the increase in the number of practitioners (Department of Health and Ageing, sub. 9).

A number of factors are contributing to the reduction in average working hours by medical practitioners. Some of these are common across the workforce as a whole, including a generational shift in attitudes to balancing work and other aspects of life, and an older workforce. Others are more specific to the medical workforce, including changes in the role of medical workers and their standing in the community, the introduction of safe working hours legislation, particularly for practitioners working in hospitals, and the increasing feminisation of the medical profession. Women, in particular, are more likely to want to work fewer hours to allow them to undertake family duties and are less likely to want to own their own practice and the longer hours this involves (DOHA, sub. 9).

That said, in overall terms, the greater feminisation of the medical workforce has not so far been the major driver of the decline in average hours worked. The decrease in average hours worked by male medical practitioners has been much more important. However, the more even gender balance in new entrants to the medical workforce will continue to place pressure on the supply of medical services in the future.

Table B.10 **Medical and nursing workforce, key trends 1996–2003 and 1997–2003**

Medical workforce	*1996*	*2003*
Number of medical practitioners	43 756	56 207
Percentage female	27.6	31.9
Average hours worked	48.1	44.4
Average male hours worked	51.1	47.5
Average female hours worked	40.2	37.8
Percentage working 50 hours or more per week	53.0	43.7
Average age in years	44.9	45.6
Nursing workforce	*1997*	*2003*
Number of nurses (enrolled and registered)	264 086	282 546
Percentage female	92.7	91.4
Average hours worked	30.7	32.5
Percentage working 35 hours or fewer per week	52.0	50.0
Average age in years	40.3	43.1

Sources: AIHW (2003b, 2004a, 2005b, 2005d).

In the second half of the 1990s, average hours in nursing were also declining. However, the latest data produced by the AIHW (2005d) indicates there was a sharp rise in the average hours worked by nurses in the 2001–2003 period. It is too early to say whether or not this is a reversal of the previous trend or merely a short term perturbation.

For the other health occupations, the trends in hours worked have been variable. For example, the proportion of pharmacists working more than 50 hours per week declined between 1996 and 2001. However, there was a modest increase for allied health professionals and medical imaging workers, and a substantial increase for dentists (see table B.11).

Increasing specialisation

There has also been a shift towards greater specialisation within the health workforce. For example, orthopaedic surgeons have become 'super specialised,' often focussing on specific joints such as knees or hips rather than the full range of orthopaedic surgery. Similarly, there has been a trend for nurses to become specialised in fields such as accident and emergency and intensive care, rather than in general nursing. This increased specialisation, particularly in the medical workforce, is one of the factors reinforcing the geographic concentration of health professionals in the major cities. That is, the more specialised the health profession, the more likely the practitioner will work in a major city where there is a large enough population to support such a practice.

Table B.11 **Dentist, pharmacy, allied health and medical imaging workforce, key trends 1996–2001**

	1996	*2001*
Dentists		
Number of dentists	7604	8206
Percentage female	21.3	26.0
Percentage working fewer than 35 hours per week	23.8	23.1
Percentage working more than 50 hours per week	13.4	18.5
Percentage aged over 45 years	39.0	43.6
Pharmacists		
Number of pharmacists	12 311	13 911
Percentage female	47.6	51.9
Percentage working fewer than 35 hours per week	28.8	28.7
Percentage working more than 50 hours per week	25.1	23.8
Percentage aged over 45 years	43.5	41.6
Allied health		
Number of allied health workers	34 038	39 457
Percentage female	72.5	77.7
Percentage working fewer than 35 hours per week	41.1	39.8
Percentage working more than 50 hours per week	9.8	11.0
Percentage aged over 45 years	27.4	31.1
Medical imaging workers		
Number of medical imaging workers	6513	8141
Percentage female	67.9	69.2
Percentage working fewer than 35 hours per week	30.7	28.6
Percentage working more than 50 hours per week	5.8	7.9
Percentage aged over 45 years	21.6	27.6

Sources: AIHW (1996, 2003a); AHWAC (2004a).

Greater reliance on overseas medical practitioners

Australia's health system has become increasingly reliant on overseas trained doctors (OTDs). At present, OTDs make up around 25 per cent of the overall medical workforce compared to 19 per cent a decade ago (DOHA, sub. 159, AMWAC 1996b). The most important source of OTDs are those arriving on temporary resident visas who are increasingly being used in designated 'areas of need', or are in Australia undertaking vocational training (AMWAC 2004). In the decade to 2002-03, there was a fivefold increase in temporary resident doctor arrivals from around 670 to about 3000.

By jurisdiction, Queensland, Western Australia and Victoria appear to be the most reliant on OTDs to fill vacancies in areas of need, primarily in regional general practice positions, locum services and some junior hospital positions. Collectively,

around 80 per cent of the OTDs working on this type of visa in 2002-03 were located in these three states (Birrell 2004).

While there are overseas trained health workers practising in Australia in areas other than medicine, other health occupations are not generally as reliant on these workers to meet their workforce requirements (see box B.2).

Box B.2 More on overseas trained health workers

For several years, Australia has been relying on overseas trained health workers to meet shortages in the medical workforce. The main attraction of using these workers is that it avoids the considerable time lag involved in educating and training new workers, thereby providing a more immediate response to these shortages. However, as several participants pointed out, it can also be a vehicle for the transfer of new skills from other countries.

There are a range of visas categories, both temporary and permanent, that can be used to bring overseas health workers to Australia. Permanent migration mainly occurs under the General Skilled Migration program, where certain health occupations have been allocated extra points in the migration points test to facilitate their entry (DIMIA, sub. 11).

However, temporary entrants account for the greatest proportion of health workforce professionals entering Australia. The most widely used form of entry is the separate visa for temporary resident doctors (TRDs), who enter Australia to work in medical positions designated as being an 'area of need' by the relevant State or Territory Health Authority. These doctors are granted conditional registration and can only gain access to Medicare rebates following a commitment to work in an area of workforce shortage. This allows State and Territory Governments to direct them to rural and regional areas through the conditions placed on their registration.

This visa category also enables overseas medical students who have completed a medical degree in Australia to remain in Australia to complete their internship.

In comparison with medical practitioners, the number of non-medical overseas trained health professionals entering Australia each year as a share of the respective health profession is very small (usually less than 2 per cent). For example, in 1999-2000 around 2000 nurses, 230 pharmacists and 70 dentists entered Australia, both on a permanent and temporary basis (SCAC 2002, AIHW 2003a). The respective workforces in these professions were around 174 000, 14 000 and 8000.

Australia's use of overseas health workers is also governed by an Australian Government Code of Practice for International Recruitment of Health Workers. This is intended to provide a framework within which international recruitment should take place to allay concerns that excessive recruitment of overseas health workers from developing countries will be detrimental to the development and the health of the population in these countries.

Changing models of care and scopes of practice

A variety of models of care have long been employed in Australia's health care system to meet the diverse care needs of patients. While some forms of care can be supplied by a single professional, others have always required a multidisciplinary approach. Similarly, there has been a blend of care provided in community, private and institutional settings.

However, the balance of the care mix has been changing and will need to evolve further in the future. The Commission was frequently told that a multidisciplinary approach to patient care involving close cooperation between medical practitioners, nurses, pharmacists and allied health professionals will become increasingly more important in the treatment of chronic disease, which is becoming a larger share of Australia's burden of disease (DOHA, sub. 9). In addition, the tightening general labour market, in conjunction with greater technological possibilities for arms-length care, is likely to see a greater emphasis on care provided in community settings.

In some cases, there has been a widening of scopes of practice, especially in rural and remote areas where lesser access to more highly qualified practitioners has put a premium on workforce flexibility and adaptiveness. But in other areas increasing specialisation has occurred.

The average per capita number of services provided has been increasing — for example, the average number of Medicare services provided per person per year increased from around 9 in 1990-91 to just over 11 in 2001-02 (AIHW 2004a). Such increased servicing trends have reflected amongst other things:

- technological changes that provide more treatment and diagnostic testing options; and
- concerns about medical liabilities which has encouraged practitioners to provide 'protective services'.

Problems with job satisfaction

Job satisfaction is reported to be low in a number of health professions and especially in rural and remote areas.

A number of causes for this have been put forward:

- A 2002 study of GPs pointed to relatively poor remuneration, often long working hours and increasing complexities of training, accreditation and administration (Access Economics 2002).

- Factors identified in a parallel study on the nursing workforce included rates of pay, safety, increased workload leading to stress and burnout, inappropriate nursing skills mix, insufficient recognition of skills and knowledge, occupational health hazards and a lack of accommodation and childcare (SCAC 2002).
- And in regard to practice in regional and rural areas, these studies gave particular prominence to the limited locum services; restricted access to peer support; fewer professional development opportunities than in the major population centres; limited opportunities for spouses and children; inadequate accommodation; lack of remuneration commensurate to qualifications and the degree of isolation (Access Economics 2002).
- There have also been suggestions that some of the current problems with job satisfaction may relate to training and expectations that do not meet the reality of the workplace.

Such problems are likely to reduce productivity and impede quality. Also, to the extent that they lead to higher turnover rates and add to difficulties of recruitment, they may exacerbate any shortages in the number of health workers.

That said, job satisfaction problems are not uniformly evident across the health workforce. For example, satisfaction amongst the allied health professions is believed to be generally high, although there are some concerns in relation to being 'overworked and undervalued' by the system (Sydney South West Area Allied Health Service, sub. 30).

Moreover, it is not clear that job satisfaction is any worse than it was in the past, is worse in the health area than in other parts of the workforce, or that it actually increases the rate of exits from the health workforce.

- Based on responses to a Household, Income and Labour Dynamics in Australia (HILDA) survey, while nursing professionals had the lowest level of overall job satisfaction among the professional groups encompassed in the survey, those classified as other health professionals had the highest overall level of job satisfaction (Webster, Wooden and Marks 2004).
- The available evidence suggests that while medical and allied health professionals are changing employment within the profession, few are exiting the profession for reasons other than age. In the case of nursing, while a large percentage of nurses leave the profession within the first year of graduating, the exit rates decline rapidly with increasing lengths of employment.

B.2 Influences on the health workforce

Australia's health system is complex with a wide range of service providers and an array of funding and regulatory mechanisms in place. There are also various pathways for gaining qualifications to practise as a health professional.

- Private and public providers of health services operate in both primary and acute settings, as well as in aged care.
- Funding is provided by the Australian Government, State and Territory Governments, health insurers and private individuals.
- Most health professions are regulated by governments primarily through bodies with delegated powers including registration boards and some accreditation bodies.
- In some cases, employers develop rules that allow for credentialing; a formal process used to verify the qualifications, experience, professional standing and other professional attributes of health practitioners.
- Education and training of the workforce involves both tiers of government, universities, vocational education and training providers, specialist colleges and professional associations, accreditation agencies and health service delivery bodies. Box B.3 provides further elaboration on the range of institutions, agencies and organisations involved in the health workforce and section B.3 provides further detail on education and training requirements.

Although there is a diverse array of entities involved, it is government that has the major impact on health workforce outcomes. Through its involvement in the funding of health, education and training, its use of numerical workforce planning, direct public provision of some services and its regulatory function, government has a pervasive influence on the overall size of the workforce, the activities it undertakes, its location and its responsiveness to changing health needs. Figure B.3 synthesises these influences, the entities involved and their roles, with a more detailed discussion in the subsequent text.

Government funding and the health workforce

Funding of health care

Government dominates expenditure on health care in Australia. Collectively, Australian Governments funded over two-thirds of the $78 billion spent on health care services in 2003-04. The Australian Government funded nearly 46 per cent and the States and Territories around 23 per cent (see figure B.4).

Box B.3 Health workforce institutions, agencies and organisations

The sheer number of institutions, agencies and organisations involved in the health workforce area makes a comprehensive listing impractical in a report such as this. However, the following provides an indication of the range and diversity of the institutions, agencies and organisations involved and their often overlapping roles.

Employers — A significant number of health workers are self-employed. However, many are also employed by State and Territory Government Departments (ie public hospitals and other facilities), Australian Government agencies (eg defence forces), community controlled entities (eg Aboriginal Medical Services), private hospitals and aged care facilities and private firms.

Regulators — Most health professions are regulated via statutory registration boards in each State and Territory. Professional bodies influence workforce deployment through their formal and informal input into accreditation, registration, credentialing and education issues. Accreditation agencies, such as the Australian Medical Council and the Australian Dental Council accredit university courses for their respective professions, which entitles graduates of those accredited courses to registration, and specialist training courses. They also assess the qualifications of overseas trained practitioners. In some cases, such as in dentistry and physiotherapy, the professional body and registration board are represented on the accreditation agency.

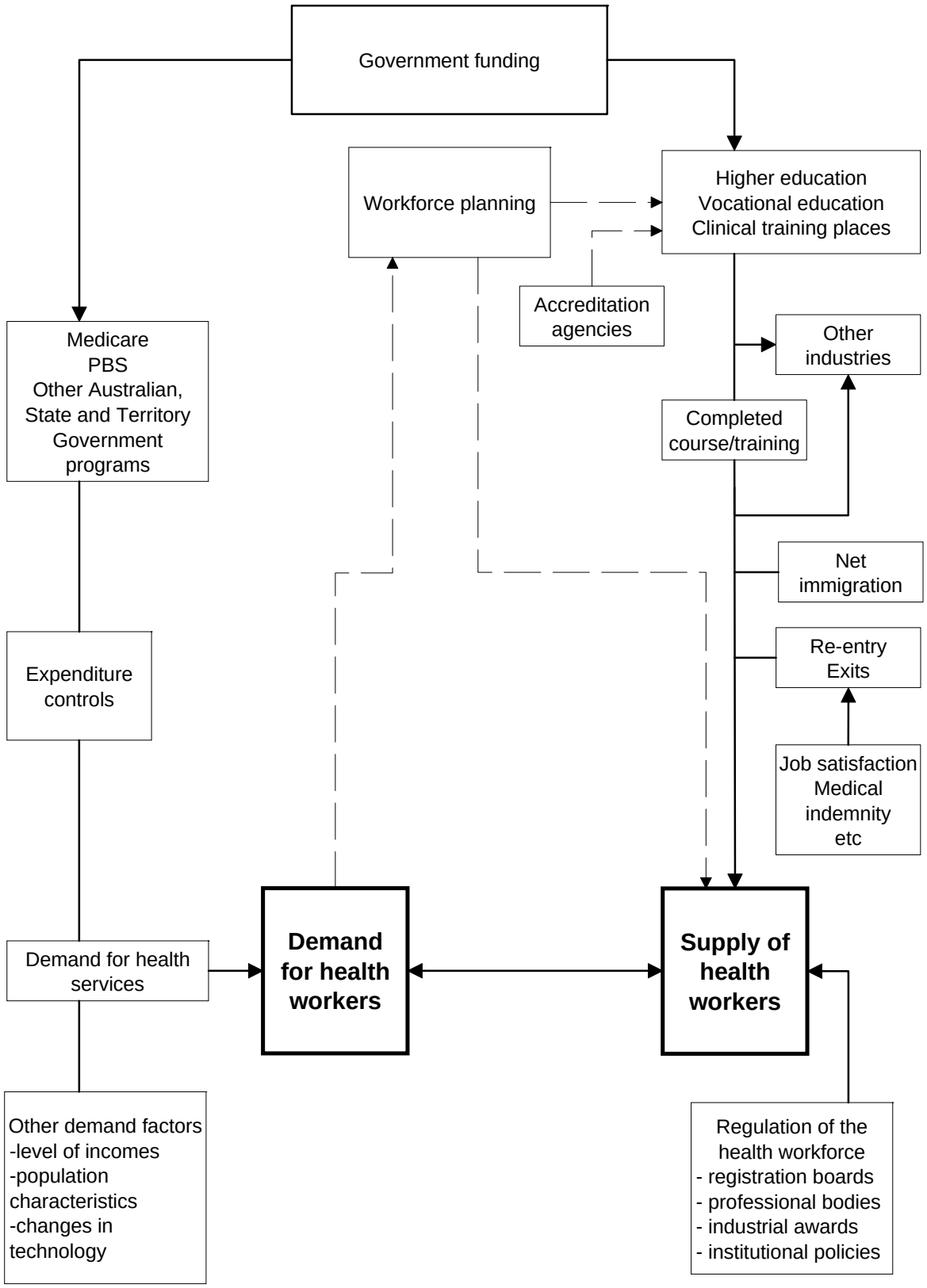
Trainers and educators — Universities offer a wide range of courses in the health area, with the cost of those courses being subsidised by the Australian Government. The TAFE system, which is funded by the States and Territories and the Australian Government, provides vocational training for enrolled nurses, personal assistants and Indigenous health workers (amongst others). The specialist colleges supervise training and set examinations for specialists in training positions mainly in public hospitals funded by State and Territory Governments. Private consortia are also involved in the training of GPs through the GPET program which contracts out GP training on a regional basis. In VET, industry skills councils comprising representatives from government, employer groups and employees, design and develop training packages, which provide the basis for competencies in particular occupations. For example, the Community Services and Health Industry Skills Council develops packages for enrolled nurses.

Funders — As discussed in the text, Australian governments provide the majority of funding for health care services, with the remainder provided by private insurers, workers' compensation agencies and private individuals.

Planning agencies — Through a system of advisory councils and committees, the Australian, States and Territory Governments are jointly involved in advising on the future number of health workers required and the implications for education and training places. State and Territory Governments also collect and report on workforce requirements at a jurisdictional level.

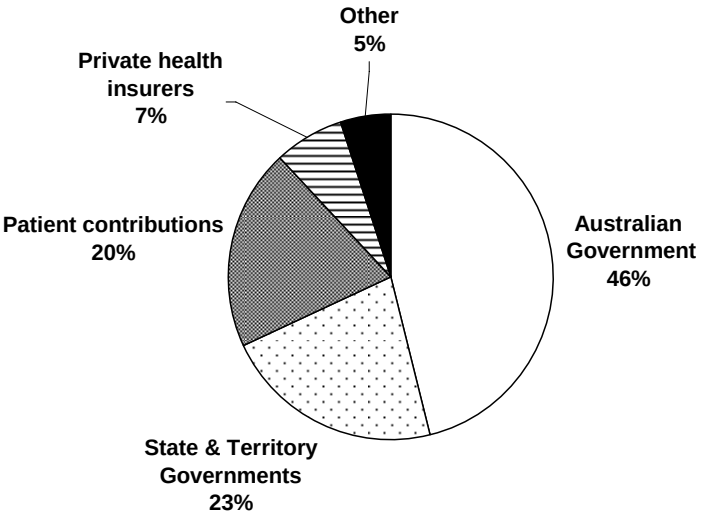
Workforce — Most professions are represented by an umbrella association and often have further specialised representation such as that provided by the various medical and dental colleges and nursing associations. In addition, there are other groups and associations representing specific sectors of the health workforce such as rural doctors and Indigenous doctors. And unions are predominant in nursing, where different unions represent enrolled and registered nurses in most jurisdictions.

Figure B.3 **Government (and other) influences on the health workforce**



- The Australian Government funds the major primary care health programs including Medicare, the Pharmaceutical Benefits Scheme (PBS) and programs to provide access to health services in particular areas, including rural and remote areas, and for specific groups such as Indigenous Australians. It also provides the health-related specific purpose payments (SPP) to the States and Territories for public hospital care, funds hospital care for veterans and funds the rebates and subsidies provided to holders of private health insurance and to those individuals or families incurring high out of pocket health expenditures in any one year (see figure B.5). This funding accounts for around 18 per cent of the Australian Government's total expenditures (Australian Government 2005).
- State and Territory Governments, drawing on health related SPPs and other revenue sources, fund the public hospital system, as well as a range of community based health care services. Provision of these services typically accounts for about 25 per cent of State and Territory budgets. The State and Territory Governments also provide a range of health services for rural and remote areas.

Figure B.4 **Sources of funding for health care, 2003-04**

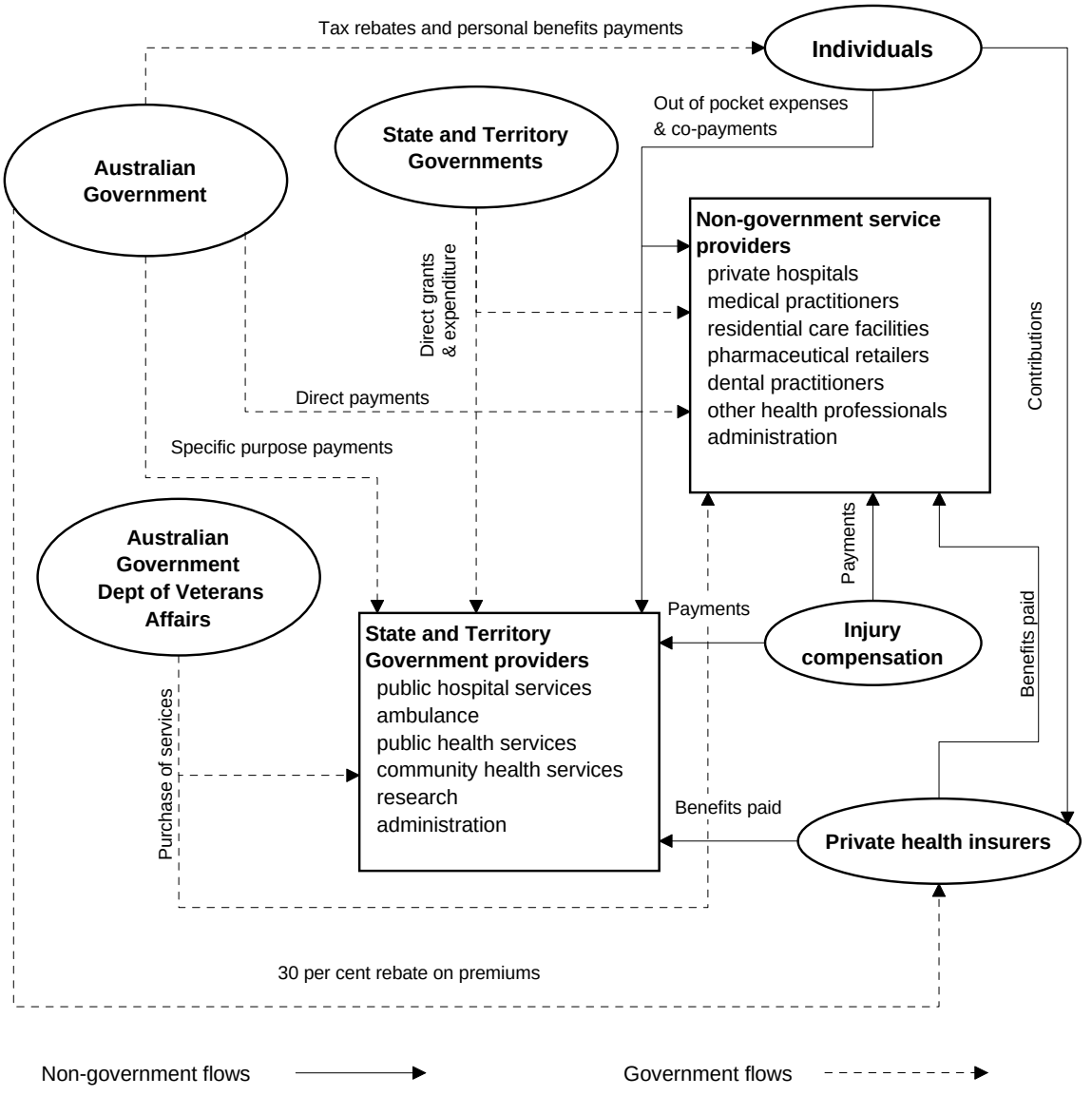


Source: AIHW (2005a).

Apart from affecting demand for health services and hence for health workers, as discussed in chapter 8, the nature of those funding mechanisms influences the mix of health workers available, where they locate, whether they work in the public or private systems and their work practices. And through their influences on relative

incomes across the health professions, funding mechanisms are one of several factors affecting the career choices made by those training to become health workers.

Figure B.5 **Health funding arrangements**

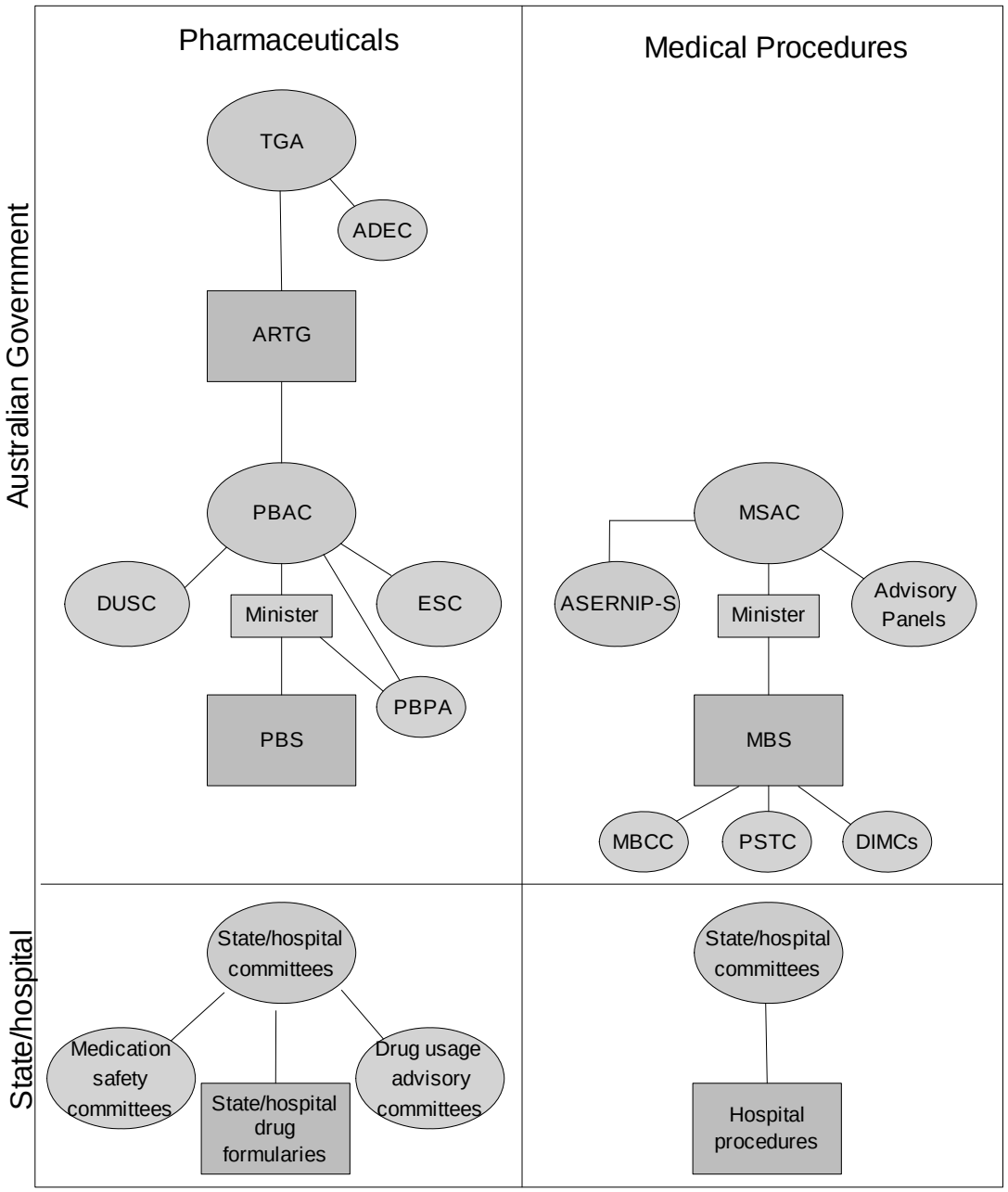


Source: Based on AIHW (2005a).

The PBS and Medicare Benefits Schedule (MBS) are important elements of the health system in Australia. The Pharmaceutical Benefits Advisory Committee (PBAC) assessment is a prerequisite for listing on the PBS. Similarly, the Medical Services Advisory Committee (MSAC) undertakes health technology assessment of most new procedures performed by eligible practitioners (mainly doctors) prior to

listing on the MBS. Some of the agencies and committees in Australia involved in this process are shown in figure B.6.

Figure B.6 **Some of the agencies and committees involved with the PBS and MBS in Australia**



The following abbreviations are used: TGA Therapeutic Goods Administration; ADEC Australian Drug Evaluation Committee; ARTG Australian Register of Therapeutic Goods; DUSC Drug Utilisation Sub-Committee; ESC Economics Sub-Committee; PBPA Pharmaceutical Benefits Pricing Authority; MSAC Medical Services Advisory Committee; ASERNIP-S Australian Safety and Efficacy Register of New Interventional Procedures – Surgical; MBCC Medical Benefits Consultative Committee; PSTC Pathology Services Table Committee; and DIMCs Diagnostic Imaging Management Committees.

Source: Based on PC (2005d).

Funding of education and training

Total government operating expenditure on higher education (universities and TAFE) was around $16 billion in 2003-04 (ABS 2005). While not as significant as expenditures on health care, such funding enables governments to influence the overall number of entrants to the health workforce and their distribution across the different professional categories.

The most important influence in this regard is the Australian Government's funding of university education, which enables it to determine the number of subsidised health workforce places within each discipline and by university (see box B.4).

Box B.4 **Government funding of university places**

The Australian Government has primary responsibility for the public funding of the university sector. To receive funds, each university enters into a funding agreement with the Australian Government via annual negotiations with the Minister for Education, Science and Training as to the number of places and the discipline cluster mix the Government will support. The Australian Government then provides a contribution, depending on the discipline cluster, towards the cost of an agreed number of student places. The exception is medicine, where the total number of places to be funded is jointly determined by the Minister for Education, Science and Training and the Minister for Health and Ageing.

Medicine and dentistry are in the second highest funding group of the 12 discipline clusters and receive a subsidy of around $15 000 per year per student place. This is in contrast with the allied health disciplines which receive a subsidy of just over $7000 per year per student place and accounting, economics and commerce which, being in one of the lower clusters, receive a contribution of around $2500 per year per student place. Nursing, which is funded as a national priority, receives a contribution of around $9700 per year per student place.

Universities can request a shift in clusters as part of annual negotiations to provide more places in certain courses. It is also possible for universities to shift their load within their existing cluster profile to commence new courses. For example, Griffith University commenced a new dentistry course in 2004. However, the number of funded places in medicine is fixed as part of the funding allocation to individual universities and cannot be subsequently altered by the universities.

To date, universities have been able to close courses without consultation with the Government. However, the Minister for Education, Science and Training has decided to include a clause in funding agreements that consultation is required before courses of national importance are closed, such as certain courses for health workers where there is a national shortage.

As of this year, the student contribution for each course is to be set by individual universities within a range determined by the Australian Government. For example, medicine and dentistry are in the top HECS band which provides for a student contribution of up to $8000 per year, while nursing as a national priority is in the lowest band requiring a student contribution of no more than $4000 per year.

Source: DEST (information supplied to the Commission).

This funding role has also been used to influence the geographical distribution of the medical workforce, for example, through locating new medical schools in regional areas with set rural place allocations, as well as through the use of bonded medical scholarships requiring the recipient to work in a rural, regional or outer metropolitan area of workforce shortage for a minimum period after completion of training.

Workforce planning

While governments, and in particular the Australian Government, have long 'shaped' the size and composition of the health workforce through their role in funding training and service delivery, arrangements to undertake more formalised projections of future workforce requirements were only introduced in 1996 (see box B.5).

Box B.5 Background to health workforce planning

While Australian Governments have long subsidised health care services and subsidised the education and training of health workers, workforce planning mechanisms to explicitly project workforce needs and the attendant education and training requirements are more recent.

Increasing attention began to be paid to the size and distribution of the health workforce in the 1980s. This was because of cost pressures resulting from advances in medical science and technology and a considerable expansion of medical education which resulted in a large increase in the number of medical practitioners. The introduction of universal subsidies for medical services in 1984 further heightened cost pressures.

Responses included slowing the overall growth of the workforce, capping medical training intakes and restricting practitioner access to Medicare benefits while increasing the supply of practitioners in certain geographic areas and particular specialties.

However, such initiatives served to highlight the constraints imposed by the lack of detailed and robust data on the health workforce. As a response to this, and flowing from a 1988 review of the medical workforce (the Doherty Report), a national Medical Workforce Data Review Committee was established to improve data administration. In the early 1990s, further work on data collection and management was also undertaken by the (then) Australian Institute of Health, primarily involving annual medical workforce surveys.

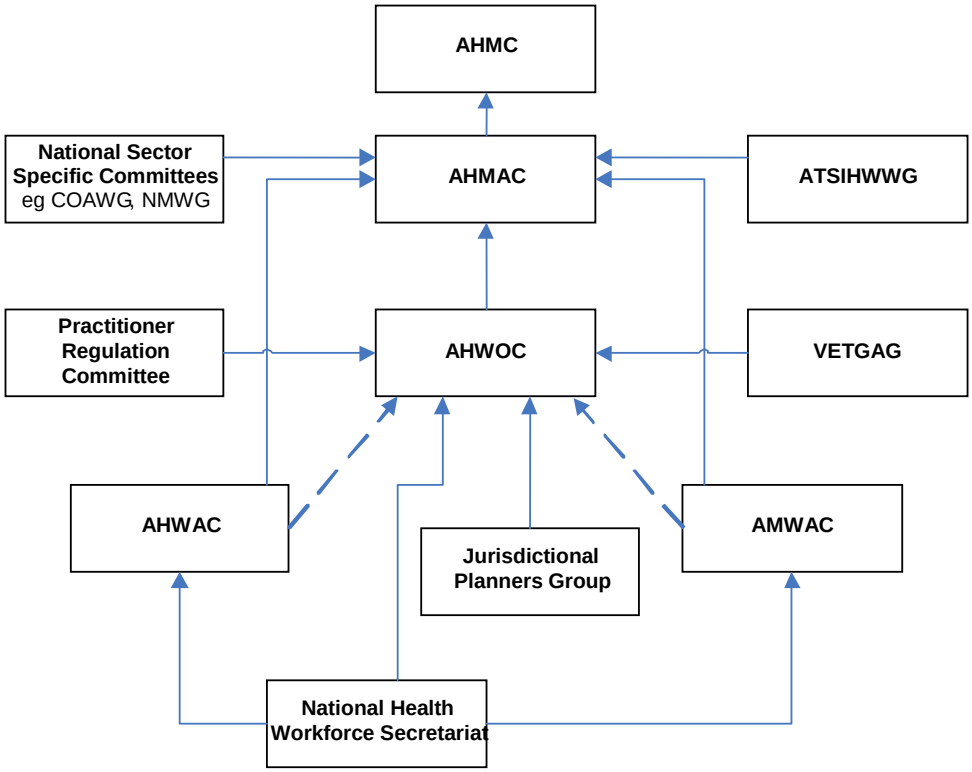
In 1996, the Australian Health Ministers' Advisory Council established a sub-committee, AMWAC, as part of a more 'strategic' approach to workforce planning and data analysis. This was followed by the establishment of AHWAC in 2000.

Source: DHAC (2001).

Under these arrangements, the Australian Medical Workforce Advisory Committee (AMWAC) advises the Australian Health Ministers' Advisory Council (AHMAC) on the number of medical professionals required to meet community health care 'needs' and the attendant education and training implications. In 2000, similar planning arrangements were extended to non-medical health professionals, such as nurses and allied health professionals, through the establishment of the Australian Health Workforce Advisory Committee (AHWAC).

As well providing advice on the future demand and supply of health workers and education and training requirements, AMWAC and AHWAC are charged with developing models to describe and predict those requirements, devising strategies to meet them and establishing and developing health workforce data sets. In addition to AMWAC and AHWAC, there are a range of other bodies and committees involved in workforce planning at the national level (see figure B.7). Most State and Territory Governments also undertake projection exercises, especially in relation to the number and type of workers required for their public health systems.

Figure B.7 **National health workforce planning reporting structure**



Source: Victorian Government (sub. 155).

Regulation

The regulatory framework in which the health workforce operates is extensive and often complex. This regulation is largely profession-based and is primarily aimed at protecting the public by determining who can work in specific health occupations, and by defining and oversighting the roles and responsibilities of those within these occupations. However, some of this regulation is also aimed at containing government expenditure on health care services.

Registration boards

The majority of the health workforce is subject to some form of professional regulation. This regulation is administered by State and Territory Governments through statutory registration boards. Professions subject to registration include medical practitioners, dentists, pharmacists, physiotherapists, optometrists, osteopaths, chiropractors and nurses. Accordingly, there is a multitude of registration bodies (see box B.6). Moreover, those professions not subject to statutory registration are generally subject to self-regulatory arrangements administered by peak professional bodies. These self-regulatory arrangements may also apply to registered professions through their peak professional bodies, such as in the case of specialist colleges.

Those professions where service provision can carry a high degree of risk, and where a requirement for the protection of the public interest is greatest, are more likely to be subject to statutory registration requirements.

However, for some professions, requirements vary across jurisdictions. For example, occupational therapists are only required to be registered in Queensland, Western Australia, South Australia and the Northern Territory. Those wishing to work in the other States, particularly in the public health system, would simply be expected to have qualifications acceptable to OT Australia, the professional association. In the case of Chinese medicine, only Victoria requires practitioners to be registered.

In addition to the applicable regulatory requirements, there are protections provided by other features of the service delivery environment, including the discipline exerted over professions through rules imposed by employers and health funds, current self-regulation activities and the demands of other health practitioners.

Box B.6 **Health workforce registration bodies**

Medicine: NSW Medical Board, Medical Practitioners Board of Victoria, Medical Board of Queensland, Medical Board of South Australia, Medical Board of Western Australia, Medical Council of Tasmania, Medical Board of Northern Territory and Medical Board of ACT.

Nursing: Nurses and Midwives Board NSW, Nurses Board of Victoria, Queensland Nursing Council, Nurses Board of South Australia, Nurses Board of Western Australia, Nursing Board of Tasmania, Nursing Board of Northern Territory, and Nurses Board of the ACT.

Physiotherapy: Physiotherapists Registration Board of NSW, Physiotherapists Registration Board of Victoria, Physiotherapists Board of Queensland, Physiotherapists Board of South Australia, Physiotherapists Registration Board of Western Australia, Physiotherapists Registration Board of Tasmania, Physiotherapists Registration Board of the Northern Territory and Physiotherapists Registration Board of the ACT.

Dentistry: Dental Board of NSW, Dental Practice Board of Victoria, Dental Board of Queensland, Dental Board of South Australia, Dental Board of Western Australia, Dental Board of Tasmania, Dental Board of Northern Territory and Dental Board of ACT.

Pharmacy: Pharmacy Board of NSW, Pharmacy Board of Victoria, Pharmacists Board of Queensland, Pharmacy Board of South Australia, Pharmaceutical Council of Western Australia, Pharmacy Board of Tasmania, Pharmacy Board of Northern Territory and Pharmacy Board of the ACT.

Optometry: NSW Board of Optometrical Registration, Optometrists Registration Board of Victoria, Optometrists Board of Queensland, Optometrists Board of South Australia, Optometrists Registration Board of Western Australia, Optometrists Registration Board of Tasmania, Optometrists Board of the Northern Territory and ACT Optometrist Registration Board.

Chiropractic: Chiropractors Registration Board of New South Wales, Chiropractors Registration Board of Victoria, Chiropractors Board of Queensland, Chiropractors Board of South Australia, Chiropractors Registration Board of Western Australia, Chiropractors & Osteopaths Registration Board of Tasmania, Chiropractors & Osteopaths Board of the Northern Territory and Chiropractors & Osteopaths Board of the ACT.

Osteopathic: Osteopaths Registration Board NSW, Osteopaths Registration Board of Victoria, Osteopaths Board of Queensland and Osteopaths Registration Board of Western Australia. (South Australian, Tasmanian, Northern Territory and ACT osteopaths are registered with chiropractors).

(Continued next page)

Box B.6 **(continued)**

Podiatry: Podiatrists Registration Board NSW, Podiatrists Registration Board of Victoria, Podiatrists Board of Queensland, Podiatry Board of South Australia, Podiatrists Registration Board of Western Australia, Podiatrists Registration Board of Tasmania and Podiatrists Board of the ACT (no registration in the NT).

Occupational therapy: Occupational Therapists Board of Queensland, Occupational Therapists Registration Board of South Australia, Occupational Therapists Board of Western Australia and Occupational Therapists Board of the Northern Territory (no registration in NSW, Vic, ACT and Tasmania).

Psychology: Psychologists Registration Board NSW, Psychologists Registration Board of Victoria, Psychologists Board of Queensland, South Australian Psychological Board, Psychologists Board of Western Australia, Psychologists Registration Board of Tasmania, Psychology Registration Board of the Northern Territory and Psychologists Board of the ACT.

Radiography (including imaging, radiation and nuclear medicine): Medical Radiation Technologists Board of Victoria, Medical Radiation Technologists Board of Queensland and Medical Radiation Service Professionals Registration Board Tasmania (other jurisdictions only require licences to operate certain radiation equipment).

Speech pathology: Speech Pathologists Board of Queensland (registration not required in other jurisdictions).

Aboriginal Health Work: Aboriginal Health Worker Registration Board, Northern Territory (registration not required in other jurisdictions).

Optical dispensing: NSW Optical Dispensers Licensing Board, South Australian Optical Dispensers Registration Committee, Optical Dispensers Licensing Western Australia (registration not required in other jurisdictions).

Chinese medicine: Chinese Medicine Registration Board of Victoria (registration not required in other jurisdictions).

Dental technicians (DT) and dental prosthetists (DP): Dental Technicians Registration Board of NSW (DT/DP), Dental Technicians and Dental Prosthetists Board of Queensland (DT/DP), Dental Prosthetists Advisory Committee, Western Australia (DP), Dental Prosthetists Registration Board, Tasmania (DP), Dental Technicians and Prosthetists Registration Board of the ACT (DT/DP) (Victorian DT/DPs and South Australian DPs registered by dental boards. No registration in Northern Territory).

Source: Various.

The role of registration boards

The legislation establishing State and Territory registration boards provides for them to undertake a number of regulatory roles including:

- *Establishing criteria for admission and reservation of title.* These typically require the applicant to have the necessary education and training and in some cases to meet certain character requirements. They also make it an offence for an unregistered person to practise and the complementary reservation of title provisions make it an offence for an unregistered person to describe themselves as a member of that profession.
- *Regulating the practice of members.* Depending on the profession, the legislation may provide for the registration board to regulate particular techniques or core practices and stipulate that certain interventions can only be undertaken by registered practitioners (Duckett 2004). (Exemptions apply for emergencies and where students are performing such a practice under the supervision of an authorised person.) However, the scope of practice for each profession is generally determined by the relevant board as part of the development of standards of practice and codes of conduct. For the most part, these codes and standards do not place prescriptive limitations on the scope of practice. Rather, they require the health professional to operate in a professional manner within their area of competency as defined by their training.
- *Enforcing compliance.* An important role of the registration boards is to enforce compliance with codes of conduct and professional standards. To this end, they receive and investigate complaints of poor performance or unprofessional conduct, including breaches of board developed standards of practice and codes of conduct, and where appropriate, impose sanctions, including deregistration.
- *Continuing professional education.* A number of the registration boards also take a role in setting further education requirements to ensure that registered professionals are up-to-date with current practices and procedures.

The make up of the boards

The members of the regulatory boards are appointed by the relevant Minister in each jurisdiction and are generally made up of registered members of the profession representing the professional association; any sub-groups within that profession; the relevant Health Department; an educational institution involved in training; and representatives of consumer and/or community interests.

Professional bodies and regulation

As noted above, peak professional bodies play an important regulatory role in the health area, in complementing statutory regulation, or in providing for self-regulation where formal registration requirements do not apply. While membership of a professional body is voluntary, access to rebates from private health insurance

funds is usually restricted to those who are registered with the statutory boards where applicable, and/or who are members of a designated professional association. Specialists are required to be members of the relevant College to receive payments through the MBS.

In addition, the activities of health workers are also influenced by workplace regulation, drugs and poisons legislation and generally applicable competition regulation (see box B.7).

B.3 Education and training requirements

University education

The majority of health professionals (ie doctors, registered nurses, dentists, pharmacists and allied health professionals) are educated at university. Completion of this training, except for medical practitioners (see below), enables registration with the relevant board and, depending on the profession, is offered on both an undergraduate and postgraduate basis. For example, the 17 medical schools in Australia offer both undergraduate and postgraduate courses. Similarly, physiotherapy qualifications can be acquired through a four year undergraduate degree or via a two year masters degree.

Accreditation

As completion of the required university degree is a prerequisite for professional registration, courses are subject to accreditation. In the case of medicine, the Australian Medical Council (AMC) undertakes the accreditation function on behalf of the state and territory medical boards. The AMC assesses medical courses for compliance with agreed national guidelines for basic medical education (including curriculum design) so as to ensure consistency in standards for entry into the medical profession and the achievement of a range of learning outcomes. The AMC also accredits specialist medical training, conducts examinations for overseas trained doctors and advises on the recognition of new specialities.

Similar accreditation of the university courses for other health professions is undertaken by bodies such as the Australian Dental Council and the Australian Council of Physiotherapy Regulating Authorities (see table B.12).

Box B.7 Other regulation impacting on the health workforce

Workforce regulation

The health workforce is also subject to institutional policies relating to supervision, delegation and support and assistant roles. For example, a hospital may have policies in place covering the delegation roles of registered nurses in relation to enrolled nurses. Other workplace policies, while reflecting the scope of practice contained in the codes of conduct developed by the registration boards, may actually prescribe and limit the role of certain health workers, for example, as to the administration of medicine and insertion of intravenous equipment.

Industrial awards and enterprise bargaining agreements may also act to reinforce professional regulation and institutional policies by further prescribing the roles and responsibilities of particular health workers.

Drugs and poisons legislation

The scope for health professionals to prescribe and administer medication is set out in the relevant State and Territory drugs and poisons legislation. For the most part, this legislation restricts prescribing of medicines to registered medical practitioners and dentists. However, there is some variation in this legislation across jurisdictions to reflect recent developments, such as the introduction of nurse practitioners in some states and territories.

Competition regulation

Associations of health professionals are regulated by the *Trade Practices Act 1974* (TPA) and individual health professionals by the equivalent State and Territory legislation which prohibits anti-competitive practices including price fixing, collusion and misleading advertising.

This regulation has been used in relation to arrangements operating within the health workforce, the most high profile case being the arrangements governing the Royal Australasian College of Surgeons' training program. Though this training program was authorised by the ACCC, the agency responsible for compliance and enforcement of the TPA, authorisation was conditional on the College meeting a number of requirements to lessen potentially anti-competitive elements of the training program.

Since then, the ACCC and the Australian Health Workforce Officials Committee (AHWOC) have reviewed the medical specialist colleges' training and accreditation arrangements. The recommendations in the review have been accepted by the Australian Health Ministers Conference and reflect the key principles of transparency, accountability, stakeholder participation and procedural fairness contained in the conditional authorisation provided to the College of Surgeons (ACCC 2005a). The role of professional bodies in training is discussed further in chapter 5.

VET

Educational requirements for enrolled nurses involve the attainment of a certificate level IV or a diploma course qualification (which teaches supervisory and advanced technical skills), either through an institution-based or apprenticeship arrangement. Institution-based education for enrolled nurses is delivered by either private training providers or through government institutes of technical and further education (TAFE).

Requirements for personal care workers and nurses aides are certificate level III. Indigenous health workers are trained to certificate level III or certificate level IV depending on the jurisdiction.

The training and qualifications provided by the VET sector are formally competency-based. Under current VET arrangements, industry skills councils are responsible for developing national training packages that describe the skills and knowledge required to work in particular occupations. Training packages provide the framework for competencies for a particular industry or occupation through a range of training pathways.

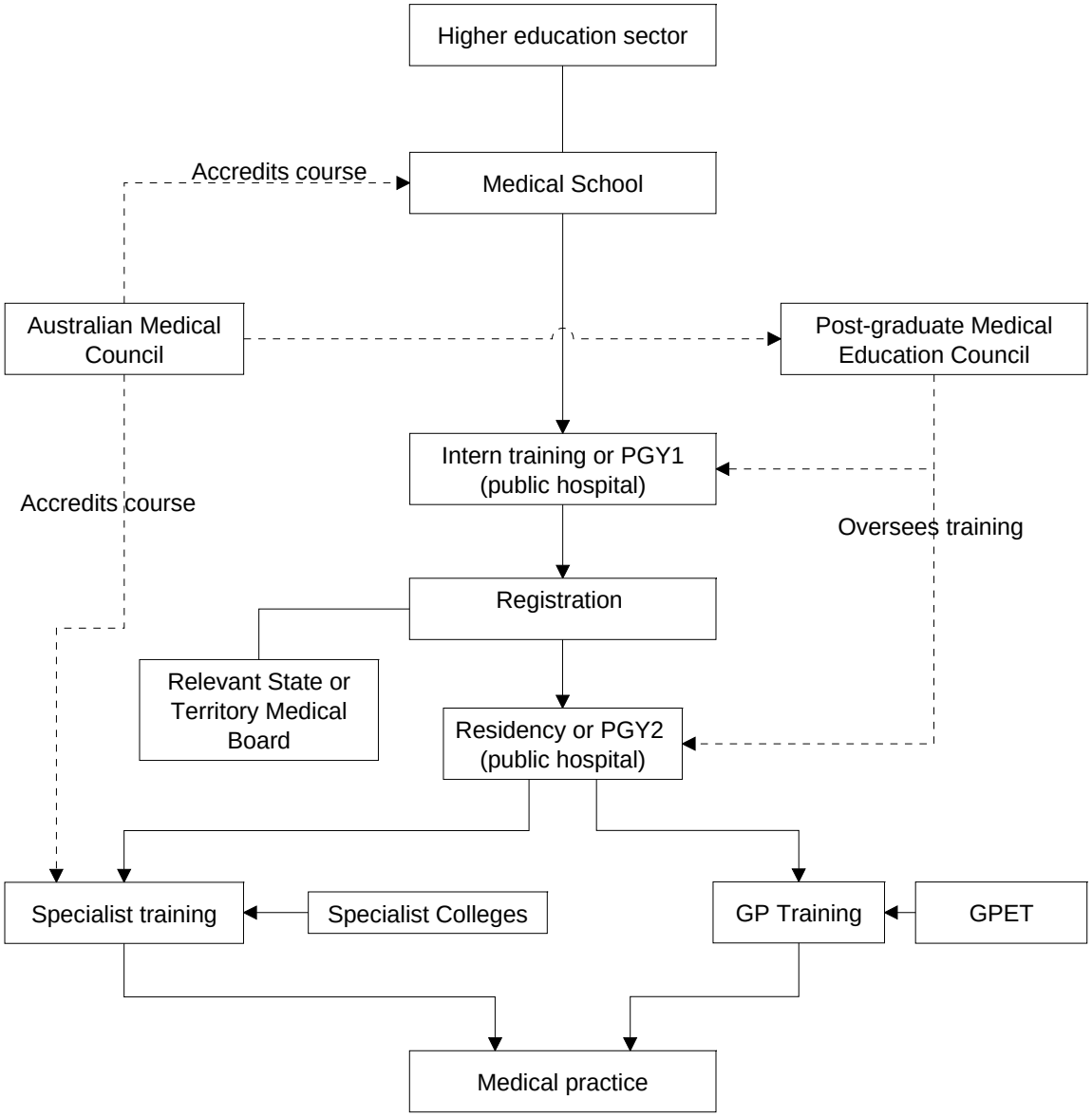
Postgraduate training

Postgraduate training is required in certain health professions prior to registration, or before graduates can obtain employment in that profession. Further post-graduate training is also required for those wishing to specialise, including for admission to specialist medical colleges (see figure B.8).

Medicine

Medical graduates enter the medical workforce as interns (postgraduate year 1) — primarily in the major public hospitals. This intern training involves a series of work rotations to specific clinical departments in a hospital environment — broadly in line with AMC guidelines on intern training and/or guidelines set by the State or Territory Postgraduate Medical Education Council (PMEC), or equivalent body. Full medical registration with the relevant State or Territory Medical Board is dependent on the successful completion of the intern year, although such registration is not sufficient to enable independent practise.

Figure B.8 **Outline of medical training in Australia**



Source: Various.

Following completion of the internship, further training is undertaken as a resident medical officer (postgraduate year 2) under guidelines set by the relevant PMEC to prepare for vocational training.

Specialist training

Successful completion of the intern year, subsequent registration by a State or Territory Medical Board and a further training period as a resident medical officer, enables junior doctors (resident medical officers) to seek admission to a vocational

training program run by one of the specialist colleges and accredited by the AMC. Many colleges require candidates to sit a primary examination and then to secure employment in a college-accredited hospital registrar position. The range of criteria for such accreditation can be extensive. However, not all colleges accredit training positions, but may instead require evidence (certified by a college supervisor) of the completion of specific clinical activities.

Advanced vocational training usually takes between three and six years depending on the specialty. As such, the total length of education and training requirements for medical practitioners (undergraduate/graduate degree programs, internship, basic and advanced training) can be in excess of ten years.

General practice training

In contrast to training programs for other specialties, general practice training is explicitly funded by the Australian Government through General Practice Education and Training Ltd (GPET) — established in 2001. The Australian Government sets the number of training positions available. Training is currently delivered by 22 regional training providers.

Prior to the introduction of this arrangement, general practice training was overseen by the Royal Australian College of General Practitioners. Before 1996, although a vocational register was introduced in 1989, there was no prerequisite training to enter general practice, other than to complete the hospital based post-graduate training (internship and residency).

GP training is a three year full-time program, conducted primarily in designated private GP training practices in a community-based setting (the program includes one year of hospital-based training). Two training pathways are provided — a rural and general pathway. Doctors electing to take the rural pathway are required to undertake the majority of their training, at least 18 months, in rural and remote areas, while those doctors in the general training pathway are required to undertake at least six months training in a rural or remote area and also a placement of at least six months in a designated outer metropolitan area.

Other professions

Pharmacists are required to undertake a year of work experience under the supervision of a registered pharmacist before they too can be registered. And while not required for registration, nurses are generally required to undertake a year of postgraduate training in a hospital setting before being offered employment as a registered nurse. Further training is required to practise in and/or be registered in

speciality nursing areas such as midwifery and mental health, or as a nurse practitioner. Similarly, although not required for registration, allied health professions will undertake further training to specialise in a particular field.

Dentists wanting to practise in one of the dental specialities (eg orthodontics, oral surgery, periodontics) undertake training in the university sector under the supervision of fellows of the relevant college.

Further details on the education, training and registration of the health workforce by profession/occupation is provided in table B.12.

Table B.12 **Selected health workforce training & registration requirements**

Profession/ Occupation	*Entry training and qualification*	*Accreditation*	*Postgraduate training to practise*	*Registration*
Medicine	MBBS both as u/grad 5-6 years and p/grad 4 years	Australian Medical Council, Postgraduate Medical Education Councils, specialist medical colleges	Yes. Internship and residency followed by GP or specialist training	Medical Board in relevant State or Territory
Nursing	Bachelor of Nursing (3 years)	Australian Nursing Council in conjunction with nurse registration boards	No, but postgraduate training required for certain specialist fields (eg midwifery)	Nursing board in relevant State or Territory
Enrolled nursing	TAFE qualification or apprenticeship or trainee program (Cert IV TAFE)	Community Services and Health Industry Skills Council[a]		Nursing board in relevant State or Territory
Dentistry	Bachelor of Dental Science (5 years)	Australian Dental Council	No, but specialist training for orthodontists, dental surgeons etc.	Dental board in relevant State or Territory
Pharmacy	Bachelor of Pharmacy (4 years)	Council of Pharmacy Registering Authorities	Yes. Postgraduate training year	Pharmacy board in relevant State or Territory
Physiotherapy	Bachelor of Physiotherapy (4 years) Masters Degree (2 years)	Australian Council of Physiotherapy Regulating Authorities	No	Physio board in relevant State or Territory
Occupational Therapy	Bachelor of Occupational Therapy or Health Science (Occupational Therapy) (4 years)	Council of Occupational Therapists Registration Boards	No	Registration only required in Qld, SA, WA and NT with relevant OT Board.
Aboriginal Health Work	Certificate III or IV in Aboriginal Health Work (Clinical) or equivalent	Community Services and Health Industry Skills Council[a]	No	Registration only required in the NT
Chiropractic	Bachelor of Chiropractic Science (4 years) or 2 year Masters	Australasian Council on Chiropractic Education	No	Chiropractors board in relevant State or Territory
Optometry	Bachelor of Optometry (4 years)	Optometry Council of Australia and New Zealand	No	Optometry board in relevant State or Territory
Podiatry	Bachelor of Podiatry (4 years)	Australasian Podiatry Council	No	Podiatry board in relevant State or Territory

a Develops competencies and training packages for enrolled nursing.

Source: Various.

C Measuring health sector productivity

This report focuses on ways of using Australia's health workforce more efficiently — that is, ways of improving productivity. It also refers to the need for improved measures of health sector productivity to facilitate the assessment of policy implications of change and to support an evaluative culture to inform health care more generally.

To date, evaluation of the productivity of the health workforce has been impeded by a lack of suitable productivity measures. Chapter 3 notes, among other things, that the appropriateness and success of health workforce reforms could be assessed against improvements in the productivity of health workers and the related quality and safety of service delivery. Chapter 9 suggests that a sound information base for workforce planning and policy appraisal is important. It reports on the need for the data to be collected and organised in an appropriately rigorous conceptual framework, particularly as related to productivity measurement.

This appendix sets out the Commission's assessment of the availability of data for productivity analysis and an approach that would enhance the quality of data for research into health workforce productivity. It considers what is involved in measuring productivity in the health sector and the data needed to do this. The discussion has been informed through consultations with the ABS, the AIHW and the Department of Health and Aging.

The appendix first provides a schematic outline of the health sector and some issues concerning the measurement of productivity in the sector. It then gives an overview of existing national studies that assess health sector performance and existing collections that appear capable of delivering the data needed to comprehensively assess productivity. The suitability of these frameworks and data sources for measuring productivity is then assessed. The appendix concludes by making recommendations to improve the suitability of Australian health data for productivity measurement.

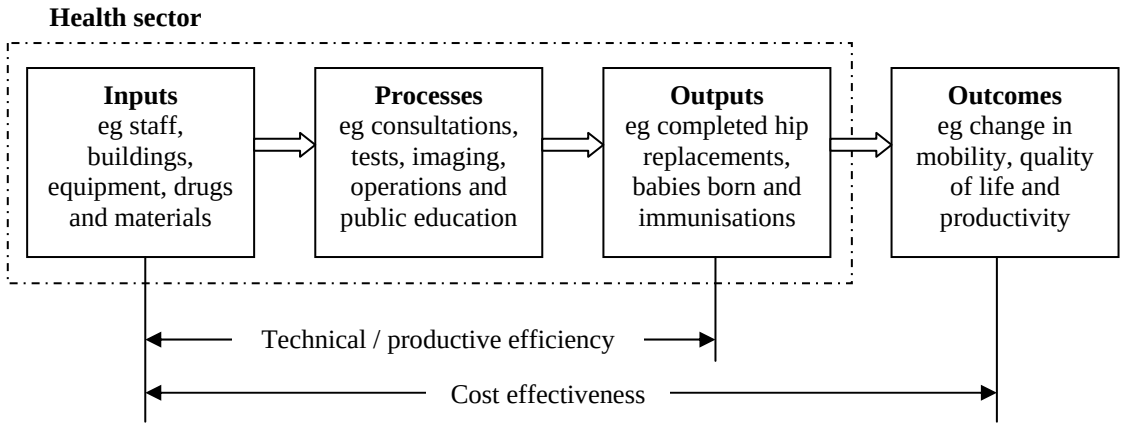
C.1 Assessing productivity in the health sector

Broad framework

The underlying demand for health care services is derived from individuals' desire for good health and the benefits in terms of quality of life and income earning capacity that good health can bring. In response, the health care sector converts physical and intellectual resources (inputs) into goods and services (outputs) (figure C.1). Its inputs consist of the health workforce (staff and their skills), buildings, land, technology, medical supplies, food, bed linen, office supplies, utilities, etc that are used to produce its outputs. The outputs of the health sector are numerous and vary substantially in character encompassing consultative and procedural services delivered in a range of community and institutional settings. They include general practitioner consultations, hip replacements, cataract operations, organ transplants, oncology treatments and immunisations. These outputs bestow benefits upon individuals and costs upon individuals, governments and third parties — to varying degrees — in the satisfaction of underlying demand.

The character and mix of inputs, processes and outputs, and the outcomes from the health care goods and services provided, varies substantially over time with the introduction of new or improved products, technological innovation affecting the delivery of products and changes in ways of working, as well as with broader influences such as relative prices and income levels.

Figure C.1 **Relationship between inputs, outputs and outcomes**



Source: Based on SCRGSP (2005b, p. 15).

At its simplest, productivity is the quantity of goods and services produced per unit of input. As such, it incorporates the technical efficiency with which inputs are turned into outputs, contributes to cost effectiveness (box C.1). Improvements in productivity can either reduce the cost of delivering a set of health services or enable more health services to be delivered for a given cost.

Box C.1 **Economic efficiency and cost effectiveness**

Economic efficiency is about maximising the wellbeing of the community. Economists commonly say that economic efficiency consists of three components.

Productive efficiency is achieved when output is produced at minimum cost. It incorporates technical efficiency, which refers to the extent to which, in the production of any good or service, it is technically feasible to reduce any input without decreasing output, and without increasing any other input. Eliminating waste is an obvious source of productivity improvement and higher living standards.

Allocative efficiency is about ensuring that the community gets the greatest return (very broadly defined) from its scarce resources. A nation's resources can be used in many different ways. The 'most efficient' allocation of resources uses them in the way that contributes most to community wellbeing. Prices received for outputs and costs paid for inputs are major factors that guide the allocation of resources. However, to promote the most efficient allocation, the prices in the marketplace of outputs and inputs may require some form of government intervention (ie to correct for 'market failures'). For example, taxes may be imposed on inputs or outputs when their market prices otherwise would not reflect true economic values, such as the adverse health effects brought on by pollution.

Dynamic efficiency refers to the allocation of resources over time, including allocations designed to improve economic efficiency and to increase productive potential. This involves finding better products and better ways of producing goods and services through activities such as education, research, development and innovation. Dynamic efficiency also refers to the ability to adapt efficiently to changed economic conditions, a capacity for optimally modifying output and productivity performance in the face of economic 'shocks'. Improvements in dynamic efficiency bring growth in consumption possibilities over time.

Improvements in economic efficiency bring improvements in living standards as resources are used to generate more income and satisfy more needs and desires in ways that reflect community values.

Cost effectiveness is a parallel concept to the components of economic efficiency. It is the cost of producing *a* given *outcome* (figure C.1). Cost effectiveness is a measure of the extent to which the resources used to produce a specified outcome are minimised. It involves comparisons of the costs of alternative ways of producing the same or very similar outcomes.

Disentangling factors that influence health sector productivity requires information on health service outputs, service quality and on all inputs. Measuring the efficiency of the health workforce, for example, requires information about the contribution of the health workforce and other inputs to the production of health services, how these vary across service providers and how they vary over time. Measuring the effectiveness of the health workforce also requires information on the extent to which the resulting health outcomes achieve the desired social or policy goals.

Productivity measurement

The economic framework supporting productivity analysis is most pertinent to goods and services produced and sold in competitive markets. That is, goods and services sold in 'the market sector'. The economic outputs of these activities can be valued at the prices at which they are exchanged in the market and provide a measure of output that is independent of the value of inputs.

The conventional approach to estimating productivity is by reference to changes in the physical outputs produced and the inputs used in production relative to some base period. These measures can be aggregated using value shares or prices. Under certain conditions, output shares measure the contribution of an additional unit of an output to wellbeing while input shares measure the contribution of an additional unit of an input to output, respectively.

Output is typically expressed in national productivity studies as the gross value of production measured in constant dollar terms. It is defined as finished goods produced or services provided that are made available for use by other producers and final consumers.

Changes in output can be decomposed into changes arising from the growth in inputs of labour, capital and materials and from the growth in other factors. At a general level, productivity growth can be measured by subtracting input growth from output growth.

Labour (ie workforce) productivity is the level of output per unit of labour input. Changes in workforce productivity can be decomposed into changes in total factor productivity and changes in the use of other factors of production — capital and materials — per unit of labour input.

In principle, improvements in the quality of the outputs and inputs should be recorded as units of output or input growth, respectively. More specifically, growth in output coming from technical or quality change embodied in capital and materials (through better design or functionality) and labour (through better education and on the job training) should be attributed to increases in factor

services. For example, where the quality of an output varies with the occupation, educational attainment and work experience of the person performing the procedure, disaggregating workforce data by occupation, educational attainment and work experience would enable quality improvements embodied in labour inputs to show up as changes in the mix of those inputs.

In practice, it can be difficult to quantify the impact of quality changes and separate the effect of such changes from price and volume changes in underlying statistical series.

Non-marketed goods and services

The concept of productivity also extends to goods and services that are not 'marketed', including health services provided by governments and governmental instrumentalities.

However, identification and measurement of outputs in a sector with a large non-marketed component, such as health, is problematic. This is particularly so when decisions on the conditions of service provision, the level of service provided and its distribution are made by service providers based on deemed medical need, and are not the result of market exchanges between health service recipients and sellers of health services based on willingness to pay and costs of service provision. In the absence of independent measures of the value of health service output, proxy measures of output based on health processes or service costs are often adopted as indicators of the relative value and level of real outputs.

The identification and measurement of the value and quality of health inputs is, in principle, more straightforward because there are well established markets for most inputs to health service provision. In this sense, measurement of inputs to health service provision is similar to the measurement of inputs to other productive sectors of the economy. In practice, quantification of the concept depends on the availability of relevant data.

Overall, the quantification of productivity in the health sector, the contribution made by the health workforce and how this changes over time requires:

- measures of the level of activity disaggregated into outputs and inputs of a similar character;
- measures of output change that are independent of the measures of input change; and
- measures of the relative economic importance of each output and input (ie weight) suitable for aggregating data to form industry and sectoral totals.

C.2 Overview of Australian data on the health sector and its performance

A large body of information about the health sector exists. Some of this information has been assembled in summary form in national performance frameworks, while other information is from statistical or administrative data collections.

This section provides an overview of key national data series covering the health sector and draws attention to information in those series that could be used to support productivity analysis.

National performance frameworks

National frameworks for assessing health sector performance in Australia have been developed by the National Health Performance Committee (NHPC) and the Steering Committee for the Review of Government Service Provision (SCRGSP).

The National Health Performance (NHP) framework provides, at its most detailed level, 44 performance indicators across 18 'dimensions' concerned with health status and outcomes; health determinants; and health system efficiency (NHPC 2001). Of the 44 indicators, two are concerned with the productive efficiency of health service delivery, namely:

- hospital costs (indictor 3.14), as represented by the recurrent expenditure per casemix-adjusted separation for public acute care hospitals;[1] and
- length of stay in hospital (indictor 3.15), as represented by the average case-mix-adjusted length of stay relative to the Australian average for public acute care hospitals.[2]

The SCRGSP framework provides 74 performance indicators of equity, effectiveness and efficiency in the health sector. The efficiency indicators included in the SCRGSP are similar to those in the NHP framework.

These frameworks are primarily applied to the provision of data for public acute care hospitals (NHPC 2004, latest and SCRGSP 2005b, latest). The SCRGSP also

[1] Case-mix adjustment weights the actual number of separations for acute care hospitals in each State by an average cost weight to adjust for differences in the cost of treatment across clinical conditions. The average cost weight is calculated using Australia-wide average costs of treating each group of clinical conditions weighted by the actual distribution of 'separations' from acute care hospitals in each State.

[2] The case-mix adjustment process for the length of stay is analogous to that used for hospital costs except that an average length of stay weight is used in place of the average cost weight.

reports on aspects of primary and community health and health management (breast cancer detection and management and mental health management).

National data collections and data series

A range of national health data collections and data series provide detailed information on:

- outputs of, and expenditures on, selected health sector activities; and
- the health workforce for groupings of health workers.

The Australian national accounts (ABS 2004a) provides economy-wide measures of value-added output and labour inputs for the health and community services sector (ANZSIC division O). This sector includes activities such as hospital and medical practitioner services, community health as well as veterinary services. The national accounts measure value added output in 'real' (ie price adjusted) terms and labour inputs in terms of hours worked. The Australian national accounts, however, do not provide a measure of capital inputs (termed capital services in the national accounts) to the health sector.

The accounts also provide information on compensation of employees (labour income), gross operating surplus and gross mixed income (other primary factor income), total (primary) factor income, and the consumption of fixed capital (depreciation) for the sector as a whole. A summary measure of efficiency is provided in terms of labour productivity (ie value-added output per hour worked). The ABS, however, does not include the health sector in its calculations that explain the contribution of technical and organisational change — measured as 'multifactor productivity' — to output and labour productivity growth. These calculations are limited to 'market sector' activities.[3]

The Australian Institute of Health and Welfare (AIHW) is the pre-eminent collector of national health data in Australia. It conducts the Bettering the Evaluation and Care of Health (BEACH) survey in collaboration with the University of Sydney, conducts other health-related surveys, draws information from other collections (including the National Hospital Cost Data Collection (NHCDC)) and administrative sources (including Medicare records) to provide information on health activities, information about the health workforce and supporting data bases

[3] The ABS market sector activities include: agriculture, forestry and fishing; mining; manufacturing; utilities; construction; wholesale and retail trade; accommodation, cafes and restaurants; transport and storage; communications; finance and insurance; and cultural and recreational services. As well as health, they exclude property and business services; government administration and defence; education; and personal and other services.

(box C.2). The AIHW also manages the National Minimum Data Sets (NMDS) which are sets of data elements agreed for mandatory collection and reporting at a national level. The National Health Data Dictionary (updated annually) identifies data elements in the National Minimum Data Sets.[4]

Key supporting national data collections noted include the NHCDC (DOHA 2004b), the BEACH collection (AIHW 2004b) and Medicare Australia administrative and statistical records. These collections provide activity and selected cost information for hospitals, general practitioners and all medical practitioners, respectively (box C.3). Information from these collections is available on an annual basis from 1996-97, 1998-99 and 1993, respectively.

C.3 Suitability of Australian health data for estimating productivity

There is a wealth of information about the health sector available. Summary 'efficiency' measures have long been compiled as part of national performance frameworks. A large body of data is collected on the activities of the health sector and there is extensive documentation of medical capabilities and processes at the micro level (including through administrative records). However, available aggregative statistics have significant shortcomings for national productivity measurement and evaluation.

Output data

As indicated, Australian health data typically define output in terms of:

- the incidence of particular procedures performed; or
- the cost of service provision.

Such output information is typically classified according to the underlying clinical condition, using frameworks such as the AR-DRG or the ICPC that characterise the industry or activity concerned and provide a basis for productivity analysis.[5]

4 Descriptions of the National Minimum Data Sets can be found on the METeOR data base managed by AIHW·

5 As the various classifications used to measure health outputs tend to be linked to the WHO's international classification of diseases (ICD), activity measures could in principle be mapped to ICD categories to form a single classification system across industries and activities. This is seldom done in practice.

Box C.2 **Overview of Australian Institute of Health and Welfare data**

Outputs and expenses

The AIHW publishes estimates of health sector *output* measured at current and constant (ie inflation adjusted) prices by activity (2004c, latest). The current value of output for each industry within the health sector is measured on the basis of the total costs incurred in service provision. Constant price output for individual health industries is measured either by aggregating individual 'physical' outputs of the industry using benchmark casemix-adjusted costs as weights; or by deflating the current value of output by an appropriate output price index.

The AIHW also publishes information on national healthcare *expenditure* by activity and source of funds — whether Australian, State and Territory governments, private health insurers or individuals (AIHW 2004c, latest available). Government expenditure is divided into direct expenditure on healthcare services and indirect funding provided through, among other things, Medicare and the Pharmaceutical Benefits Scheme. The expenditure is reported in total with no breakdown by type of input (ie labour, capital and materials costs) to the provision of the service.

Health workforce

The AIHW collects details on the health workforce with the assistance of State and Territory registration boards (AIHW sub. 58). Annual data are published in respect of doctors and nurses (AIHW 2005b,d latest and AIHW sub. 58, p. 6). Survey data in respect of allied health professionals (eg audiologists, chiropractors, occupational therapists and podiatrists) are collected periodically (eg AIHW 2002 for podiatrists).

Data on the average number of hours worked by persons in the health workforce by occupation are compiled by the AIHW from data collected in its surveys of the health workforce (eg AIHW 2005b,d). These averages include health professionals employed in industries other than health. Little information is available on earnings by occupation and industry of employment.

The AIHW also compiles information on characteristics of the health workforce collected in the five-yearly ABS Census of Population and Housing (AIHW 2003a).

Health sector data bases

The AIHW maintains four national health-related data bases on: public hospital establishments; non-admitted emergency care; elective surgery waiting times; and hospital morbidity. These data bases contain a range of information on health outputs, inputs and service quality. Selected information from the AIHW health sector data bases is freely available on-line (eg hospital separations by disease type). Additional data are available from the AIHW on request.

Box C.3 **Key national data collections and supporting classifications**

Data collections

The National Hospital Cost Data Collection (NHCDC) provides activity and cost data for hospitals based on annual surveys of public hospitals, private hospitals and private same day care facilities (DOHA 2004a,b latest). Activity is measured on the basis of the number of 'separations' by clinical group, where separations refer to completed episodes of patient care (regardless of whether the patient is discharged, dies, is transferred to another hospital or the type of care changes). Clinical conditions are grouped according to Australian Refined Diagnosis Related Groups (AR-DRGs). Cost data are classified by item as set out in the National Minimum Data Sets of the National Health Data Dictionary.

The Bettering the Evaluation and Care of Health (BEACH) program provides data on general practitioner activity from annual randomised surveys (AIHW 2004b, latest). Data for general practice are classified according to the Australian version of the International Classification of Primary Care — Version 2 (ICPC-2) called ICPC-2 PLUS which covers reasons for encounters, problems managed, clinical treatment, procedural treatment, referrals, pathology test orders, imaging test orders and other investigations.

Medicare Australia (formerly the Health Insurance Commission) provides detailed information on the number and total cost of procedures funded by Medicare (termed 'services' and 'benefits', respectively). The data provide activity counts for general practitioners, specialists, optometrists, some allied health professions and different types of tests undertaken (eg pathology services). The data also provide information on the extent of public funding.

Supporting classifications

The version 5.1 of the AR-DRG (latest) defines 24 major diagnostic categories (MDC), which are subdivided into 665 diagnosis related groups (DRGs), based on similarity of condition and cost of treatment.

The International Classification of Primary Care – 2 PLUS (ICPC-2 PLUS): ICPC-2 was developed by the World Organization of Family Doctors (Wonca) and accepted by the World Health Organization (WHO). The ICPC is the national standard in Australia for reporting of health data from general practice and patient self-reported health information (AIHW 2004b, p. 8).

The availability of output information, however, varies between activities. Detailed output information is available on an annual basis for some health activities including hospitals, mental health services and medical practitioners. Information for other aspects of the health sector, such as optometrists and podiatrists, is variable regarding source, frequency of collection and coverage. Gaps in output series restrict the activity scope of health productivity measures.

Even when such output data are available, the measures have limitations for analysing productivity.

First, they lack information about service quality needed for comparisons over time. For example, technological change has seen the treatment of cataracts of the eye go from a procedure involving hospitalisation, substantial operating and physician time and frequent complications, to an outpatient treatment routinely performed in under half an hour with fewer complications and improved postoperative visual quality (Shapiro, Shapiro and Wilcox 2001). Use of incidence-based indicators of output, without adjustment, would show little change in the level of 'real' output even though the level of quality-adjusted real output has risen significantly. (Moreover, lower input requirements per procedure performed would be a reflection of productivity improving technical change rather than any lowering of service levels.)

Similarly, output in any year measured on the basis of the cost of the 'old' technology would be given a higher weight than output measured on the basis of the 'new' technology, all other things remaining equal. Hence, between years, the use of cost-based weights without adjustments for changes in service quality would, all other things being equal, result in a decline in measured 'real' output resulting from the introduction of new, lower cost treatment for cataracts.

Second, for publicly provided or funded health services, the level and mix of services is determined through an interaction of clinical and administrative decisions. As such, the implicit service price (ie the observed unit cost) is unlikely to be the same as the price for the service had it been provided in a competitive market. Consequently, the cost of health provision may not accurately reflect the value that the community places on those services. As a result, the use of health costs as the basis for measuring health output or as weights to aggregate incidence measures of output may not be appropriate for measuring productivity in the health sector. Moreover, any resulting productivity estimates would not be strictly comparable with parallel measures for marketed activities.

Incorporating service quality into the measurement of the value of health outputs is problematic and a number of approaches have been canvassed to address the issue. The NHPC (2004) explored the possibility of using quality-adjusted life years, disability-adjusted life years and disability adjusted life expectancy delivered by

health procedures. A limitation of these measures is that they would be influenced by other factors, such as education, diet, community services and personal circumstances, and, as such, only provide a qualified quality-adjusted indicator of actual health service output. A further problem is systematically converting these indicators into metrics for either estimating weights that should be attached to each health service, or projecting benchmark estimates forward over time.

Finally, estimating real output on the basis of costs depends on comprehensive measures of inputs that take account of changes over time in input prices and quality.

Health inputs

In addition to information on the total cost of health service provision needed to support estimates of the output of the health sector, the Australian health information system provides input data in terms of:

- sixteen 'cost-buckets' by AR-DRG group for selected hospitals;
- broad expenditure items for selected health services, including hospitals; and
- the health workforce for various groupings of health workers.

In national data series, detailed input data classified by input item are available on an annual basis for hospitals (DOHA 2004a,b). While information for hospitals is detailed, a limitation of the data is the grouping of disparate cost items within cost buckets that mask the nature of underlying expenditures. For example, the cost buckets 'ward medical' and 'ward nursing' cover medical and nursing salaries only. On the other hand, the cost bucket 'critical care' includes labour costs, medical supplies, other goods and services and depreciation of capital. It would be necessary to look behind these costs to quantify changes in the quality of individual inputs and how the real levels of inputs change over time.

Outside of hospitals, input data is somewhat patchy in detail and coverage. Moreover, although definitions for collecting such information are provided in the National Minimum Data Sets, the classification categories are often aggregative or broad in nature. For example, the data set divides measures of costs into non-salary operating costs, other recurrent expenditure, repairs and maintenance and salaries and wages. Again, it would be necessary to look behind such costs to quantify changes in the quantum and quality of inputs over time. It appears that in national data sets, this classification has only been applied to the compilation of data for community mental health establishments and public hospital establishments (NHDC 2003, pp. 704–16).

Cost data for hospitals and other health activities, when available, is typically provided only in terms of current dollars. A limitation of information provided on such a basis is that it does not have a physical dimension, that is, it is not expressed in real (price-adjusted) terms over time. It is therefore not well suited to tracing changes in the real value of service inputs over time or for assessing the impact of quality changes on inputs. While this gap is filled by aggregate cost data on a price-adjusted basis for activities across the health care activities and the health sector in total (AIHW 2004c), that data lacks the detail needed to draw links between inputs of the health workforce, capital and materials and output and its growth.

With respect to health workforce information, detailed collections covering health professionals and medical practitioners are generally separate from collections of inputs of ancillary service providers such as health administrators and caterers. These limitations further restrict the scope for drawing links between labour inputs to health service provision, health sector output and growth.

Finally, at this stage, only limited information is available on capital inputs by industry. Where such information is available, it is typically compiled according to historic accounting concepts rather than economic concepts.[6]

In summarising the availability and suitability of workforce planning data in Australia for measuring productivity, the following observations by the AIHW are a good synthesis:

> The inventory of data sources … provides information on many of these features. But the information base is far from ideal:
>
> - it must be patched together from a variety of sources, which are not based on consistent concepts – so judgment or synthetic methods must be invoked to construct the data needed for policy design and evaluation.
> - some key segments of the workforce are unmeasured or poorly measured or suffer from significant problems of data quality.
> - some data that are important for policy design and evaluation are available only with a long time lag. (AIHW sub. 58, p. 4)

[6] In this context, it should be noted that the SCRCSSP paper on *Asset Measurement in the Costing of Government Services* found, in relation to public hospitals, that: 'variations in asset measurement techniques may lead to substantial differences in reported capital costs'. However, it also found that for hospitals, when viewed in the context of total unit cost, these differences in capital costs are generally immaterial. Data therefore appear to be reasonably comparable for the purposes of the *Report on Government Services'* (SCRCSSP 2001, p. 41).

C.4 Improving Australian health sector productivity measures

The preceding discussion demonstrates that available information is disparate and does not provide integrated measures of health sector outputs and inputs needed to support the measurement of sector-wide productivity or productivity of the health workforce. Factors that limit the usefulness of current information for this purpose include:

- the quantification of health sector output on a basis that emphasises processes and process costs (such as expenditure on diagnostic and clinical procedures and 'separations');
- the resulting absence of measures that indicate how the quality of output changes over time and the valuation of outputs from the point of view of the consumer; and
- the absence of comprehensive information on the inputs, appropriately classified to items of a similar character and health-service activity.

These factors limit the scope for productivity analysis, including analysis of health workforce productivity, across health care categories and the analysis of changes over time. They concomitantly limit analysis of the impact of technology on the cost of delivering diagnostic and health services and the provision of transparent and reliable information for health care planning in the short, medium and longer-terms.

In a recent study looking into the measurement of government service provision and its productivity in the United Kingdom, the Atkinson Review (2005, p. 187) proposed nine broad principles covering outputs, inputs, deflators and productivity, three of which are:

- The output of the government sector should be measured in a way that is adjusted for quality, taking account of the attributable incremental contribution of the service to the outcome (principle B).
- Measurement of inputs should be comprehensive (principle F).
- Pay and price deflators should be sufficiently disaggregated to take account of changes in the mix of inputs; and should reflect full and actual costs (principle G).

Applying these principles to health, the Atkinson Review recommended outputs should be:

- weighted together according to 'marginal social values'; and

- quality measures should be developed covering all functions of the national health system.

However, giving effect to these sorts of recommendations is far from straightforward owing to the absence of comprehensive price-based measures of output and the absence of established procedures for projecting micro data about the health system and its performance to national productivity measures.

Against this backdrop, and as a first step towards developing robust and 'cost effective' productivity measures in the health workforce and the health sector more generally, the Commission considers that measures to support the quantification and evaluation of the productive contribution of the health sector to national output and the wellbeing of the community should:

- be based on independent measures of outputs from, and inputs to, the health sector;
- allow for quality differences between outputs and inputs and the incremental contribution of changes in quality to outputs and inputs;
- be comprehensive and inclusive of preventative, curative and management health services;
- be measurable and capable of being applied consistently across different health sector activities and aggregated to broad sectoral indicators of performance;
- maintain an output focus and avoid concentrating on component care processes, procedures and ancillary services;
- avoid creating adverse incentives for health workers, or for administrative or ancillary staff;
- be capable of evolving over time as medical technology, ways of working and outputs change;
- avoid unnecessary compliance costs for service providers and governments; and
- be compiled in a clear and transparent manner according to methods that are made available for evaluation.

What these principles mean at a practical level

At the outset, it needs to be re-iterated that the basis for valuing the economic outputs and productivity for a sector with a large non-market component such as health differs from that for sectors where the market component predominates. Because of these differences, data comparisons between sectors and across time are qualified.

That said, health sector output, as measured, contributes to national product. Further, any income generated by the health workforce contributes to national income. The deployment of labour into the health workforce also influences national labour productivity. To support quantification and evaluation of health sector contributions to the national economy, outputs and inputs first need to be categorised by industry as defined in the Australian national accounts. In particular, health sector activities need to be distinguished from other activities contributing to the health function, including education, medical equipment suppliers and pharmaceutical producers and suppliers.

Second, health sector measures of the value of output used to aggregate individual activities need to conform to the measures used to aggregate activities within other economic sectors. For health service output measured on the basis of supply costs, these values would be represented by the actual total cost of inputs.

Independence of outputs and inputs is crucial to measure that part of output growth that is accounted for by input growth and that part of output growth that is accounted for by other factors. Recent developments in the Australian national accounts have established an output and labour input data series conforming to this principle. These data are supportive of productivity measurement at the aggregate level. Detailed AIHW data appear to include independent indexes of physical outputs and some inputs that afford the opportunity to disaggregate the aggregative national accounts information. There would be merit in examining the scope for meaningful measurement of health sector productivity at the sub-sector level.

The absence of quality adjustments is a major deficiency of current output and input series for the health sector (see above). To some extent, the gap on quality is filled by parallel data on ‘health outcomes’ in the national performance frameworks. However, such measures are imprecise indicators of the incremental contribution of health service quality to output and inputs and are not integrated with the health sector output and input series as such. There would be merit in developing quality-adjusted output and input measures (box C.4). As part of the development of quality adjusted input series, there would be merit in disaggregating workforce data into occupational and/or other skill groups, as appropriate, in order to assess the incremental contributions of alternate health workforce groups to sectoral output.

Box C.4 **Measuring quality in healthcare**

Many factors bring about changes in output and input quality.

For example, research may lead to a better understanding of illness that leads to the development of more effective drugs, treatments and technology or the redesign of existing systems and processes. Likewise, better education and on the job training may translate into a more 'effective' health workforce. Quality may also vary with resource inputs and the competing demands being placed on the health workforce.

Some aspects of quality are measurable against objective or pre-defined standards (eg average waiting times, infection rates, babies delivered without complications and unsuccessful separations). Surveys can elicit important aspects of quality care such as courtesy, cleanliness and friendliness from the perspective of patients. Accreditation of health facilities and staff qualifications by external organisations may also be indirect indicators of input quality.

Measures of quality can be incorporated into assessments of productivity in various ways. Ideally, the quality of outputs and inputs should be recognised explicitly, either by treating quality as a component of output or input in its own right (along the lines of the performance indicators of quality used by the NHPC 2004 and SCRGSP 2005b) or by using quality-adjusted measures of output and inputs. Quality can also be incorporated implicitly by adjusting the weights used to aggregate outputs and inputs.

However, not all aspects of quality in healthcare are easy to measure. The impact of illness and the resulting treatment on patient wellbeing (morbidity), for example, is difficult to measure, as is the contemporaneous skill of medical staff in operations. As a result, it is difficult to incorporate all aspects of quality into any assessment of health sector productivity. Nevertheless, the inclusion of soundly based and unbiased quality indicators would add valuable information to measures of the productivity of health services provision.

Comprehensiveness can refer to the coverage of transactions or the coverage of health-related activities. Comprehensiveness of transactions is facilitated by the inclusion of *all* economic outputs and inputs of relevant activities. Comprehensiveness is needed to avoid biases from omission in estimates of productivity. Expediting the inclusion of capital services and material inputs in benchmark national accounts series would be of value for health sector productivity analysis. The expansion of existing data collections within the health sector to provide more information on the use of homogeneous groupings of all inputs, especially capital, would also be beneficial.

Comprehensiveness of coverage of activities contributing to the 'health function' would enable the incremental impact of output and input decisions across functions to be quantified. It would also enable assessments to be made of the implications of changes in one health-related activity on other activities. For example,

- how ancillary health services influence the productivity of hospitals or, similarly, how the input and output decisions of hospitals affect ancillary services; and
- how improvements in one area (eg better preventative or ameliorative measures) alter the average health workforce and other input requirements of other health care services — such as acute treatment, as those treatments shift toward the 'more difficult' cases which have higher input requirements.

As the health function crosses a number of national accounting industries, there would be merit in examining the desirability and feasibility of establishing a national health 'satellite' account which disaggregates national benchmark data.

The large body of data available in the Australian national accounts, AIHW and other health-related series suggests that most health outputs and some inputs can be quantified on a regular basis. The national accounts provide data with quarterly and annual frequency, while other data are more typically available annually. There is also evidence that outputs and inputs can be disaggregated into categories of like items that would support productivity analysis. However, the lack of industry detail limits the usefulness of much of the data available. Further, data collections on the 'quality' of outputs have not been operationally integrated with health services provision data. These areas would benefit from significant further development and, where practicable, should be compiled from existing management information systems.

Economic outputs are conventionally measured in terms of goods and services used by patients (the consumers of health services) or as an input to industry. However, important outputs in the sector (including hospital outputs) are measured on the basis of health events such as 'separations' or completed episodes of patient care. For non-market production, these events may not represent service packages that would otherwise be agreed between willing buyers and sellers of such services. Event-based measures of health services may warrant adjustment to proxy (unobserved) economic output.

Biases in estimated productivity could provide adverse incentives to service providers using that information to guide decision making and could potentially distort decisions. For example, the omission of a quality adjustment from indexes of output could lead to the judgement that a lowering of costs per unit of output is solely attributable to an improvement in 'efficiency'. Similarly, an increase in the incidence of 'separations' due to greater specialisation in health functions and an associated higher level of 'intra-industry trade' could lead to a judgement that output per unit of input has increased. Such biases should be avoided as far as practicable, or data qualified as appropriate.

To be capable of evolving over time with changes in technology and ways of working, the estimates need to be based on an information system that includes quality changes and a disaggregation of outputs and inputs that would enable sources of change to be identified and subjected to credibility checks. The omission of quality adjustments in the current series and the omission of capital and material inputs from the ABS estimate are significant impediments to satisfying this principle.

The avoidance of unnecessary compliance costs, and need for clear and transparent data collection and analysis are general principles governing regulation design. The sources and methods should be published, be widely available and be subject to peer review.

Overall, currently available information does not support the full assessment of health sector productivity and hence the efficiency of health service provision. It would be possible to improve the relevance and reliability of measures of health sector outputs and inputs and fill this information gap. The design principles for measuring health sector productivity listed above and the discussion of what these mean in practice should assist in the process of improvement.

The Commission will continue to work with the ABS, the AIHW, the Department of Health and Aging and other interested parties with a view to mobilising the large body of micro data and information necessary to translate these principles into concrete national productivity estimates for the health sector and the health workforce. Among other things, the availability of such measures would:

- facilitate independent evaluation of outcomes of policies to improve service delivery;
- strengthen ongoing analysis of the performance of the health sector as a whole; and
- provide a valuable resource that could be drawn on by a range of researchers and by various government agencies involved in health care policy formulation, implementation and evaluation.

The Commission intends to report on the progress of this stream of work.

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