

# Review of Australian Government Health Workforce Programs

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## Executive summary

This review of the health workforce programs funded by the Australian Government was commenced in October last year, with terms of reference to:

- analyse existing programs to ensure these are aligned with workforce priorities;
- analyse existing rural health programs to ensure optimal service delivery;
- analyse existing information and key stakeholder experiences to evaluate whether the objectives of current measures are being met and whether these programs could be improved;
- provide opportunities for stakeholder consultation;
- identify opportunities to better align measures with workforce priorities, including through modifications and amendments to existing measures, or development of new measures; and
- provide advice to government about how to support the delivery of a high quality, well distributed optimally utilised and responsive health workforce.

The remit of this review has been tightly focused and time limited, concentrating on appropriate evaluation of those programs currently funded and administered through the Health Workforce Division of the Department of Health and Ageing (DoHA). The aim has been, so far as possible, to make concrete recommendations for practical reforms which are administratively achievable in the short to medium term.

The programs which are the subject of this review are important and significant. However, “root and branch” reform of the major drivers of the Australian health workforce cannot be achieved by the levers available to Health Workforce Division, or indeed DoHA, alone. Two other review processes are therefore important. The first is the scheduled analysis of the ongoing role and function of Health Workforce Australia, as part of the National Partnership Agreement on Hospital and Health Workforce Reform, which is due to expire at the end of 2012-13. The second is a fresh analysis of the health workforce in its entirety by the Productivity Commission, which has been foreshadowed to take place in the medium term and which would undoubtedly be valuable.<sup>1</sup>

Without the active cooperation of the states in addressing many of the issues facing Australia’s health workforce, and comprehensive data from the private sector and nongovernment organisations, as well as industry policy, immigration and the wider tertiary sector, initiatives in this area will continue to be piecemeal at best.

With respect to the review’s methodology, a triangulated approach was taken which was designed to provide extensive analysis of the health workforce programs funded through the Health Workforce Division. The three major activities undertaken were:

- *Analysis* of each individual program/activity managed by Health Workforce Division and other workforce programs implemented by other divisions within the department;
- *Research* and development by the secretariat of a series of papers including ‘context papers’ written to provide background on health workforce issues. A

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<sup>1</sup> There is some discussion of these forthcoming reviews in Chapter 9 of this report.

literature review was also undertaken of all relevant program evaluations, reports and parliamentary inquiry reports; and

- *Consultations* with stakeholders, undertaken between October and December 2012, which included interviews, written submissions and roundtable discussions aimed at identifying health workforce issues and program delivery concerns.

Some overarching themes have emerged from this review:

- The health system exists in order to improve the health of the population and of health consumers. Health workforce programs, in turn, exist to assist in meeting patient need. While this should be self-evident, it is too easy in considering health workforce programs to become focused on whether they meet the needs of practitioners or institutions, rather than those of patients and consumers.
- The current system, despite reforms, continues to be focused heavily around increasingly expensive and specialised acute care in major metropolitan centres, rather than on measures to redirect resources to the provision of high quality primary care, population health initiatives and preventative care. This is both unaffordable in terms of escalating future cost, and inimical to optimum patient care, particularly of chronic conditions.
- It is imperative both economically and for population health to move beyond a focus on specialist medicine and acute care beds, to appropriate generalist skills, team based community care and the training and development of the nursing and allied health workforce.
- The most significant health workforce issue, particularly in the area of general practice medicine, is not one of total supply but one of distribution, which is to say inadequate or non-existent service provision in some rural and remote areas, and to populations of extreme disadvantage, most particularly the Aboriginal and Torres Strait Islander communities and some outer metropolitan communities.

In recognition of the importance of these issues, the strongest recommendations arising from this review concern the imperative to create a coherent pathway for rural and regional education and training – in the short term and as a matter of urgency for medical training, especially generalist training – but which over time should also produce more appropriate resource allocation to nursing, allied health and dentistry. If implemented, these recommendations have the potential not only to achieve better health workforce outcomes in rural and regional areas, but to foster more generally an emphasis on generalist medicine and integrated primary care.

Substantial recommendations are made for the reform of a number of programs, particularly the rural classification system currently used to determine eligibility for incentives. The most ambitious recommendation concerns the development over time of a regionally determined incentive model, moving away as far as possible from a centrally mandated incentive structure toward a model under which packages of incentive funding may be flexibly deployed to meet identified local need and service gaps.

Consistent with the identified priorities of the Health Workforce Fund (through which the bulk of the programs are funded), the report and recommendations are organised thematically to focus upon strategies to:

**Ensure a capable and qualified workforce** – through registration, accreditation, training and development;

**Increase the supply of workers in all health professions** – and facilitate a more even distribution of workforce in terms of geography and of the types of services provided;

**Support the Indigenous health workforce** – through activities that promote an increase in the Aboriginal and Torres Strait Islander health workforce and increase the capacity of the broader health workforce to address the needs of Indigenous people.

**Address health workforce shortages in regional, rural and remote Australia** – through, for example, rural workforce programs and better targeting of workforce incentives.

The report also contains specific sections on the nursing and midwifery workforce, the dental and allied health workforces and on program management reform within DoHA.

## Chapter 1: Review background

Chapter 1 of this review outlines the review methodology and consultation process. This chapter provides a short summary of the various Australian Government health workforce programs. Part of the agenda of this review is to make available to stakeholders and the wider public a substantial amount of material which has not previously been in the public domain.

It is clear that there has been a substantial growth in Commonwealth funding for health workforce programs – from \$286 million in 2004-05 to a projected \$1.79 billion in 2016-17. Growth in funding for medical training programs has demonstrably increased, particularly to support rural medical training and the expansion of vocational training programs (GP and specialist training).

There has also been an increasing emphasis on support for nursing/midwifery and dentistry and, to a lesser extent, allied health.

The investment in Health Workforce Australia (HWA) has been a major factor in the growth in Australian Government funding for health workforce development. The data collated and analysed by HWA – summarised in chapter 2 – is subject to continuing refinement and improvement, but provides a strong foundation to inform evidence-based policy for the future.

## Chapter 2: Health workforce context

This chapter provides an overview of the current Australian health workforce, largely drawn from HWA's *Health Workforce 2025 – Doctors, Nurses and Midwives* (HW2025), including data by professional group, and distribution as well as projected education and training requirements.

It is clear that the distribution of the workforce, work practices and an ageing population profile all heavily affect the supply of health services.

Labour force survey data shows that the average working hours of many health professionals are reducing and research shows that the working hours of future graduates will continue to fall. Given the ageing of the workforce, and reduction in work hours from both genders, the evidence is that the increased training, graduation

and recruitment of health workers will in many locations lead only to a small net increase in the number of full-time equivalent (FTE) practitioners.

The current geographic spread of the health workforce does not reflect the distribution of the population. With the exception of nurses and midwives, the relative number of health professionals diminishes for communities located further away from major centres. Allied health, dental practitioners and medical specialists are in severe shortage in outer regional, remote and very remote areas. This has been a key focus of the review.

### *Demand*

The demand for health services is projected to increase for a variety of reasons including increased chronic disease, greater consumer expectations and a treatment and funding model which has been built around short-term acute interventions. The increasing prevalence of chronic disease has implications not only for the number of health workers required in the future but also the skill mix and models of care required. Multi-disciplinary and team-based care is becoming increasingly important in the management of many chronic diseases.

### *Health Workforce 2025 report*

In the context of increasing demand for health services and current shortages, a workforce projection study was undertaken by HWA to assist in future workforce planning. The study modelled future health workforce supply and demand across a number of possible policy scenarios taking into account the ageing population and current service utilisation rates. Without reform, the report predicts a shortage of 109,490 nurses and a shortage of 2,701 doctors by 2025. The recruitment and training of this number of health professionals is neither possible nor affordable and is predicated upon an unsustainable model of health care delivery. Many of the issues and challenges identified in this report have been considered during the review.

### *Reform/policy environment*

It is important to recognise the implications of wider changes to health policy for the development of the health workforce. In particular, the national health reform process is predicated upon a shift in focus away from acute care and toward more coherent delivery of connected primary health care, with a focus on the prevention and better management of chronic disease.

Even with substantial reform, it is likely that the increasing demand for health services will result in a shortage of doctors, nurses and a likely shortage of dentists and some allied health professionals. This has consequences for government policy in terms of training, immigration, role redesign and incentives used to encourage a more even distribution of health professionals across Australia.

The HWA modelling indicated that the most effective policy intervention for meeting the increased demand would be to adopt a process of reform and innovation to increase the productivity of the future workforce. Along with the use of technology, increased productivity can be gained through role redesign which will allow health practitioners to work at the fullest extent of their scope of practice, encourage greater flexibility and multidisciplinary learning, and allow practitioners to use more varied and transferable skills. There is a need to reshape health services, particularly for



chronic conditions, to a patient centred model built around consumer engagement. The primary care concept of the “medical home” is an important model here.<sup>2</sup>

### Chapter 3: Ensuring a capable and qualified health workforce

This chapter outlines the quality framework applying to health professionals, and describes, in broad terms, the Australian health education and training system. It discusses the Commonwealth programs that support this system and investments in clinical training for health professionals, and vocational training for medical practitioners. There is also discussion of the impact of the introduction of the National Registration and Accreditation Scheme (NRAS) in 2010.

This chapter also examines the use of scholarships as a mechanism to promote the growth and sustainability of specific sectors of the health workforce.

#### *Quality framework*

The introduction of NRAS was intended to assist health professionals to move around the country more easily, reduce red tape, provide greater safeguards for the public and promote a more flexible, responsive and sustainable health workforce. However, while the introduction of the scheme has delivered many benefits, there are a number of residual issues that may be impeding the ability of some health practitioners to provide the full range of care allowed within the relevant professional scope of practice.

In particular, strong evidence to this review was that the introduction of a requirement to undertake new degree level study for nurses and midwives who have been out of the workforce for more than ten years is one of a number of disincentives discouraging return to the workforce. This has particular impact in rural settings and for Aboriginal and Torres Strait Islander communities. The review suggests that supports for re-entry for this group should be a priority.

Another issue relates to arrangements for prescribing. A range of health professionals currently prescribe medications in Australia, but authority to prescribe is determined by state and territory drugs and poisons legislation, and there are differences between the jurisdictions in terms of the authorised professions and associated conditions. This creates some barriers to the benefits of workforce flexibility and mobility that were delivered with the introduction of national registration.

HWA has been undertaking work in this area with a view to advancing a nationally consistent approach to prescribing by health professionals other than doctors. The Health Professionals Prescribing Pathway (HPPP) project is aiming to establish a common framework for all non-medical prescribers to advance workforce reform.

Several professions made representations during the review seeking to be included in NRAS, and raising concerns about the decision of Health Ministers to limit consideration of national registration for any extra professions. They perceive that this has had an unintended consequence of stratifying the allied health professions with loss of professional status for those not registered, and in some cases, the professions being overlooked to assist in service delivery under Commonwealth and state programs.

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<sup>2</sup> The ‘Medical home’ concept is described in Box 2.4 of the report.

## *Health education and training*

### *Clinical training*

Concerns about the capacity of the health sector to support the clinical training needs of an increasing number of undergraduate health students have been expressed over a number of years, and were consistently raised during the course of the review.

HWA's Clinical Training Funding program is discussed in the review and some stakeholder concerns are expressed about unintended consequences of the provision of this funding, including an escalation of the cost of clinical training services, mainly in the hospital sector.

The private health care providers consulted as part of the review consider that there is a significant level of untapped capacity in their sector for the clinical training of all health professions.

While the move to a demand-driven system of university places (outside medicine) will assist in responding to Australia's future health workforce needs, its impact on the clinical training system needs close monitoring, given the extensive clinical placements required as part of a health professional's training. Expanded use of simulated learning environments is likely to be necessary.

### *Intern training*

With the increase in medical students, there has also been a substantial increase in the overall number of intern training positions, from around 1,500 in 2004 to 2,753 in 2011.

Despite this growth, current accreditation requirements have been raised as a barrier to more innovative solutions to expanding intern capacity, particularly in the rural and private sectors. The Australian Medical Council is implementing new national standards for the accreditation of intern positions. This is likely to improve the consistency between jurisdictions in the medium term. Discussions are ongoing about the adoption of a new national process for intern selection, and indeed about a fresh approach to the definition of internship going forward.

### *Prevocational training*

The Australian Government's major contribution to prevocational medical training to date has been its support for the Prevocational General Practice Placements Program (PGPPP).

PGPPP has been used as a solution to building prevocational training capacity. Moving interns out of hospital settings, even for a short period, frees up additional placements in settings which provide training for interns.

The current challenge is to develop a system that maintains the benefits of prevocational training in private general practice and community settings while establishing a more cost-effective and sustainable funding base for this activity. One element of such a proposal in the form of a new rural training pathway is outlined in Chapter 4.

### *Vocational training*

Stakeholders have advocated for an increase in the overall number of placements on the Australian General Practice Training (AGPT) program on top of current growth,

with a suggested expansion of up to 600 additional places to a total of 1,800 per annum.

Stakeholders have presented strong arguments during this review that increasing the number of GPs and “generalists” needs to be a key priority in workforce planning and future funding for medical training. This is supported by the findings of the third volume of HW2025 – Medical Specialties – released in November 2012.

### Specialist training

Concern is frequently expressed about the lack of clear linkages between the different initiatives investing in medical education. There is no requirement for universities, GP regional training providers or specialist colleges managing the Specialist Training Program (STP) to collaborate to ensure that career pathways are transparent for either students or graduates participating in these initiatives.

The STP has been successful in extending vocational training into new settings, particularly the rural and private sectors. It has demonstrated that specialist colleges can take a flexible approach to accrediting new positions and to supporting networked training arrangements involving multiple health care settings, sometimes in different regions. However, the program’s national application rounds have been consistently oversubscribed and there is no further growth built into the program beyond 2014.

Although the STP is widely regarded as a successful initiative, there is no clear pathway for graduates interested in working in the type of settings supported by STP (i.e. rural and private) to enable them to plan to undertake placements in this program. This problem persists beyond STP, and the lack of structured pathways into vocational training outside general practice is an issue.

The Standing Council on Health (SCoH) has recently acted to address this lack of coordination in the medical training system through the introduction of a National Medical Training Advisory Network (NMTAN), which was agreed in November 2012. The NMTAN has strong potential to improve the connection of the various stages of the medical training pipeline and the capacity to make evidence-based decisions.

### Inter-professional learning

Inter-professional learning (IPL) presents opportunities for efficiencies in how training is delivered which could be applied in a broader range of settings.

Some institutions which coordinate rural clinical placements – particularly universities delivering the Rural Clinical Training and Support (RCTS) program and the University Departments of Rural Health (UDRH) initiatives – have demonstrated success in pursuing a more inter-disciplinary approach.

There has reportedly been a degree of professional resistance to the concept of IPL.

### *Health education scholarships*

The majority of the scholarship programs in the Health portfolio are managed within Health Workforce Division, although scholarship programs have also been established elsewhere in the Department, in areas including Ageing and Aged Care Division and Pharmaceutical Benefits Division.

There is limited evidence to show whether desired workforce outcomes are actually achieved through scholarship programs. There is some evidence (mostly career intention data) to support continued investment in scholarships targeted at

distribution, e.g. the Rural Australia Medical Undergraduate Scholarship Scheme (RAMUS).

As part of the review's consultations there was detailed discussion of the Medical Rural Bonded Scholarship (MRBS) scheme. Evidence is lacking that coercive schemes of this type result in longer term positive connection to rural life. The scheme is administratively expensive, relying on complicated contractual arrangements and enforcement action. This review recommends that it should be phased out and funds redirected to non-bonded scholarship schemes such as RAMUS which is targeted at those from rural backgrounds and with demonstrated financial need. Administrative and other savings should enable broadening of support beyond medical students with additional funds to nursing and allied health professions, which is both equitable and desirable in health workforce terms.

The rationalisation of some scholarship schemes in 2010, while not universally popular, did produce administrative savings and program efficiencies. There was discussion during the review process as to whether further consolidations should occur, as there are still many Commonwealth health scholarship programs.

This could encompass programs managed within HWD and might extend to include all scholarship programs managed within DoHA, including aged care scholarships and pharmacy scholarships. There is potential for external scholarship administration to be streamlined.

There are inconsistencies between the criteria under which different scholarships are awarded. It would be beneficial to have some consistency amongst the different schemes, allowing for the necessary differences in the target recipients. A commitment to a consistent evaluation framework based on workforce outcome data should be built into all contracts with scholarship administrators going forward.

In some areas, particularly nursing and midwifery, Commonwealth scholarships are in competition with those offered by the states and territories. This could represent a duplication of resources, and is likely to be causing some confusion among students.

Key stakeholders, including the Australian Nursing Federation, have asked the Commonwealth to consider increasing the number of scholarships available to nursing and allied health students. Allied health stakeholders also raised this issue during review consultations.

### Chapter 4: Addressing health workforce shortages in regional, rural and remote Australia

This chapter examines workforce distribution programs, including educational initiatives, rural incentive schemes and professional support programs, such as the various locum initiatives. The chapter also outlines options for reform of the much contested Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA) system, including a discussion of issues surrounding its usage across different programs.

#### *Health education strategies for rural distribution*

The use of education and training programs to influence health workforce distribution has been a major focus over more than a decade. Policy and programs targeted at this issue are based on evidence that students who come from rural backgrounds and/or those who spend (well supported) time training in a rural setting will be more likely to pursue a rural career upon qualification.

Rural training programs received strong stakeholder support during the review and in general, issues related primarily to new proposals to expand activities to enhance distribution outcomes. The evidence supporting rural training initiatives is encouraging but not yet conclusive. The review suggests a number of program reforms to enhance outcomes, with the major issues discussed below.

Most Australian medical schools receive Government funds under the RCTS program. There are currently 17 universities participating in the program. The RCTS program targets include:

- 25% of Australian medical students are to undertake a minimum of one year of their clinical training in a rural area (defined as ASGC-RA 2–5) by the time they graduate;
- 25% of Commonwealth supported medical students are to be recruited from a rural background; and
- all Commonwealth-supported medical students must undertake at least four weeks of structured residential rural placement in an ASGC-RA 2–5 region.

A consistent theme in recent studies of the RCTS program has been the suggestion that longer placements generate better outcomes. It is recommended that the current mandatory short-term placements be abolished and replaced by longer term elective placements. This would mean that the considerable cost of supporting rural placements for all medical students should be diverted towards other priorities within the program. In particular, nursing, allied health and dentistry students may thereby gain access to supports such as accommodation which are currently entirely absorbed by short-term medical student placements.

The UDRH program establishes a university presence in rural areas and offers clinical training opportunities for medical, nursing and allied health students. It also offers research and educational opportunities for students and health professionals in rural areas. There are 11 UDRHs nationally.

UDRHs are managed under funding agreements with a single host university, but often support student placements from multiple universities. A benefit of both the RCTS program and the UDRH program is the infrastructure support they provide to rural centres and their ability to reduce the professional isolation of local practitioners. Important initiatives for support and training of locally recruited students and staff offer the best prospects for long-term retention of a viable health workforce.

#### Rural education strategies for allied health

At present, the UDRHs are very active in coordinating rural clinical placements for allied health students, with pharmacy, physiotherapy, dentistry, occupational therapy, dietetics and oral hygiene students among those regularly placed. A number of UDRHs, such as the Broken Hill UDRH, have recently pioneered a new service learning model aimed at strengthening clinical training.

The model is based on the principles of improving community access to health care while providing enhanced student learning, and involves students providing services to patients under supervision in carefully controlled clinical environments. Expansion of this model is constrained by current UDRH funding limitations. The role of UDRHs could be enhanced with further funding.



It has been suggested that current university rural origin entry targets for medicine should be extended to the allied health disciplines. Due to the high numbers of allied health courses and the large number of allied health and nursing students in the tertiary education sector, the costs of implementing such a target could be significant, as well as difficult to set and monitor.

### Rural training pathway - post university

Training doctors in rural areas is a key part of the strategy to ensure that there is a measurable increase in the supply of health services to those communities. All medical graduates need to complete an internship to gain general registration. Under current models, the intern year tends to be spent in metropolitan centres where teaching hospitals are located – rotations in medicine, surgery and emergency medicine are compulsory but not available everywhere.

During the review stakeholders cited the lack of a clear pathway from undergraduate rural training into employment as a rural doctor (post-fellowship) as a key reason why students who are interested in rural health are regularly lost to the metropolitan health system. There is strong merit in exploring more structured investments in networked intern places based in rural areas, involving a combination of acute care and primary care training in a range of settings (e.g. private, community or Aboriginal Medical Service), with transfers back to metropolitan areas for rotations where necessary.

A rural training pathway already exists for general practice under the AGPT. However, the missing link is the availability of rurally-based internship positions through which rurally trained medical students can transition directly to vocational GP training.

In the other specialties, this lack of rurally-based intern positions is further hampered by limited rural training opportunities for trainees seeking fellowship of a specialist medical college, noting that the STP (see Chapter 3) has made some difference in this area.

One of the key recommendations of the rural chapter and indeed the report is that a more integrated rural training pathway focused on encouraging generalist training should be developed, the genesis of which could be funded through some redirection of existing program funding. The chapter outlines a potential model for delivering this integrated pathway, with a significant emphasis on the need to foster regional partnerships and ensure greater collaboration between the various programs to ensure sustainability and better clarity on options for students. There is also potential for extending this model to other health disciplines, particularly in areas such as advanced nurse training.

While some existing program resources could be used to establish the national rural pathway, it is likely that new funding would be needed to support large numbers of graduates.

### *Rural recruitment and retention strategies*

Financial incentives for rural doctors should continue to be supported by the Government. However, there are concerns around whether current programs are effective and financially sustainable. The causal impact of financial incentives upon recruitment and retention is often asserted, but seldom demonstrated. The evidence suggests that these payments are only one factor in a complex series of influences

on whether health professionals choose to stay in, or move to, rural areas. Local recruitment, training and professional development opportunities as well as community engagement have been demonstrated to be the key factors in attracting a stable long-term health workforce.

The discussion in this report mainly focuses on the General Practice Rural Incentives Program (GPRIP) and recommends this program should undergo substantial reform to address stakeholder concerns and problems identified in its design.

The unsustainable growth in GPRIP retention payments to doctors in inner regional areas (RA2), relative to those in more remote locations, is a concern, as is the demonstrable lack of impact of currently available relocation payments. It is suggested that the current focus on financial incentives for doctors, at the exclusion of other health professional groups, is neither equitable nor evidence-based.

Chapter 4 outlines a new program concept to replace GPRIP based on a regionalised system for distributing incentives to doctors and other health professionals. This option is based on transferring GPRIP funds to a capped incentive pool which could be allocated through a combination of the Rural Workforce Agencies and the Medicare Locals.

This proposed system would shift incentives away from the current entitlement approach and allow funded agencies to determine need at the local and regional level, guided by overarching program parameters set by the Government. This would allow flexibility in how different regions use incentives (either for relocation or retention) to support workforce development in their area. While this proposal appears to offer a number of advantages, it will require substantial operational development.

An alternative solution relates to how the current rural classification system is used to determine eligibility. It is suggested under this second option that GPRIP could be retained but underpinned by an enhanced classification system allowing incentives to be more sharply targeted towards smaller and more remote communities with greater workforce needs (see below).

Allied health and nursing groups strongly support the extension of the HECS Reimbursement Scheme to their professions. However, the current program is administratively complex, effectively operating as a cash grant to rural doctors rather than a revenue foregone scheme involving discounting HECS debts through tax returns.

It is suggested that rather than expand the current DoHA program, it should instead be integrated with the similar scheme for nurses managed by the Department of Industry, Innovation, Climate Change, Science, Research and Tertiary Education through the Australian Taxation Office. Subject to funding availability, this might provide a platform for the extension of HECS forgiveness to other professions targeted as areas of future workforce need such as the allied health professions.

The Rural Health Continuing Education program provides professional development support for rural health professionals in two streams – one for specialist doctors (stream 1) and the other for allied health professionals, GPs, nurses/midwives and Aboriginal health workers (stream 2). Both streams are oversubscribed, with particularly strong demand for more support under stream 2, and it is recommended that the Commonwealth should consider expanding this program. The value of the various rural locum programs as an important support mechanism assisting with

rural workforce retention is also acknowledged. However, it is suggested that there could be efficiencies in streamlining the administration of the various schemes while still enabling funds to be directed towards specific workforce groups.

### *Reform of the ACGC-RA rural classification system*

The impact of the adoption of the ASGC-RA classification system was one of the key issues raised by stakeholders during the review process. The issues with the current system revolve around the large area of the country classified as RA2 and, to a lesser extent, RA3, which contain a diverse mix of large and small towns, and which the evidence suggests may have very different workforce challenges.

A broad stakeholder working group was formed as part of the review to examine options for improving the current classification system. While there were some divergent views, general consensus was reached around a number of key principles, which revolve around better use of evidence to determine the relative needs of communities while maintaining a stable, regularly updated geographic system that measures both town size and remoteness without being subject to arbitrary changes.

It was recognised by the group that any system will have imperfections. There was general agreement that the core of the ASGC-RA system should be retained but that it should be customised to provide a more advanced system of classifying rural locations for health policy decisions.

The enhancement to ASGC-RA proposed by the Monash University School of Rural Health is a valuable one. At the heart of the “Monash model” is the recognition that smaller communities (population less than 15,000) are more vulnerable to workforce pressures and have a greater need for financial incentives.

While using population size as a determinant of need has its limitations, it appears to be based on reasonable evidence derived from data generated through the *Medicine in Australia: Balancing Employment and Life* (MABEL) Study.

While the “Monash model” is supported, it should be further refined to allow continued consideration of remoteness to be a factor in funding and program eligibility decisions.

A “modified Monash model” is therefore recommended which would provide an extra layer of discrimination between large and small towns in ASGC-RA bands 2 and 3, while retaining the current RA4 and 5 areas. The analysis of this hybrid model outlines that while some weaknesses in the model remain and there would be some complexities in implementation, the new system would be an improvement and should be developed further in consultation with an implementation working group.

## Chapter 5: Aboriginal and Torres Strait Islander health workforce

This chapter provides an overview of the Aboriginal and Torres Strait Islander health workforce and Commonwealth programs (and national initiatives) that are intended to strengthen Aboriginal and Torres Strait Islander health workforce capacity and improve the ability of the broader health workforce to address the needs of Aboriginal and Torres Strait Islander people.

### *Aboriginal and Torres Strait Islander health workforce participation*

There has been a relative increase in Aboriginal and Torres Strait Islander participation in health-related training and education as well as in the health workforce, although the fundamental issue of underrepresentation across the board



remains. Under-representation of Aboriginal and Torres Strait Islander people in the health workforce is clearly one factor contributing to the lower rates of Aboriginal and Torres Strait Islander people accessing health services.

Increasing the rates of participation and completion of training by Aboriginal and Torres Strait Islander people in the Australian health workforce, along with improving their employment and education generally, is fundamental to achieving better health outcomes.

Leadership, mentoring, prevocational training, vocational training and work experience are highlighted as being crucial in providing an appropriate Aboriginal and Torres Strait Islander health workforce and developing a broader health workforce able to deliver culturally appropriate care.

### National initiatives

The Council of Australian Governments (COAG) National Partnership Agreements have been a key contributor to improved Aboriginal and Torres Strait Islander health outcomes and increased health workforce participation in recent years. Other key national initiatives assisting with Aboriginal and Torres Strait Islander health outcomes and the increased rates of participation include:

- National Aboriginal and Torres Strait Islander Health Plan;
- Aboriginal and Torres Strait Islander Health Performance Framework;
- National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework;
- the National Registration and Accreditation Scheme; and
- Health Workforce Australia activities.

While these significant ongoing consultation, planning and policy development processes are all important steps in addressing Aboriginal and Torres Strait Islander health outcomes they will not, by themselves, translate into measurable change at the community level. The report stresses the importance of cohesive implementation of recommendations arising from this review with the soon to be finalised National Aboriginal and Torres Strait Islander Health Plan. This will necessitate close and cooperative work with the National Congress of Australia's First Peoples' National Health Leadership Forum, the collective and consultative forum of peak Aboriginal and Torres Strait Islander health workforce bodies.

### Collaboration

There are many crossover points in Aboriginal and Torres Strait Islander health workforce funding, not only within DoHA but also between other Commonwealth agencies. It is important to take a more collaborative approach to the training of the Aboriginal and Torres Strait Islander health workforce.

Aboriginal and Torres Strait Islander leadership is recognised internationally as a key factor in the development and sustainability of programs aimed at increasing workforce capacity, and influencing the non-Aboriginal and Torres Strait Islander workforce to provide culturally safe and appropriate services. Aboriginal and Torres Strait Islander leadership is also relevant in guiding tertiary education for Aboriginal and Torres Strait Islander students and developing health courses that integrate Aboriginal and Torres Strait Islander health competencies.

There is no standardised approach to incorporating Aboriginal and Torres Strait Islander health competencies as part of curricula in Australian universities. In many

cases, it is left up to individual universities to incorporate these competencies into their programs, with variable outcomes. Developing Aboriginal and Torres Strait Islander health competencies and cultural competencies has the potential to improve the integration of Aboriginal and Torres Strait Islander health into health training.

There are no standardised Aboriginal and Torres Strait Islander health student targets in Australian universities. Currently, it is up to the individual universities to set their Aboriginal and Torres Strait Islander student admissions. Setting or incentivising targets would lead to growth in the Aboriginal and Torres Strait Islander health workforce, allow progress to be more easily measured, and increase accountability for outcomes. This area may require new funding support across disciplines.

Incorporating later-year elective placements in Aboriginal and Torres Strait Islander communities appears to be an effective way to increase non-Aboriginal and Torres Strait Islander students' ability to provide culturally safe care, provided students are well prepared in terms of cultural knowledge and have well-supported access to clinical training.

### Training package

There is currently funding for a number of Aboriginal and Torres Strait Islander organisations, including Aboriginal community-controlled registered training organisations (RTOs) to promote pathways for Aboriginal and Torres Strait Islander people into the health workforce. Funding allocations however are inconsistent between groups.

Funding to RTOs has not been reviewed until recently (as part of the Battye Review). In line with the Battye Review's recommendation, this review finds that funding to RTOs would be better aligned with the expertise of the education portfolio(s).

More generally, there is a need to progress the implementation of the recommendations of the Battye review to bring some certainty to this area of policy.

## Chapter 6: Managing the supply of health workers to meet community needs

This chapter links in with many of the workforce supply issues discussed in Chapters 3 and 4, but focusses more on regulatory issues, primarily for overseas trained health professionals. This includes suggesting substantial reforms to the current districts of workforce shortage (DWS) system.

The chapter also recommends major reform of the Bonded Medical Places (BMP) program and discusses broader issues about the effectiveness of return of service schemes for health professionals, and concludes with an analysis of the various workforce distribution measures for non-vocationally recognised (VR) doctors; the "other medical practitioners" and "section 3GA" programs.

### *International recruitment, support and regulation*

This section discusses current activities to recruit and support overseas trained doctors (OTDs) to work in Australia. The recruitment activities of Rural Workforce Agencies under the International Recruitment Strategy (IRS) are outlined, with some suggestion that current targets should be reviewed.

The activities of both HWA's International Health Professionals Program and DoHA's IRS are valuable in attracting overseas trained health professionals to Australia.

However, it is suggested that arrangements for these initiatives may be better managed through a single fund holder.

Information systems, training arrangements and support mechanisms for OTDs are discussed in the following section, with reference to the findings of the House of Representatives Standing Committee's inquiry into OTDs, *Lost in the Labyrinth*. Many of the recommendations of this report, relating to enhancing training and support, are endorsed.

The need to increase awareness of the diversity of the OTD workforce, with its corresponding need for targeted support reflecting different backgrounds and skill levels, is a major theme. The interplay between the immigration, registration and assessment systems in Australia often presents barriers to OTDs wishing to work in the country.

### *District of workforce shortage (DWS) classification system*

While the core principles of the current system, which regulates the locations where OTDs are able to work in Australia and access Medicare rebates, are supported, significant reforms are suggested in the use of the DWS system. A DWS stakeholder working group was convened as part of the consultation process and, while continued use of a system such as DWS was generally supported, there was a strong view that there are areas for improvement.

This is a complex and technical area (and is linked to the rural classification system issues discussed in chapter 4), but the proposed reforms can essentially be broken down into:

- The use of more up to date population data, as well as adopting the more refined ASGS system developed by the ABS.
- Providing greater certainty in the way general practice is treated, with the suggestion to move away from quarterly updates against the national service level average to annual updates.
- Ceasing use of out-dated metropolitan area classifications.
- Providing automatic DWS status for smaller population areas in RAs 3–5, if possible aligning this with the “modified Monash model” for the enhanced rural classification system. Once implemented, this approach would be used for both GPs and specialists.
- Allowing flexibility in the DWS assessment process by applying a 10% buffer for locations marginally higher than the national service average.

The most potentially contentious change is the proposed alignment of automatic DWS areas with location population size through the enhanced ASGC-RA system. This presents some complexity in implementation, and will need to be carefully worked through with an implementation working group.

### *Return of service obligations*

Stakeholders have expressed strong concerns about the potentially stigmatising effect of the Bonded Medical Places scheme upon students and upon the nature of rural practice itself. There are also concerns about lack of international evidence for the success of mandatory or bonded schemes in terms of achieving long-term sustainable increases in the rural health workforce.

However, given the very long lead time in medical training, very few students have yet become eligible for return of service under this scheme and it may well be argued

that without meaningful data it is premature to consider abandoning the scheme in the absence of an effective alternative. The review has with some reluctance, supported the continued retention of the Bonded Medical Places scheme, but suggests major reforms to address stakeholder concerns and improve administrative sustainability. The following changes are suggested:

- broadening the settings for the return of service obligation (RSO), to include rural and remote areas (regardless of DWS status) and settings such as Aboriginal Medical Services and defence force facilities;
- retaining “scaling”;<sup>3</sup>
- changing the point of commencement of the RSO so that it applies after attainment of fellowship (offset by a shorter RSO period); and
- changes to the buy-out arrangements.

The review also gives some consideration to the more dramatic option of extending RSO arrangements to all new medical graduates, with reference to international models in countries such as South Africa and Canada. Section 51(xxiiiA) of the Constitution (civil conscription) presents a major obstacle to this approach. Nevertheless, the review flags broader use of RSO arrangements as a future option if current workforce distribution mechanisms don’t prove to be successful.

### *Distribution arrangements for non-VR medical practitioners*

The various other medical practitioners (OMPs) programs are discussed in the final section of the chapter. The review supports maintaining arrangements which encourage non-VR doctors to pursue college fellowship training, while also serving as a workforce distribution mechanism. However, administrative complexity and the proliferation of different OMPs programs is presented as a problem that could be addressed by consolidating four of the OMPs programs into one measure.

It is also suggested that there could be efficiencies in consolidating the various programs relating to Section 3GA of the *Health Insurance Act 1973*, such as the Approved Medical Deputising Service Program and the Special Approved Placements Program.

## Chapter 7: Nursing and midwifery workforce

This chapter considers issues relating to the nursing and midwifery workforce which is the largest part of the health workforce. As the major employer of nurses and midwives, the states and territories are largely responsible for recruitment and retention.

The Australian Government has a less direct but important role, contributing funding for the delivery of health services and for university education of nursing and midwifery students. However, given the predicted future shortfall of nurses, the Commonwealth has recently increased its investment in nursing and midwifery supply and support measures, including investments in practice nursing and

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<sup>3</sup> The scaling initiative was announced in the 2009-10 Federal Budget as part of the Rural Health Workforce Strategy. It applies to a range of government programs including rural incentive payments and programs with a return of service obligations such as the BMP Scheme, based on the principle of providing greater incentives for more remote areas.

scholarships. These nursing initiatives totalled about 34% of the funding under the Health Workforce Fund in 2011-12.

### *Nursing and midwifery education*

This section covers issues raised during the consultation process around student numbers, access to quality clinical placement experiences, perceptions of graduates' "work readiness" and current Commonwealth programs that relate to education (both academic and clinical experience requirements).

Increasing the number of students undertaking registered nursing courses at university is clearly not achievable at a level which would enable projected supply to meet HWA's forecast "as is" demand by 2025 for this workforce.

Current limitations on the education of enrolled nurses will need to be addressed to ensure this is not an inhibiting factor in greater use of this workforce.

Effort is required to enhance workforce retention, particularly by offering nurses and midwives the opportunity to upskill and take on more senior and diverse roles.

Commonwealth effort in this area should focus on ensuring access to appropriate ongoing educational opportunities to keep more nurses in the workforce. In addition, there should be better targeting of financial support via scholarship schemes aimed at nurses considering postgraduate studies.

Access to education to enable easier re-entry to the nursing profession is also presented as an issue of high importance that needs to be resolved in some jurisdictions.

A major recommendation arising from this section is that the Commonwealth should work with the profession and across jurisdictions to establish a National Nursing and Midwifery Education Advisory Network (NNMEAN) that would develop nursing education plans across the whole training pipeline from enrolled and undergraduate nurse training to advanced scopes of practice and nurse practitioner candidates.

Other suggested actions include workforce innovation and reform including a greater role for nurse practitioners, and roles commensurate with the skills of registered nurses, enrolled nurses and the personal care workforce – at the top of their scope of practice.

### *Nursing and midwifery workforce development and retention*

The review outlines stakeholder concerns about the immediate employment prospects of newly graduated registered nurses, as recently discussed by health ministers.

HWA has undertaken a short-term project to address recruitment issues for graduate nurses and midwives, including a web-based information portal providing links to existing graduate programs.

The main focus of recommendations arising from this section is based on the premise that there should be two separate but complementary actions to help in retaining nursing and midwifery staff:

- assistance with further career development and the opportunity to adopt more advanced roles for nurses (such as an eligible midwife or nurse practitioner);
- enhancing non-salary conditions of employment including organisational culture and the behaviour of an employee's manager.



A major recommendation is that the Commonwealth should consider providing seed funding for a feasibility study of a national rollout of leadership courses to mid-level nurse and midwife managers, based on the NSW Government sponsored Essentials of Care program.

It is also suggested that the Commonwealth should consider investing in a new training model based on the Remote Vocational Training Scheme (RVTS) to assist rural Nurse Practitioner candidates and other nurses seeking to undertake advanced roles.

### *Nursing and midwifery workforce sustainability*

This section discusses a range of issues including nurse and midwifery career development, registration, credentialing and re-entry requirements and their impacts on opportunities for nurses and midwives to remain in or return to the workforce.

It also highlights the need for innovation and reform in the way nursing and midwifery care is delivered, and in job/role redesign and improvements in the productivity of the current workforce, including the development of trained assistant roles and extended scopes of practice.

The discussion extends the arguments presented in the education and retention section of this chapter, in that sustainability of the nursing and midwifery workforce is closely linked with educational and career progression opportunities across the spectrum from assistants in nursing, to nurse practitioners and independent practising midwives.

The subsequent recommendations suggest that funding should be considered for pilot studies of new and innovative methods of service delivery, developed through analysis of the best available evidence both nationally and internationally to inform policy development in this area.

The NNMEAN, once established, could lead this work (including commissioning research) with HWA.

## Chapter 8: Developing the dental and allied health workforce

This chapter provides an outline of the current dental and allied health workforce, and Commonwealth initiatives and jurisdictional approaches aimed at increasing the supply and distribution of both the dental and allied health workforce.

This chapter is informed by discussions at the Dental Workforce and Allied Health round tables as part of this review. The dental section of the chapter is also informed by the Final Report of the National Advisory Council on Dental Health (NACDH), released in 2012.

### *Dental workforce*

There is currently a significant maldistribution of the dental workforce between the public and private sectors and geographically. All of the HWD dental workforce initiatives currently in place, as well as those under development, have a central objective of addressing distribution issues.

Collaboration across the key dental stakeholders is vital if workforce reforms are to be successful. This includes clarity about funding responsibilities (between the Commonwealth and jurisdictions). Two initiatives which have improved collaboration are the National Oral Health Plan and the NACDH.

### Supporting dental students and the academic workforce

Dental schools in Australia are currently experiencing a shortage of academic dental personnel. A key reason is disparity between the salaries for academics and those of dentists in the private sector.

The academic dental workforce is ageing. Incentives for experienced dentists to join academia and strategies to retain current academics (for example, ensuring flexible employment conditions) are vital.

The Australian Rural Health Education Network (ARHEN) submitted a submission proposing a new program for supervised clinical training for final year dental students on placement with a UDRH for 12 or more weeks. Clinical training would occur in public dental services and students would deliver services supervised by a qualified dentist/academic. The program model is based on principles of community-engaged learning and teaching and service learning.

University dental schools support the activities undertaken by the UDRHs to increase dental education and training in rural locations. There is potential for greater collaboration with UDRHs, with an increased number of dental students taking up rural training placements.

The Australasian Council of Dental Schools provided advice that economies of scale would allow them to increase their student training target under the Dental Training Expanding Rural Placements (DTERP) program from five to ten FTE with modest additional funding, creating greater opportunities for increased student numbers and longer rotations.

The review supports both the expansion of DTERP and further examination and potential funding of the ARHEN dental education proposal.

### *Allied health workforce*

#### Collaboration

With allied health being a key part of the primary health care team with a focus on prevention and maintenance of function in the community, it is important that health outcomes from allied health management are better understood.

Collaboration and communication in patient care between allied health disciplines is crucial, particularly given the increased focus in recent years on a more multidisciplinary approach to patient health care.

Further investigation into the overlap of roles/skills between allied health disciplines, and indeed with nursing, should be explored when developing new models of care. The use of allied health in specific areas of extended scope of practice in interdisciplinary teams also merits further work.

Innovation in telehealth and online training as well as development of professional networks for support is required. Inspirational leadership in allied health is required to move services from traditional service delivery to innovative interdisciplinary approaches.

#### Leadership

Allied health leadership and management positions are important as they provide allied health disciplines with a “voice” in policy decision making as well as impetus to

continue to work towards integrating allied health services into core health service delivery.

Consideration should be given to a Coalition of National Nursing Organisations–type model where allied health stakeholder representatives would meet on, for example a quarterly basis. It is possible that the new Australian Allied Health Alliance could play a role here.

Allied health organisations have been advocating for a Chief Allied Health Officer in DoHA for some years. Additionally, the recent Senate Inquiry into ‘the factors affecting the supply of health services and medical professionals in rural areas’ recommended a rural allied health officer role in DoHA.

The recent establishment of a Commonwealth Chief Allied Health Officer position within DoHA is supported by the review. It will be important for DoHA to consider and liaise with relevant areas to determine the scope of this role and the type of representation that is necessary across disciplines.

### Allied health assistant roles

The allied health assistant role is a possible solution to increase access to services in rural and remote communities. Research into the clinical effectiveness and safety of allied health assistants needs to be conducted, to see efficiencies and productivity gains as well as increased access to services.

Rural allied health professionals and local managers appear to be supportive of allied health assistant roles. However, advocacy and peak groups for the sector are less supportive. At the consultative Allied Health round table for this review there were strongly expressed views in favour of increased specialisation in some allied health disciplines and opposition to any erosion of professional boundaries.

### Data

Currently, reliable data sources are limited for the allied health workforce across the different sectors and settings. Better data collection across settings should provide useful information for policy development. This is particularly important in regard to the disability sector, with the establishment of the National Disability Insurance Scheme, as well as in aged care.

## Chapter 9: Opportunities for reform in program delivery and policy development

This chapter examines recent reforms by DoHA to streamline grants management processes; roles, responsibilities and relationship between DoHA’s Health Workforce Division and HWA and the potential for better alignment; and current arrangements for providing funding support for the operation of organisations representing health professionals.

### *Grants management reform*

As a result of a strategic review in 2010 the Health Workforce Fund (HWF) was established (along with a number of other flexible funds across DoHA) and an updated IT system to streamline funds management was introduced.

The new grant-related funds have been envisaged to provide a reduction in red tape through a simplified application and funding agreement establishment process.



This is consistent with the more general whole-of-government work, led by the Department of Families, Housing, Community Services and Indigenous Affairs under the National Compact to free up non-government agencies from reporting requirements, improve information sharing and reduce over-regulation.

However, the benefits of grant reform have yet to flow through to stakeholders, some of whom continue to report high levels of compliance-based reporting, red tape and the continued involvement of DoHA staff (from multiple divisions of the Department) on questions of detail and process, rather than outcomes. The report recommends that the Department needs to “keep itself honest” by appropriate mechanisms to measure the degree to which reform is actually occurring, including regular feedback from peak groups and stakeholders.

#### More effectively integrated policy development

Consultations with DoHA staff outside Health Workforce Division in the course of this review indicated that policy proposals developed within DoHA have not always demonstrated appropriate internal consideration of current and future workforce impacts. There would be merit in developing a formal process within DoHA to ensure that, for all new policy proposals or activity streamlining and amalgamating programs an internal health workforce impact statement/check sheet is completed through collaboration between divisions of DoHA.

#### Program evaluation and risk assessment

During the course of this review, a large number of programs were identified which had been established over recent decades without any evaluation framework or meaningful performance measures. There are a number of programs which have grown out of historically based grants funding, and others which require administration costs out of all proportion to demonstrated health workforce benefits. It is a matter of some urgency that a comprehensive outcomes-based evaluation framework for each health workforce program should be developed. This should be complemented by an assessment of risk management across health workforce programs following this review.

#### *Health Workforce Division and Health Workforce Australia*

The National Partnership Agreement (NPA) on Hospital and Health Workforce Reform, which governs the allocation of funding to HWA, is scheduled to expire at the end of June 2013. A broad review of the overarching NPA is expected.

States and territories have not provided funding directly to HWA. HWA has a complex governance structure requiring it to report to all Health Ministers. The CEO of HWA reports to the Board consisting of a Chair, three independent members and nominees from all jurisdictions. Following approval of the Board, HWA then seeks approval from all health ministers through SCoH for major pieces of work.

While there is general acknowledgement that HWA has done valuable and important work, in terms of ongoing program management there is uncertainty from the perspective of stakeholders about HWA roles and responsibilities, as against those of DoHA. This needs to be resolved.

There are three broad options for HWA’s ongoing operation that could be considered in the context of the NPA review:

- HWA becomes a data and policy agency, with a brief to fund innovative or pilot programs, and ceases to manage mature programs;

- HWA takes over the management of selected DoHA programs; or
- HWA operations remain the same.

While the first option has strong advocates, it will be a matter for the forthcoming NPA review to determine which of these options is to be preferred.

### *Health workforce data*

Allied health professional groups expressed a sense of grievance in the course of this review that the need for coherent data for their sector had not yet been addressed, particularly for professions not covered by NRAS.

This review has also revealed some challenges in the sharing of data between organisations, which could be impeding some program outcomes. It has been suggested that overly prescriptive interpretations of the *Privacy Act 1988* have been used by some organisations to avoid sharing even de-identified participation data that could be of great benefit to inform policy development and program delivery.

## Conclusion

The future unaffordable escalation in health expenditure has been well documented, as has the contribution to future costs of a health system configured increasingly around highly specialised acute care services concentrated in the most affluent parts of the major metropolitan centres.

In seeking to create a health system which is more affordable, more equitable and more responsive to primary health care needs, health workforce programs are a key policy lever. For that reason, this review has focused on measures which might strengthen those programs which are built around the identification of local need and more investment in regionally-based education, training and incentive programs.

Wherever possible, the report recommends consolidation of programs and reduction of regulatory and administrative processes, to maximise expenditure on direct programs. In parallel, local and regionally-based funded agencies need to be given strong incentives, including through contracting and tendering processes toward more formal collaborative structures

Recommendations are outlined in each chapter and a comprehensive schedule of all recommendations is found at page 345.

There are numerous recommendations aimed at more specific administrative or legislative problems raised during the consultation phase of the review. It is hoped that the cumulative effect of these recommendations, some of which are relatively simple, will provide an opportunity to improve the efficiency and fairness of the system. The chair would very much like to thank the secretariat for their hard work, most particularly in organising the consultative roundtables, which were uniformly positive and productive, but also for preparing enormous quantities of background and research material, only a fraction of which is reflected in the material provided here.

The chair would also like to thank the participants in the formal roundtables, and the many individuals and organisations who provided formal submissions and informal suggestions and feedback. A number of Federal Members of Parliament from all sides of politics gave valuable insights about the impact of health workforce issues on the lives of their constituents.

Any mistakes, omissions or errors of fact are mine.

## Acronyms and abbreviations

AAHA	Australian Allied Health Alliance
AAS	Additional Assistance Scheme
ABS	Australian Bureau of Statistics
ACD	Acute Care Division
ACEM	Australasian College of Emergency Medicine
ACETI	Aged Care Education and Training Initiatives
ACN	Australian College of Nursing
ACNS	Aged Care Nursing Scholarships
ACRRM	Australian College of Rural and Remote Medicine
ADA	Australian Dental Association
AGPT	Australian General Practice Training
AHMAC	Australian Health Ministers' Advisory Council
AHMC	Australian Health Ministers' Conference
AHOMPs	After Hours Other Medical Practitioners program
AHPA	Allied Health Professionals Australia
AHPRA	Australian Health Practitioner Regulation Agency
AHWMC	Australian Health Workforce Ministerial Council
AIDA	Australian Indigenous Doctors Association
AIHW	Australian Institute of Health and Welfare
AINs	Assistants in nursing
AMC	Australian Medical Council
AMDS	Approved Medical Deputising Service
AMLA	Australian Medicare Local Alliance
AMS	Aboriginal Medical Service
AMSA	Australian Medical Students' Association
AoN	Area of need
APED	Approved Private Emergency Department Program
ARCPOH	Australian Research Centre for Population Oral Health
ARHEN	Australian Rural Health Education Network
ARIA	Accessibility/Remoteness Index of Australia
ASGC-RA	Australian Standard Geographical Classification - Remoteness Area
ASGS	Australian Statistical Geography Standard
ATAPS	Access to Allied Psychological Services program

ATO	Australian Taxation Office
ATSIHRTONN	Aboriginal and Torres Strait Islander Health Registered Training Organisations National Network
ATSIHWWG	Aboriginal and Torres Strait Islander Health Workforce Working Group
ATSIPSS	Aboriginal and Torres Strait Islander Pharmacy Scholarship Scheme
BMP	Bonded Medical Places scheme
BSBC	Better Skills Better Care program
BSP	Bonded Support Program
CATSIN	Congress of Aboriginal and Torres Strait Islander Nurses
CDM	Chronic Disease Management
CEO	Chief executive officer
COAG	Council of Australian Governments
CoNNO	Coalition of National Nursing Organisations
CPD	Continuing professional development
CPE	Continuing professional education
CRANApplus	Council of Remote Area Nurses Australia
CSP	Commonwealth Supported Place
DBA	Dental Board of Australia
DEEWR	Department of Education, Employment and Workplace Relations
DEST	Department of Education, Science and Training
DHS	Department of Human Services
DIAC	Department of Immigration and Citizenship
DI-ERRWS	Diagnostic Imaging – Enhancing the Rural and Remote Workforce Scheme
DIICCSRTE	Department of Industry, Innovation, Climate Change, Science, Research and Tertiary Education
DoHA	Department of Health and Ageing
DRISS	Dental Relocation and Infrastructure Support Scheme
DSRU	Dental Statistics and Research Unit
DTERP	Dental Training Expanding Rural Placements program
DWS	District of workforce shortage
EDPSCS	Emergency Department Private Sector Clinical Supervisor Program
EMET	Emergency Medicine Education and Training program

FaHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs
FGAMS	Foreign graduate of Australian medical school
FIFO	Fly-in, fly-out
FLEC	First Line Emergency Care program
FoFMS	FaHCSIA Online Funding Management System
FTE	Full-time equivalent
FWE	Full-time workload equivalent
GDP	Gross Domestic Product
GP	General practitioner
GPET	General Practice Education and Training Ltd
GPPTSP	General Practice Procedural Training Support Program
GPRA	General Practice Registrars Australia
GPRIP	General Practice Rural Incentives Program
HECS	Higher Education Contribution Scheme
HELP	Higher Education Loan Program
HPPP	Health Professionals Prescribing Pathway
HSCDF	Health System Capacity Development Fund
HW2025	Health Workforce 2025 report
HWA	Health Workforce Australia
HWD	Health Workforce Division
HWF	Health Workforce Fund
HWPC	Health Workforce Principal Committee
IAHA	Indigenous Allied Health Australia
IDG	International dental graduate
IHPA	Independent Hospital Pricing Authority
IHPP	International Health Professionals Program
IHT	Indigenous Health Training
IMG	International medical graduate
IPE	Inter-professional education
IPL	Inter-professional learning
IPP	Inter-professional practice
IRCTN	Integrated Regional Clinical Training Network
IRS	International Recruitment Strategy
JFPP	John Flynn Placement Program

KPI	Key performance indicator
LHN	Local Health Networks
LIME network	Leaders in Indigenous Medical Education network
MAHS	More Allied Health Services program
MBA	Medical Board of Australia
MBS	Medicare Benefits Scheme
MDANZ	Medical Deans of Australia and New Zealand
MOMPs	Medicare Plus Other Medical Practitioners program
MRBS	Medical Rural Bonded Scholarship Scheme
MSOAP	Medical Specialist Outreach Assistance program
MSOD	Medical Schools Outcomes Database
NACCHO	National Aboriginal Community Controlled Health Organisation
NACDH	National Advisory Council on Dental Health
NAHRLS	Nursing and Allied Health Rural Locum Scheme
NAHSSS	Nursing and Allied Health Scholarship and Support Scheme
NATSIHWA	National Aboriginal and Torres Strait Islander Health Worker Association
NCWS	National Cancer Workforce Strategy
NDIS	National Disability Insurance Scheme
NGO	Non-government organisation
NiGP	Nursing in General Practice program
NMTAN	National Medical Training Advisory Network
NNMEAN	National Nursing and Midwifery Educational Advisory Network
NPA	National Partnership Agreement
NRAS	National Registration and Accreditation Scheme
NRHA	National Rural Health Alliance
OATSIH	Office for Aboriginal and Torres Strait Islander Health
OECD	Organisation for Economic Cooperation and Development
OHTGYP	Oral Health Therapist Graduate Year Program
OM-OMPs	Outer Metropolitan Other Medical Practitioners program
OMPs	Other medical practitioners
OTD	Overseas trained doctor
OTDNET	Overseas Trained Doctor National Education Training
PADWS	Preliminary Assessment of District of Workforce Shortage
PBS	Pharmaceutical Benefits Scheme

PGPPP	Prevocational General Practice Placements Program
PGY	Postgraduate year
PHMSS	Puggy Hunter Memorial Scholarship Scheme
PNIP	Practice Nurse Incentive Program
RA	Remoteness area
RACGP	Royal Australian College of General Practitioners
RAHC	Remote Area Health Corp
RAMUS	Rural Australia Medical Undergraduate Scholarship Scheme
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
RCS	Rural Clinical School
RCTI	Recipient created tax invoice
RCTS	Rural Clinical Training and Support program
RDAA	Rural Doctors Association of Australia
RHCE	Rural Health Continuing Education program
RHEF	Rural Health Education Foundation
RHMT	Rural Health Multidisciplinary Training program
RHPP	Rural Health Professionals Program
RHWA	Rural Health Workforce Agency
RHWS	Rural Health Workforce Strategy
RLRP	Rural Locum Relief Program
ROMP	Rural Other Medical Practitioners program
RPHS	Rural Primary Health Services
RPSS	Rural Pharmacy Scholarship Scheme
RRMA	Rural, Remote and Metropolitan Areas
RSO	Return of service obligation
RTOs	Registered training organisations
RTPs	Regional training providers
RVTS	Remote Vocational Training Scheme
RWAs	Rural Workforce Agencies
SA	Statistical area
SAPP	Special Approved Placements Program
SARRAH	Services for Australian Rural and Remote Allied Health
SCoH	Standing Council on Health
SLA	Statistical local area

SSD	Statistical sub-division
STP	Specialist Training Program
TROMPs	Temporary Resident Other Medical Practitioners program
TTR	Teaching, training and research
TTRWG	Teaching, Training and Research Working Group
UDRH	University Departments of Rural Health
VDGYP	Voluntary Dental Graduate Year Program
VET	Vocational education and training sector
VR	Vocationally recognised
WBA	Workplace based assessment



## Chapter 1: Review background

The review of Australian Government health workforce programs was announced as part of the 2012-13 Budget process.

The Acting Minister for Health Mark Butler announced the commencement of the review process on 27 September 2012, along with the Terms of Reference.

This is an independent review that has been carried out with secretariat support provided by the Department of Health and Ageing (DoHA).

### Terms of Reference

The objective of the review is to analyse and assess the appropriateness, effectiveness and efficiency of the programs and activities, and to ensure that they are aligned with Australia's workforce priorities – actual and emerging health workforce issues and challenges – including those identified in Health Workforce Australia's *Health Workforce 2025* Report.

The review will:

- analyse existing programs to ensure these are aligned with workforce priorities;
- analyse existing rural health programs to ensure optimal service delivery;
- analyse existing information and key stakeholder experiences to evaluate whether the objectives of current measures are being met and whether these programs could be improved;
- provide opportunities for stakeholder consultation;
- identify opportunities to better align measures with workforce priorities, including through modifications and amendments to existing measures, or development of new measures; and
- provide advice to government about how to support the delivery of a high quality, well distributed optimally utilised and responsive health workforce.

### 1.1 Review methodology and consultation process

A triangulated approach was taken during the review process which was designed to provide extensive analysis of all Australian Government health workforce programs funded to enable a robust report.

The three major activities undertaken were:

- *Analysis* of each individual program/activity managed by Health Workforce Division – and other workforce programs implemented by other divisions within the department;
- *Research* and develop a series of papers including 'context papers' written to provide background on health workforce issues. Also undertake a literature review of all relevant program evaluations, reports and parliamentary inquiry reports; and
- *Consultations* with stakeholders which included interviews, written submissions and roundtable discussions aimed at identifying health workforce issues and program delivery concerns.

### Program analysis

During this phase, analysis was undertaken to scope out the health workforce programs that are currently being funded. This included gathering details of program objectives and outcomes, funding arrangements and perceived stakeholder support for each program.

Each program was assessed against a number of criteria to analyse the extent to which funding was being used effectively to deliver government services aimed at addressing health workforce issues.

The program assessment criteria included the level to which the program met the following criteria:

- Strategic alignment – to what extent is the activity consistent with government policy priorities;
- Integration – how the program fits within the policy and operating environment – how the program interacts with other programs.;
- Appropriateness – reason for government intervention and the choice of policy instrument;
- Performance assessment – measure (where data was available) the outcomes against the program objectives;
- Effectiveness – how well the program outcomes are meeting the stated program objectives; and
- Efficiency – how effective are resources used to deliver program outcomes.

### Research

The research phase was mostly a data gathering exercise to gain an understanding of current and future priorities, trends and issues as well as projections of future workforce needs through workforce data. Evaluations of current programs were sourced from public and internal program evaluations and recommendations as well as relevant parliamentary inquiries. A list of major evaluations is provided at Appendix vii.

Summaries of research findings were presented as context and issues papers to provide detailed background information and highlight continuing health workforce issues and workforce requirements.

### Stakeholder consultations

The final phase was in accordance with the Review's terms of reference, enabling stakeholders to have the opportunity to contribute to the review process. A series of themed stakeholder roundtable meetings, working groups and one on one consultations were held between October and December 2012 to ensure extensive stakeholder engagement in the review.

A broad range of stakeholders were invited to participate across a number of peak organisations including program fund-holders and within the department.

## Stakeholder consultation list

Aboriginal and Torres Strait Islander Practice Board of Australia	CRANAPlus - Council of Remote Area Nurses
Allied Health Professions Australia	Dental Board of Australia
Australasian Council of Dental Schools	Dental Hygienists Association of Australia
Australian and New Zealand Council of Chief Nurses	Department of Regional Australia, Local Governments, Arts and Sport
Australian Association of Occupational Therapists	Department of Industry, Innovation, Climate Change, Science, Research and Tertiary Education
Australian Association of Practice Managers	Dietitians Association of Australia
Australian Association of Social Workers	Federation of Australian Rural Medical Educators
Australian College of Midwives	General Practice Education and Training Ltd
Australian College of Nursing	General Practice Registrars Australia
Australian College of Rural and Remote Medicine	Group of Eight Deans in Medicine
Australian Council of Pro Vice-Chancellors and Deans of Health Science	Health Consumers of Rural and Remote Australia
Australian Dental and Oral Health Therapists Association	Healthscope
Australian Dental Association	Health Workforce Australia
Australian Dental Council	Health Workforce Principal Committee
Australian Health Practitioner Regulation Agency	Health Workforce Queensland
Australian Indigenous Doctors Association	Indigenous Allied Health Australia
Australian Institute of Health and Welfare	James Cook University
Australian Institute of Radiography	Kidney Health Australia
Australian Medical Association	La Trobe University
Australian Medical Council	Medical Deans of Australia and New Zealand
Australian Medical Students Association	Monash University
Australian Medicare Local Alliance	Mount Isa Centre for Rural and Remote Health
Australian Nursing and Midwifery Accreditation Council	National Aboriginal Community Controlled Health Organisation
Australian Nursing Federation	National Rural Health Alliance
Australian Physiotherapy Association	National Rural Health Students Network
Australasian Podiatry Council	Nursing and Midwifery Board of Australia
Australian Private Hospitals Association	Onemda VicHealth Koori Health Unit
Australian Psychological Society	Optometrists Association of Australia
Australian Rotary Health	painaustralia
Australian Rural Health Education Network	Pharmacy Guild of Australia
Australian Society of Ophthalmologists	Queensland Health
Baptist Community Services	Ramsay Healthcare
Catholic Health Australia	Remote Vocational Training Scheme
Coalition of National Nursing Organisations	Royal Australasian College of Dental Surgeons
Committee of Presidents of Medical Colleges	Royal Australian and New Zealand College of Obstetrics and Gynaecology
Confederation of Postgraduate Medical Education Councils	Royal Australian College of General Practitioners
Congress of Aboriginal and Torres Strait Islander Nurses	Rural Doctors Association of Australia
Council of Academic Public Health Institutions Australia	Rural Health Education Foundation
Council of Deans of Nursing and Midwifery (Australia and New Zealand)	Rural Health Workforce Australia
	Services for Australian Rural and Remote Allied Health
	Speech Pathology Australia
	University of Melbourne
	University of Sydney

The stakeholder roundtable meetings were divided into the following themes to ensure focused discussions:

- Aboriginal and Torres Strait Islander Workforce;
- Allied Health Workforce;
- Dental Workforce;
- National Health Education;
- Nursing Workforce;
- Private Health care;
- Rural Health Education;
- Rural Workforce; and
- Scholarships.

At the roundtable discussions, each organisation delivered a brief presentation outlining their role, key workforce policy priorities and their views on the development of current workforce programs. At the end of each roundtable session the outcomes were summarised and have been documented at Appendix x.

Working groups were also convened to discuss both the rural classification system (Australian Standard Geographic Classification – Remoteness Areas) and the Districts of Workforce Shortage classification system. Through these working groups, stakeholders were given the opportunity to identify and discuss issues regarding the classification systems that are currently being used to guide health workforce policy and program development.

State and territory governments were provided with an opportunity to provide views through the Health Workforce Principal Committee meeting on 15 November 2012. Some states also provided written submissions, as listed at Appendix xi.

In addition to the above consultations, an opportunity was provided for written submissions to be lodged through the Review's website, with a total of 26 submissions being received from various organisations. These submissions are listed at Appendix xi.

A departmental reference group also contributed to the review process and included representatives of divisions including Acute Care, Ageing and Aged Care, Primary and Ambulatory Care, Mental Health and Chronic Disease and the Office of Aboriginal and Torres Strait Islander Health. The Department's Chief Nursing and Midwifery Officer also participated, along with the Principal Medical Adviser for Acute Care and Health Workforce Divisions, as a representative of the Chief Medical Officer.

### ***1.2 Health workforce programs summary***

The bulk of the Australian Government's health workforce programs are managed by Health Workforce Division (HWD), with a stated mission to develop and implement policies and innovative strategies to improve the capacity, quality and mix of Australia's health workforce.

The division manages total funding of over \$5.9 billion across the forward estimates, up to \$1.5 billion per year.

The various activities funded by the division are centred on supporting health service delivery through programs designed to expand the numbers, ensure the quality and encourage the distribution of health professionals. Funding activities focus on the health workforce more broadly, as well as rural workforce development, with aims including to:

1. Increase the number of health professionals working in regional, rural and remote Australia.
2. Support rural teaching, training and infrastructure.
3. Establish Health Workforce Australia to ensure improvements in Australia's health workforce planning capacity and ability to promote workforce innovation and reform.
4. Support the Commonwealth's engagement with the National Registration and Accreditation Scheme.
5. Build the health workforce, through targeted medical education and training programs as well as nursing and allied health scholarships.
6. Support rural health practitioners (including locum support to enable health practitioners to keep their skills up to date).
7. Improve the health education and training opportunities for Aboriginal and Torres Strait Islander people.
8. Expand the dental workforce, particularly in regional, rural and remote Australia and the public sector.

### The Health Workforce Fund

In the 2011-12 Budget the Government announced the establishment of flexible funds for the Health and Ageing portfolio whereby 159 predominantly grant programs were consolidated into 18 new or expanded flexible funds with the expressed aim of cutting red tape for grant holders, increasing flexibility, and more efficiently providing evidence-based funding for the delivery of health outcomes in the community. This process included the establishment of the Health Workforce Fund (HWF).

The total value of funds available under the HWF is up to \$4 billion over the period 2012-13 to 2015-16. Through the fund, via her Department, the Minister for Health, who is the key decision maker for the HWF, expends funds to strengthen the capacity of the health workforce to deliver high quality care by targeting the following areas which have been nominated as priorities:

1. **Increase the supply of workers in all health professions** – and facilitate a more even distribution of workforce in terms of geography and of the types of services provided.
2. **Ensure a capable and qualified workforce** – through registration, accreditation, training and development.
3. **Support the Indigenous health workforce** – through activities that promote an increase in the Aboriginal and Torres Strait Islander health workforce and increase the capacity of the broader health workforce to address the needs of Indigenous people.
4. **Address health workforce shortages in regional, rural and remote Australia** – through, for example, rural workforce programs and better targeting of workforce incentives.

There are currently 24 activity areas under the HWF. The Health Minister is responsible for approving the identified priority areas for activities under the fund, as well as approving individual items of expenditure.

The flexible arrangements for the fund mean that underspent funds can be readily deployed towards other activity areas experiencing high demand, provided this reallocated investment aligns with the government's priorities.

### Existing Health Workforce Division programs

Ongoing programs managed by the Health Workforce Division include:

- The Rural Health Multidisciplinary Training program, which includes the Rural Clinical Training and Support program, the University Departments of Rural Health program and the Dental Training Expanding Rural Places program.
- A large number of scholarship programs, including scholarships for doctors (the Rural Australia Medical Undergraduate Scholarship Scheme, the Medical Rural Bonded Scholarships and procedural training for GPs), the Nursing and Allied Health Scholarship and Support Scheme, Puggy Hunter scholarships for indigenous health students and Rotary scholarships.
- The Bonded Medical Places program which applies to 25% of all new medical school places and imposes a return of service obligation in Districts of Workforce Shortage for students taking up those places.
- The funding agreement with General Practice Education and Training Limited (GPET) for vocational training of doctors under the Australian General Practice Training program and the junior doctor rotations provided under the Prevocational General Practice Placements Program.
- Other GP training programs including the Remote Vocational Training Scheme, and organisational support for General Practice Registrars Australia.
- The Specialist Training Program, which supports vocational specialist trainees to rotate through an expanded range of settings beyond traditional public teaching hospitals. Since 2010 the STP has provided a single platform for Commonwealth grants support for specialist training initiatives.
- New dental workforce programs, including the Voluntary Dental Graduate Year Program and the Oral Health Therapist Graduate Year Program, and the new rural relocation and retention and infrastructure program for dentists in key areas of need.
- Support for peak Aboriginal and Torres Strait Islander health workforce organisations, to assist them with mentoring and developing Aboriginal and Torres Strait Islander health workers and professionals.
- The Practice Nurse Incentive Program, which encourages general practices to employ nurses and allied health professionals to provide a range of expanded services.
- The General Practice Rural Incentives Program, which encourages doctors to practice in regional, rural and remote communities through scaled financial incentives, and promotes careers in rural medicine.
- Other programs to encourage rural medical practice include the scaled HECS Reimbursement Scheme and the National Rural Locum Program, which provides support to rural communities and their practitioners, particularly for those requiring obstetrics and anaesthetics skills.



- The Telehealth Support Program, which funds a large number of organisations to provide innovative training tools and support to assist the health workforce in adapting to and delivering Telehealth services, until the end of 2012-13.

Appendix i outlines the detail of funding provided to HWD initiatives across the forward estimates.

While the overwhelming majority of the Department's workforce programs are managed by HWD there are instances where key initiatives are located elsewhere in the Department. Examples of such programs include:

- Aged care workforce initiatives, including scholarships (Ageing and Aged Care Division).
- Pharmacy scholarships and training investments such as pharmacy academics (Pharmaceutical Benefits Division).
- The teaching component of the Practice Incentives program (managed by Primary and Ambulatory Care Division).
- The dental capital and workforce fund (Acute Care Division). Note this program is not currently included in the workforce funding figures as it has not yet been implemented.

Appendix i also outlines the health workforce programs managed outside the Health Workforce Division which directly involve health workforce development.

To maintain this review at a feasible size, programs which are managed elsewhere in DoHA that are primarily focused on service delivery arrangements, rather than health workforce, have been considered out of scope for this project and have not been included within the specific program analysis. These programs include the Practice Incentives Program, the Medical Specialist Outreach Assistance Program and the Mental Health Nurse Incentive Program. Nevertheless, such initiatives do have linkages with workforce programs, are of keen interest to stakeholders and at times, necessarily there will be discussion of the intersection of these programs with those covered within the terms of review.

It is probably unremarkable to note that in an organisation the size of DoHA, challenges to effective communication and coordination will frequently arise. Based on observations in the course of this review, there is a need for a mechanism to ensure that workforce development issues are more systematically considered by staff in policy and program areas across the Department. This will be more fully discussed in a later chapter.

### Growth in funding

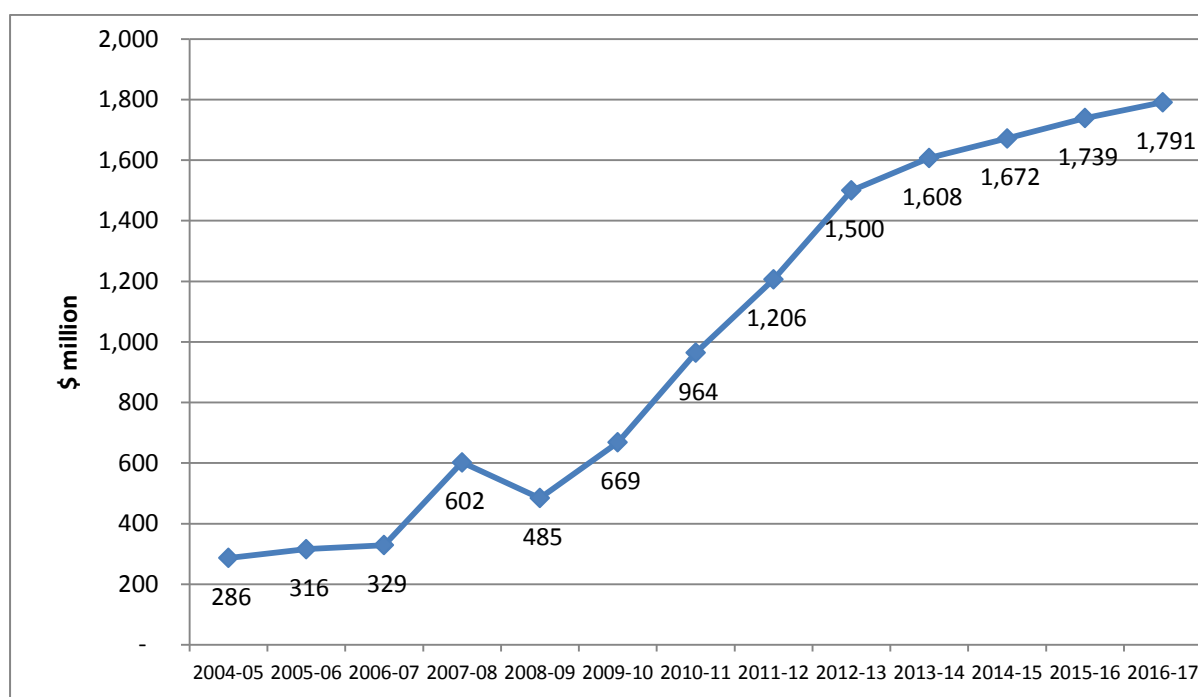
It is clearly the case that Australian Government funding for health workforce initiatives has increased substantially over the last decade. This reflects a number of factors including:

- enhanced efforts to improve rural workforce distribution;
- substantial growth in the number of graduating students across a number of disciplines, particularly medicine and nursing, requiring increased investment in existing programs such as the Australian General Practice Training Program and the Specialist Training Program;
- new partnership agreements through the Council of Australian Governments (COAG) and the establishment of Health Workforce Australia (HWA);

- increased Australian Government focus on supporting the development of the nursing and allied health workforce such as the Practice Nurse Incentives Program; and
- new investment to support the development of the aged care workforce.

Figure 1.1 shows the growth in total (Commonwealth) health workforce program expenditure since 2004-05 and projected growth under the forward estimates (noting this includes all workforce programs managed across the department):

*Figure 1.1: Total workforce program expenditure*



Source: Health Workforce Division Administered Funding Summary, 2012 (unpublished)

The overall growth in funding for workforce programs reflects a substantial expansion in the number of trainees across all health disciplines in this period.

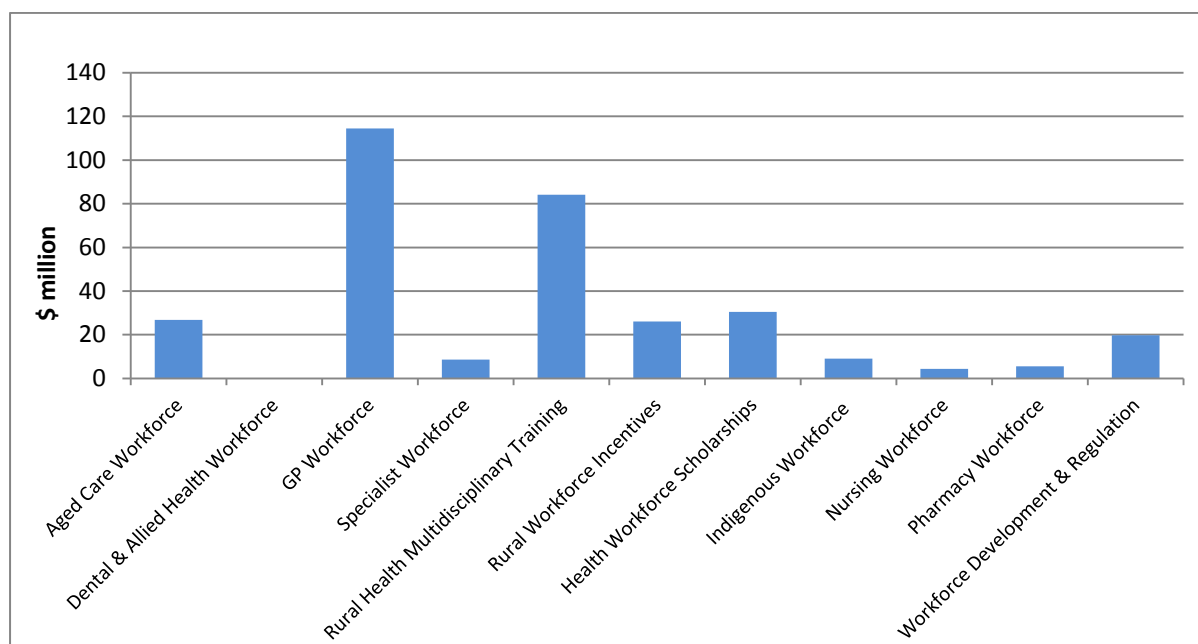
### Distribution of funding

At the same time as the Australian Government's investment in health workforce programs has increased, the allocation of funds for new purposes to meet government priorities and to support the development of different professional groups has begun to change.

Figure 1.2 shows that in 2006-07 the bulk of the government's overall investment was to support training and incentive programs for medical graduates such as GP Training, Rural Workforce Incentives (for doctors) and the Rural Health Multidisciplinary Training Program (where the greatest proportion of funding supports rural training for medical students).



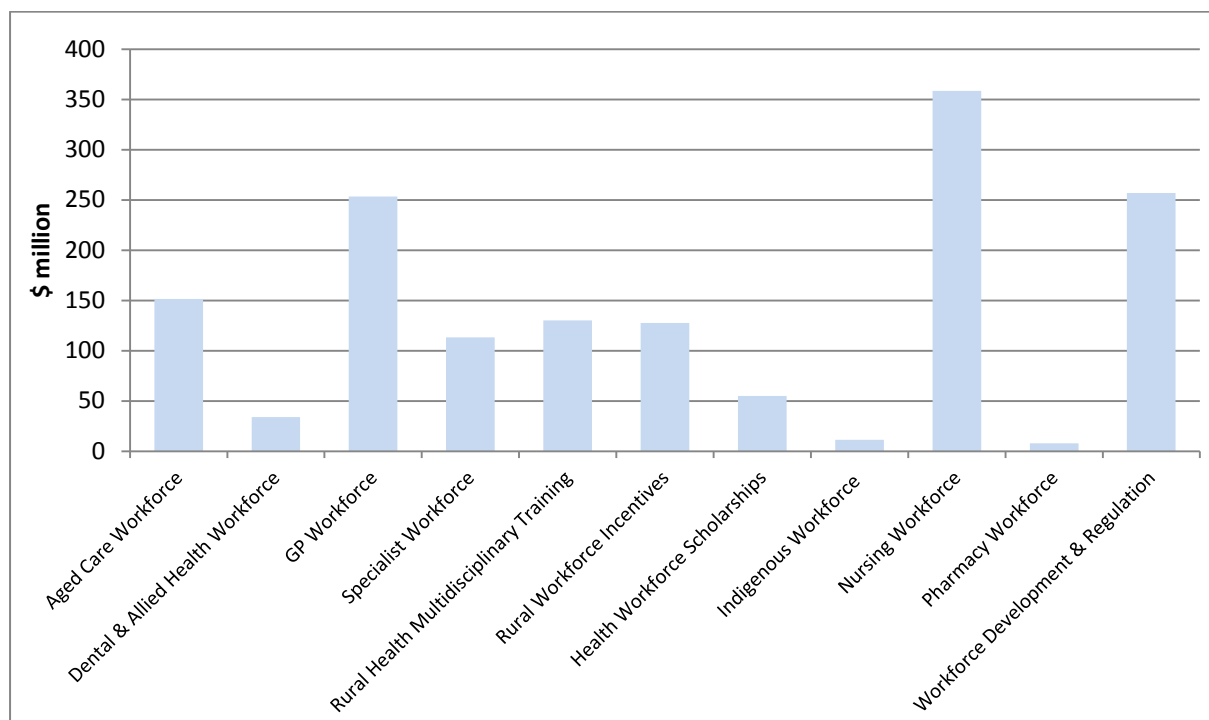
Figure 1.2: Total funding by workforce group – 2006-07



Source: Health Workforce Division Administered Funding Summary, 2012 (unpublished)

By 2012-13 the distribution of funding between professional groups shows a degree of change, reflecting large investments in the Practice Nurse Incentive Program (noting that this is directed through general practices) and the aged care workforce (primarily nursing based), as well as new investments in dental training measures and multidisciplinary scholarships. Figure 1.3 outlines this.

Figure 1.3: Total funding by workforce group – 2012-13

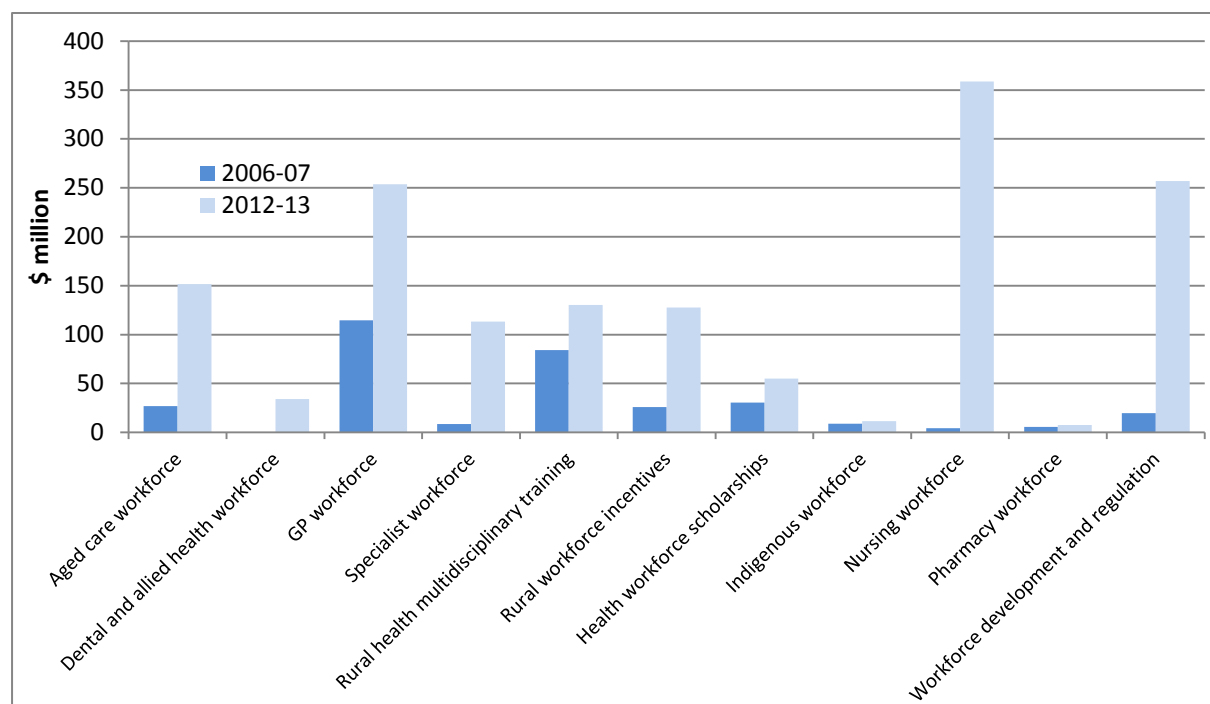


Source: Health Workforce Division Administered Funding Summary, 2012 (unpublished)

Note that the growth in expenditure on “Workforce Development and Regulation” in this period includes the establishment of HWA, with investment in better workforce planning and data systems.

The scale of the change in the funding profile is more apparent when 2006-07 funding is compared directly to 2012-13 allocations, as shown in Figure 1.4.

*Figure 1.4: Total funding by workforce group*

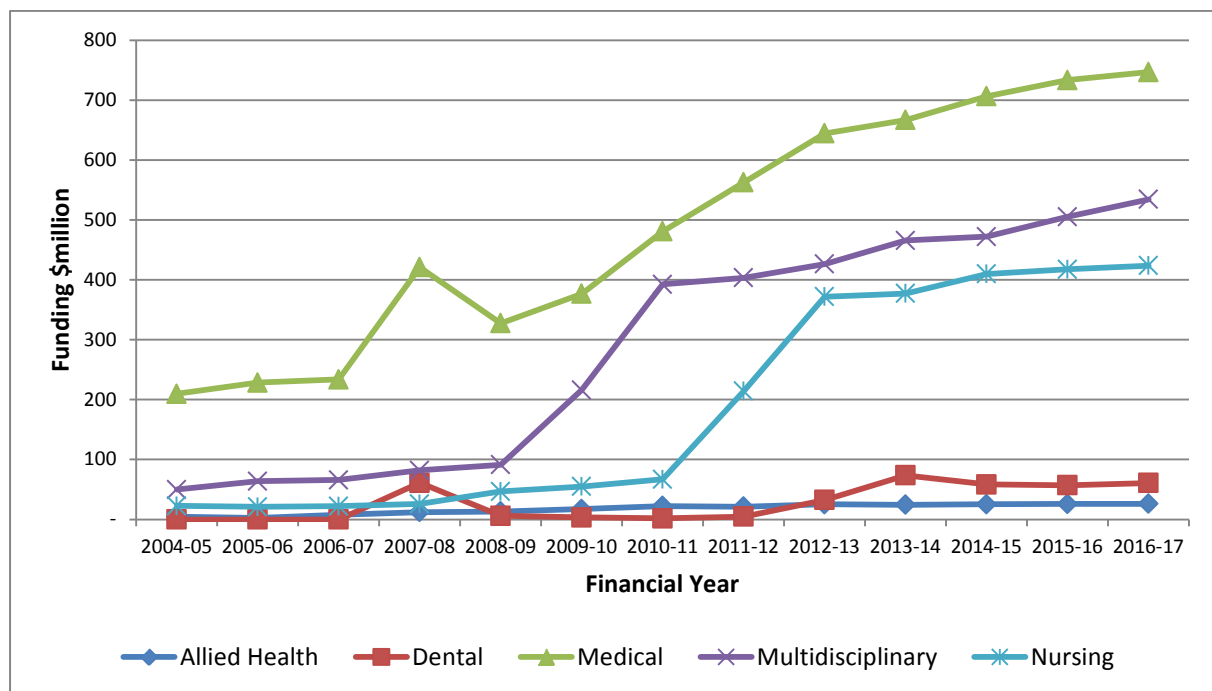


Source: Health Workforce Division Administered Funding Summary, 2012 (unpublished)

While there has been substantial investment in new professional groups in recent years, the level of funding for programs targeted at medical graduates has also increased. This includes additional funding for specialist training and substantial growth in the ongoing investment in GP training places, reflecting commitments made by the Government through the current National Partnership Agreement for Health and Hospital Reform.

Figure 1.5 shows real and projected growth in funding across professional groups since 2004-05.

Figure 1.5: Growth in funding by workforce group

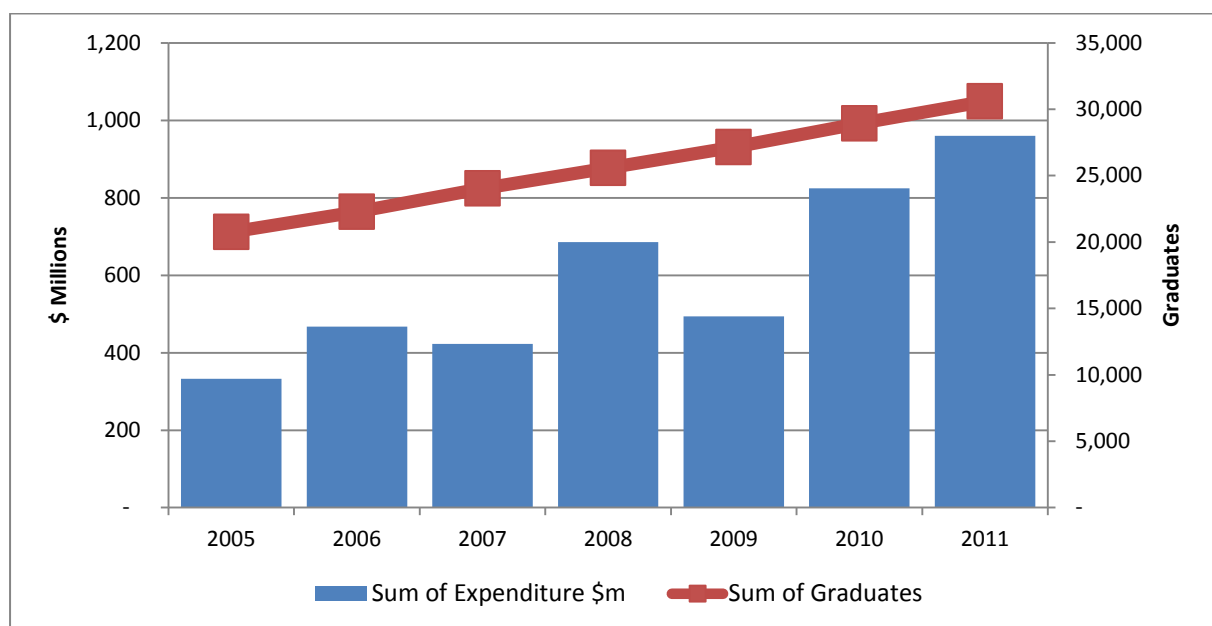


\*NB – "Multidisciplinary" relates to programs that provide funding for more than one health discipline, including Medicine, Nursing and Midwifery or Allied Health.

Source: Health Workforce Division Administered Funding Summary, 2012 (unpublished)

Figure 1.6 shows the growth in overall health graduates (all disciplines) compared to consolidated health workforce program funding.

Figure 1.6: Growth in health graduates



\*NB – graduate numbers include Medicine, Nursing and Midwifery, Dentistry and 17 Allied Health disciplines.

Source: Health Workforce Division Administered Funding Summary, 2012 (unpublished)

It is clear from Figures 1.1 through to 1.6 that the Commonwealth has substantially enhanced its focus on health workforce development over the last decade, with unprecedented intervention to address national health workforce supply pressures to meet community needs. The expansion to workforce supply has been complemented by a much more diversified investment in support and distribution mechanisms across professional groups, while still maintaining a strong focus on more traditional Commonwealth activities targeting medical workforce development.

The complex challenges facing the Commonwealth in undertaking national workforce planning and influencing workforce development across all professional groups are described in more detail in Chapter 2 to follow.

## Chapter 2: Health workforce context

### 2.1 Background

Australia's health workforce comprises a range of professionals working across diverse settings. Information on roles and demographic characteristics of the Australian health workforce should assist in better understanding the effectiveness of current workforce policies. Understanding the existing workforce and anticipated trends should aid in the development of policy reform.

It is of course always important to remember that workforce development is not a goal in itself, the ultimate goal is to provide appropriate access and service for the Australian population, and to produce improved health outcomes across the country.

This chapter provides an overview of the Australian health workforce, including current numbers, distribution and education and training requirements.

For the purpose of this review, the term 'health workforce' generally refers to medical practitioners (general and specialist), nurses (registered and enrolled) and midwives, dental (dentists and other oral health professionals) and certain allied health practitioners. These allied health workforces include, but are not limited to, those subject to the National Registration and Accreditation Scheme (NRAS) – chiropractors, optometrists, osteopaths, pharmacists, physiotherapists, podiatrists, psychologists, Aboriginal and Torres Strait Islander health practitioners, Chinese Medicine practitioners, medical radiation practitioners and occupational therapists. Other groups, such as audiologists, dietitians, exercise physiologists, genetic counsellors, paramedics, speech pathologists, social workers, prosthetists and orthotists, are also usually included as part of the health workforce.

Concerns about the capacity of Australia's health workforce to meet community needs was identified in the first Intergenerational Report<sup>4</sup> released as part of the 2002-03 Budget, which highlighted the future expected increase in government spending. The report focused on the implications of demographic change for economic growth and an assessment of the financial implications of continuing current policies and trends over the following four decades.

The report found that Commonwealth spending on health was projected to increase to 4.3% of Gross Domestic Product (GDP) by 2011-12 and to 8.1% of GDP by 2041-42. Projections showed spending on Medicare Benefits Scheme (MBS) subsidies as a proportion of GDP was expected to grow by 60%, with hospital and health services expenditure growing by 40%.

In 2005, the Productivity Commission was requested to undertake a research study on health workforce issues, including supply and demand pressures over the next ten years. This study arose from a decision by the Council of Australian Governments (COAG) in June 2004.

The report was also to cover the efficacy of health workforce planning and its linkages to health services planning and the education sector, as well as workforce-

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<sup>4</sup> Australian Government, [Intergenerational Report 2002-03](http://archive.treasury.gov.au/contentitem.asp?ContentID=378&NavID=) accessed at <http://archive.treasury.gov.au/contentitem.asp?ContentID=378&NavID=>, viewed 30 August 2012.

related policy measures that would help to ensure efficient and effective delivery of quality health services.

The research report<sup>5</sup> was released on 19 January 2006 and included several recommendations to COAG. The Productivity Commission found that:

- Australia was experiencing workforce shortages across a number of health professions despite a significant and growing reliance on overseas trained health workers. The shortages, which in many cases were a question of uneven distribution rather than absolute numbers, were most 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 would increase while the labour market was likely to tighten. New models of care were also required.
- There was a need to train more health workers and there would also be benefits in improving the retention and re-entry to the workforce of qualified health workers.
- The report also found that it was critical to increase the efficiency and effectiveness of the available health workforce, and improve its distribution.

In November 2010 (the newly created) Health Workforce Australia (HWA) was requested by the Australian Health Ministers' Conference to undertake a workforce planning exercise for doctors, nurses and midwives over a planning horizon to 2025. This study resulted in the release of *Health Workforce 2025*, a three volume report, which aimed to model future health workforce supply and demand across a number of possible policy scenarios. *Health Workforce 2025* will be discussed in further detail later in this chapter.

## 2.2 Current status of the Australian health workforce

In 2010, the Australian Bureau of Statistics Labour Force Survey found that there were 500,600 employed people in direct health-care occupations. The rest (236,800) held other occupations (hospital caterers, hospital cleaning staff, clerical workers, etc), and 266,200 people in health occupations were not working in health services industries but in other industries that support and complement health care (health professionals teaching at university, dietitians in sport and recreational facilities, pharmacists working in pharmaceutical manufacturing, and so on).<sup>6</sup>

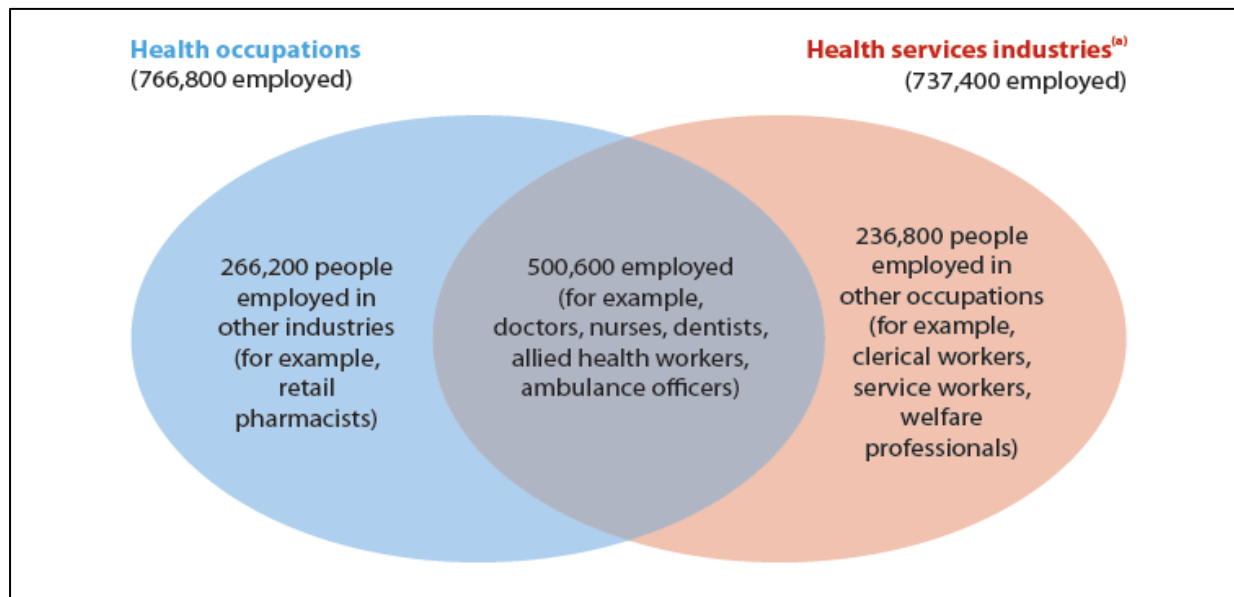
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<sup>5</sup> Productivity Commission, [Australia's Health Workforce, 2006](http://www.pc.gov.au/projects/study/health-workforce/docs/finalreport), accessed at <http://www.pc.gov.au/projects/study/health-workforce/docs/finalreport>

<sup>6</sup> Australian Institute of Health and Welfare. *Australia's health 2012*. Cat. no. AUS 156. Canberra; AIHW. 2012. p. 495



Figure 2.1: Australia's health workforce



Source: Australian Institute of Health and Welfare, *Australia's health* 2012. p 495

### Medical practitioners

Medical practitioners work in various health care settings using their knowledge and skills as qualified health practitioners. Under the National Law, a medical practitioner is a person who holds registration with the Medical Board of Australia (MBA).<sup>7</sup> A medical practitioner is a person whose primary employment role is to diagnose physical and mental illnesses, disorders and injuries and prescribe medications and treatment to promote or restore good health. Within the scope of medical practitioners there are many different titles including but not limited to clinicians and non-clinicians, specialists and non-vocationally trained medical practitioners.

To become a medical practitioner, students must undertake a university undergraduate course ranging from four to six years full-time study. When medical practitioners have completed their studies at university they receive provisional registration and enter the medical workforce as interns (also referred to as postgraduate year 1 – PGY1). An internship lasts for 12 months and is designed to broaden a medical graduate's clinical expertise. Internships are primarily undertaken in hospitals, but may include placements in community settings such as general practice. When medical practitioners have completed their internship they are granted general medical registration by the MBA. Doctors often spend several years working in the hospital system to broaden their clinical experience prior to commencing specialist training. This period of on-the-job training is known as residency or PGY2 and PGY3.

**Specialists** are vocationally trained medical practitioners specialising in a chosen medical field. A large number of specialist disciplines are recognised in Australia, including general practitioner (GP), medical administration and medical

<sup>7</sup> 'National Law' refers to the Health Practitioner Regulation National Law Act 2009 which enables the National Registration and Accreditation Scheme (discussed further in Chapter 3).

academic/researcher. After receiving general medical registration, medical graduates undertake specialist training of between three and seven years and are known as registrars. Upon completing this training, specialists must pass examinations leading to membership of the appropriate professional college to be registered to practise in that specialty.

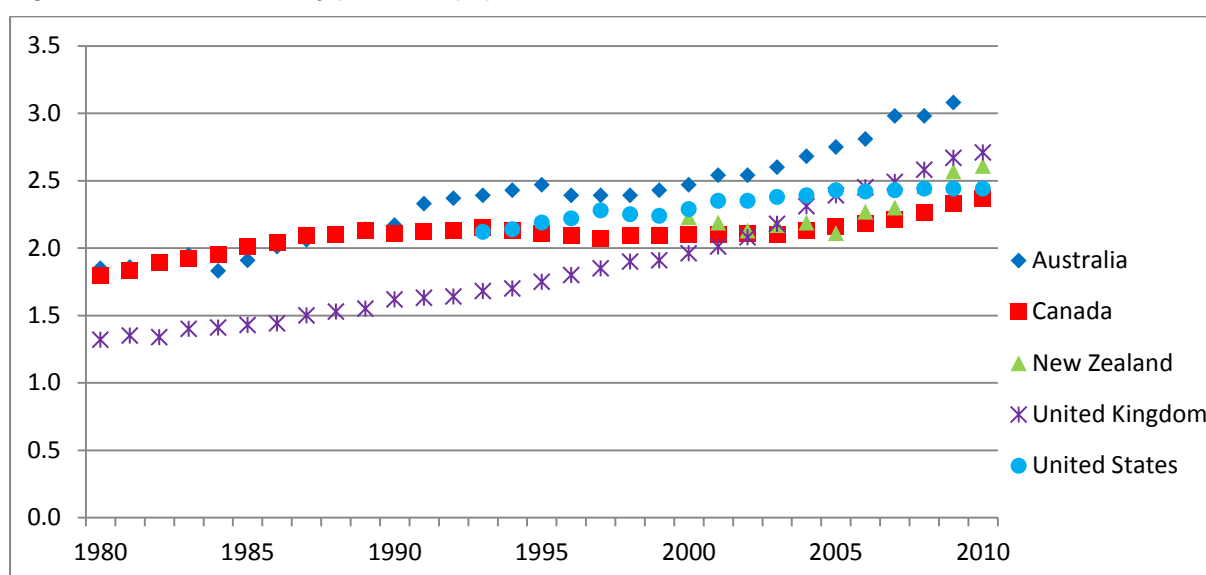
**Clinicians** are medical practitioners who spend the majority of their working hours involved in the area of clinical practice. The clinical group comprises several subfields: general practitioner, hospital non-specialist, specialist, registrar (trainee specialist) and other clinicians. A non-clinician is a medical practitioner who spends the majority of their working hours involved in non-clinical practice. This can include health administration, education or research.

**General practitioners** are defined as specialists trained to provide care for individuals in a whole of person approach and in the context of their work, family and community. General practitioners care for people over a period of their lifetime and across all disease categories.

### Box 2.1: Medical practitioner workforce in Australia<sup>8</sup>

**Number:** In 2011, there were 87,790 medical practitioners registered in Australia. Between 2007 and 2011, the number of medical practitioners employed in medicine increased by 17.3% from 67,208 to 78,833. Compared to similar countries, this has been a very substantial increase in the number of doctors providing services to the Australian community as demonstrated in the following chart:

Figure 2.2: Doctors, density per 1,000 population



Source: OECD Health Data 2012: Health Care Resources (stats.oecd.org)

**Area of practice:** In 2011, 93.8% (73,980) of employed medical practitioners were working as clinicians, of whom 33.1% were non-general practice specialists and 33.9% were general practitioners.

<sup>8</sup> Sources: Australian Institute of Health and Welfare. *Medical workforce 2011*. National health workforce series no. 3. Cat. no. HWL 49. Canberra, 2013; AIHW; Medical Training Review Panel, *Fifteenth Report*. Canberra: DoHA; L Hawthorne, *Health Workforce Migration to Australia, Policy Trends and Outcomes 2004-2010*, Health Workforce Australia, 2012, p. 55

Of those employed as non-clinicians (6.2% of all employed medical practitioners), more than half were researchers (26.9%) or administrators (27.7%).

**Distribution:** Between 2007 and 2011, there was an increase in the supply of employed medical practitioners across all areas. The supply across regions ranged from 407.6 full-time equivalent (FTE) clinicians per 100,000 population in major cities, to 261.0 FTE clinicians per 100,000 population in inner regional areas, 236.9 FTE clinicians per 100,000 population in outer regional areas and 258.2 FTE clinicians per 100,000 population in remote/very remote areas.

**Age:** The average age of employed medical practitioners decreased slightly from 2007 to 2011 (45.9 to 45.5 years).

**Gender:** The proportion of female medical practitioners in the workforce increased to 37.6% of employed practitioners in 2011 (up from 34.0% in 2007). Among clinicians in 2011, women accounted for 48.0% of hospital non-specialists compared to 25.6% of specialists.

**Aboriginal and/or Torres Strait islander status:** In 2011, 264 employed medical practitioners identified themselves as Aboriginal or Torres Strait Islander.

**Overseas trained professionals:** In 2009, 24.5% of employed medical practitioners were trained overseas.

**Students:** In 2011, 3,770 students commenced their medical studies at Australian universities. Of these, 3,241 (86.0%) were domestic students.

In 2011, there were 2,964 medical graduates from Australian medical schools. A total 2,507 of them were domestic graduates.<sup>9</sup>

### Nursing and midwifery

Nurses and midwives provide direct clinical and personal care to patients and are involved in the education of patients around health and disease management and health promotion activities. Nurses and midwives practise in many settings including the home, community, hospitals, residential and extended care settings, clinics or health units, and educational institutions.

**Registered nurses** provide nursing care to people of all ages and cultural groups, including individuals, families and communities. Registered nurses assess, plan, implement and evaluate care in collaboration with individual/s and multidisciplinary health care teams to achieve outcomes. The role of the registered nurse includes promotion and maintenance of health and prevention of illness for individual/s with physical or mental illness, disabilities and/or rehabilitation needs, as well as alleviation of pain and suffering at the end stage of life. The minimum qualification for a registered nurse is a Bachelor degree.

**Midwives** work in partnership with each woman to give support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures. The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the

<sup>9</sup> Medical Training Review Panel, *Sixteenth Report*, Commonwealth of Australia, 2013 (not yet released).

community. Midwives can first qualify as a registered nurse and then undertake additional education and supervised clinical practice in midwifery or undertake direct entry midwifery programs. Direct entry midwives are registered to practise midwifery only; whereas other midwives are also able to practise general nursing, providing they maintain currency requirements to do so under NRAS.

**Nurse practitioners** are registered nurses who have completed both advanced university study (at Masters degree level) and extensive clinical training to expand upon the traditional role of a registered nurse. Nurse practitioners are also required to complete an NRAS accredited and approved program of study in prescribing medicines. They use extended skills, knowledge and experience in the assessment, planning, implementation, diagnosis and evaluation of care required. Through their training and expertise, nurse practitioners are able to autonomously perform advanced physical assessment, order diagnostic tests, interpret the results of these tests, initiate referrals to relevant health providers, and prescribe appropriate medications and other therapies as needed.

**Eligible midwives** work in collaboration with a specified medical practitioner, and can provide Medicare rebate-able antenatal services, care during labour and delivery in a hospital setting (including a hospital birthing centre) and postnatal care for the first six weeks post-delivery. Eligible midwives can also request a range of diagnostic tests, refer patients to obstetricians and paediatricians and prescribe certain medicines under the Pharmaceutical Benefits Scheme (PBS). To attain status as an eligible midwife for Medicare purposes under the National Law, midwives' qualifications and experience are examined to ensure the high standards required by the Nursing and Midwifery Board of Australia's eligible midwife registration standard are met. Eligible midwives are also required to complete an NRAS accredited and approved program of study in prescribing medicines.

**Enrolled nurses** work under the supervision of a registered nurse or midwife to provide patient-centred nursing care including recognition of normal and abnormal in assessment, intervention and evaluation of individual health and functional status. Responsibilities also include providing support and comfort, assisting with activities of daily living to achieve an optimal level of independence, and providing for emotional needs of individuals. Where state law and organisational policy allows, enrolled nurses may administer prescribed medicines or maintain intravenous fluids. Registration requirements for enrolled nurses include completion of an accredited Diploma level course.

**Assistants in nursing and personal care workers** provide direct personal care to older and more vulnerable members of the community and are employed mostly in the aged care and disability sectors in both residential and community care settings. They are also employed in the acute and sub-acute health care sectors. There are no mandated qualifications for the workforce, however Certificate III is the common standard.

**Box 2.2: Nursing and midwifery workforce in Australia<sup>10</sup>**

**Number:** In 2011, the total number of nurses and midwives registered in Australia was 326,669, a 6.8% increase since 2007. Between 2007 and 2011, the number of nurses and midwives employed in nursing or midwifery increased by 7.7% from 263,331 to 283,577. Of these people employed in nursing and midwifery, 51,532 (18.2%) were enrolled nurses and 36,074 (12.7%) were midwives (including 1,517 people registered as midwives but not nurses), though only 15,523 reported working in midwifery as the principal area of their job.

**Area of practice:** In 2011, 59.3% of all employed nurses and midwives worked in the public sector. In 2011, 65.2% of all employed clinical nurses and midwives worked in hospitals. The clinical area of nursing and midwifery with the largest number of workers in 2011 was aged care (40,443), which also had the highest proportion of enrolled nurses (41.5%).

**Distribution:** Nursing and midwifery supply across regions ranged from 1,101.6 FTE nurses and midwives per 100,000 population in major cities to 994.7 in outer regional areas to 1,335.5 in very remote areas, based on a 38-hour week.

**Age:** The average age of the nursing and midwifery workforce increased between 2007 and 2011 from 43.7 to 44.5 years. The proportion of nurses and midwives aged 50 or older increased from 33.0% to 38.6% over this period.

**Gender:** Nursing and midwifery is a female-dominated profession, with women comprising 90.1% of employed nurses and midwives in 2011 (down from 90.4% in 2007).

**Aboriginal and/or Torres Strait Islander status:** In 2011, there were 2,212 nurses and midwives employed in Australia who identified themselves as Aboriginal or Torres Strait Islander.

**Students:** The number of students in university nursing and midwifery courses has increased from 7,926 commencements in 2003 to 16,338 in 2011. The number of completions by Australian students has also increased from 5,306 in 2003 to 9,973 in 2011 which included both domestic and international students. In 2009, there were 2,945 domestic enrolled nursing graduates and 328 international enrolled nursing graduates.

**Dental practitioners**

**Dentists** diagnose and treat dental disease, injuries, decay and malformations of the teeth, periodontal tissue (gums), hard and soft tissue found in the mouth and other dento-facial structures using surgery and other techniques. To register as a dentist in Australia, a student must undertake a five-year undergraduate degree or a four-year graduate-entry degree if they have previously completed a bachelor degree in any discipline. This includes both theoretical knowledge and clinical training.

Dentists are assisted by a number of other oral health practitioners who often work beside or under their supervision. Training programs for dental hygienists, dental therapists and oral health therapists are primarily three-year bachelor degree programs, however there are also accredited courses at the graduate diploma and associate degree level.

**Dental hygienists** carry out preventative dental procedures under the direction of a dentist. To register as a dental hygienist in Australia, students must complete a

<sup>10</sup> AIHW. *Nursing and midwifery workforce 2011*. National health workforce series no. 2. Cat. no. HWL 48. Canberra: AIHW, 2012

three-year Bachelor of Oral Health degree or a two-year Advanced Diploma in Dental Hygiene.

**Dental prosthetists** are responsible for the construction and fitting of dentures and sporting mouthguards. They maintain, repair and relines dentures either by direct consultation with a patient or by referral from a dentist. Training for dental prosthetists is provided through vocational education training (VET) advanced diploma courses.

**Dental therapists** examine and treat diseases of the teeth in preschool, primary and secondary school children under the supervision of a dentist. After completing an undergraduate degree a dental therapist can undertake additional training to further specialise in oral health.

**Oral health therapists** are a new dental profession representing those with dual qualifications as hygienists and therapists, more recently qualified in a newly introduced Bachelor degree in Oral Health. Oral health therapists provide a wide range of dental care in a variety of settings to children, adolescents and adults.

**Dental assistants** and **dental technicians** are members of the dental practitioner workforce that are not required to register with the Australian Dental Board. Dental assistants prepare patients for dental examinations and assist other dental practitioners to provide patient care. Dental technicians construct and repair dentures and other dental appliances. Dental assistants and dental technicians have usually completed a VET-based course at the certificate, diploma or advanced diploma level.

#### Box 2.3: Dental practitioner workforce in Australia<sup>11</sup>

**Number:** In 2011, there were 18,803 dental practitioners registered in Australia of which 16,924 were employed. In 2011 there were 12,734 dentists, 1,065 dental hygienists, 1,044 dental therapists, 1,088 dental prosthetists and 994 oral health therapists employed in Australia. Between 2006 and 2011, the number of employed dentists increased by 22.4% from 10,404 to 12,734.

**Area of practice:** In 2011, 78.2% (9,959) of employed dentists worked in private practices. The majority of dental hygienists, dental prosthetists and oral health therapists worked in private practices. In 2011, 48.9% of dental hygienists worked in public health dentistry across schools and community health care services.

**Distribution:** In 2011, major cities had more dentists per capita (64.1 FTE per 100,000 population) than other areas (inner regional 42.1 FTE per 100,000 population and outer regional 33.5 FTE per 100,000 population). In the case of dental hygienists and oral health therapists, the per capita workforce decreases with further remoteness. However for dental therapists the per capita workforce is greater in inner regional (4.5 FTE per 100,000 population), outer regional (5.3 FTE per 100,000 population) and remote/very remote (4.9 FTE per 100,000 population) areas than in major cities (3.0 FTE per 100,000 population). The per capita portion of dental prosthetists is also greater in inner regional areas (6.2 FTE per 100,000 population) than in major cities (5.6 FTE per 100,000 population).

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<sup>11</sup> AIHW. *Dental workforce 2011*. National health workforce series no. 4. Cat. no. HWL 50. Canberra: AIHW, 2013



**Age:** The average age of employed dentists in 2011 was 43.2 years with 23% of the employed workforce aged over 55 years of age. Employed oral health therapists, dental hygienists, dental therapists and dental prosthetists were 32.6, 37.4, 46.3 and 49.3 years old on average, respectively.

**Aboriginal and/or Torres Strait Islander status:** In 2011, 26 employed dentists, 11 employed dental hygienists, 6 employed dental therapists, 4 employed dental prosthetists and 7 employed oral health therapists identified themselves as Aboriginal or Torres Strait Islander.

**Students:** In 2011, 362 Australian students completed qualifications as dentists in Australia and 542 Australian students commenced studies to gain a dental qualification. Enrolments in vocational education and training courses leading to qualifications as a dental hygienist, prosthetist, technician or therapist have increased by 40.0%, from 903 in 2007 to 1,264 in 2011.

### Allied health

The term 'allied health' represents various health disciplines, excluding doctors, nurses and midwives, and dentists. The definition of allied health can vary depending on context. The list below is not exclusive.

Allied health professionals work across a number of settings. For most allied health professions the minimum training requirement is an undergraduate degree, however, many may complete postgraduate degrees and in the case of some professions, including but not limited to audiology, pharmacy and psychology, a period of postgraduate supervised practice or training is required.

**Aboriginal and Torres Strait Islander health practitioners** provide clinical and primary care for Aboriginal and Torres Strait Islander individuals, families and community groups. In order to become a registered Aboriginal and Torres Strait Islander health practitioner, students must complete a VET Certificate IV qualification, this may be which may be undertaken as part of a traineeship or apprenticeship.

**Audiologists** provide diagnostic assessment and rehabilitation services related to human hearing defects. To be an accredited audiologist, students are required to complete a two year postgraduate degree at the Masters level.

**Chiropractors** provide diagnosis and treatment of neuromuscular disorders, with an emphasis on treatment through manual adjustment and/or manipulation of the spine. To become a registered chiropractor in Australia students must complete an accredited five year undergraduate university degree.

**Chinese medicine practitioners** provide holistic health care that may include (but is not limited to) acupuncture, herbal medicine, Chinese massage and breathing exercises in order to prevent and treat disease. In order to become a registered Chinese medicine practitioner students can undertake a number of tertiary VET and university courses.

**Dietitians** assist individuals, groups and communities to attain, maintain and promote health through good diet and nutrition. To be eligible through the Dietitians Association of Australia (DAA), dietitian students must undertake a three to four year university undergraduate course accredited by DAA. Dietitians can then choose to become an accredited practising dietitian by meeting certain criteria.

**Medical radiation practitioners** operate X-ray and other radiation producing and imaging equipment for diagnostic, monitoring and treatment purposes under the direction of radiologists and other medical practitioners. In order to become a

registered medical radiation therapist, students need to undertake a three to four year university undergraduate course.

**Occupational therapists** assess the function of people whose abilities are impaired and assist people to participate in the activities of everyday life. To become a qualified occupational therapist, students must complete a four-year university undergraduate course in occupational therapy or postgraduate Masters degree.

**Optometrists** perform eye examinations and vision tests to determine the presence of visual, ocular and other abnormalities, and prescribe lenses and other optical aids or therapy. To become a registered optometrist, students need to complete a four-to five-year university undergraduate course, with postgraduate qualifications available to specialise.

**Osteopaths** use techniques such as stretching and massage for general treatment of the soft tissues (muscles, tendons and ligaments) along with mobilisation of specific joints and soft tissues to treat injuries and illnesses. To be a registered osteopath, five years of university study is required.

**Pharmacists** prepare or supervise the dispensing of medicines, ointments and tablets and advise members of the public and other health professionals about medicines, including appropriate selection, dosage and drug interactions, potential side effects and therapeutic effects. To be registered as a pharmacist, students need to undertake a three to four year undergraduate pharmacy degree, complete approved supervised practice, complete an intern program and pass written and oral examinations.

**Physiotherapists** assess, treat and prevent disorders in human movement caused by injury or disease. To be registered as a physiotherapist, students must undertake a four-year undergraduate degree or postgraduate (Masters) degree.

**Podiatrists** prevent, diagnose and treat health conditions of the lower limbs, including those resulting from bone and joint disorders, muscular pathologies as well as neurological and circulatory diseases. To be registered as a podiatrist, students must complete a three- to four-year undergraduate degree.

**Psychologists** are experts in human behaviour, having studied the brain, memory, learning, human development and the processes determining how people think, feel, behave and react. Psychological therapies are used to treat individuals and families and can also be applied to groups and organisations. To become eligible for general registration as a psychologist there are three different pathways including a four-year undergraduate degree followed by a two-year internship, a five-year undergraduate degree followed by a one-year internship or an accredited postgraduate degree.

**Social workers** work with individuals, groups and/or communities in times of crisis. Their clients may include families, students, hospital patients or the elderly. To become an accredited social worker students can undertake either an undergraduate or postgraduate (Masters) degree.

**Speech pathologists** assess and treat people with communication disorders including speech, language, voice, fluency and literacy difficulties or people who have physical problems with eating or swallowing. To become an accredited speech pathologist, students can undertake either an undergraduate or postgraduate (Masters) degree.

### *Allied health professionals in Australia*

There is limited data available on allied health disciplines, especially those not included in the NRAS. HWA has commenced work on *Health Workforce 2025 – Selected Allied Health Professions*.

The professional boards registered under the NRAS release quarterly registration numbers for each profession with limited demographic details. There were 11 allied health professions registered under NRAS as of December 2012 and the total number of registered professionals was 128,508 which includes those with provisional registration.

The allied health professions account for 22.1% of the total registrations across all registered health professions. The table below shows the number of registrations by profession and the percentage of these across all registered allied health practitioners.<sup>12</sup>

*Table 2.1: Number of registered allied health practitioners as at December 2012<sup>13</sup>*

Professions	Number of registrations	Percentage of total registrations
<b>Aboriginal and Torres Strait Islander health practitioners</b>	298	0.2%
<b>Chinese medicine practitioners</b>	3,952	3.1%
<b>Chiropractors</b>	4,610	3.6%
<b>Medical radiation practitioners</b>	13,508	10.5%
<b>Occupational therapists</b>	14,255	11.1%
<b>Optometrists</b>	4,586	3.6%
<b>Osteopaths</b>	1,761	1.4%
<b>Pharmacists</b>	27,425	21.3%
<b>Physiotherapists</b>	24,304	18.9%
<b>Podiatrists</b>	3,825	3.0%
<b>Psychologists</b>	29,984	23.3%
<b>TOTAL</b>	<b>128,508</b>	<b>100%</b>

The size of the allied health workforce has increased in recent years. The limited demographic data available from the national boards in the NRAS show that the median age of most allied health professionals is between 36 and 40 years of age with occupational therapists being younger with the median age, between 31 and 35 years of age. Aboriginal and Torres Strait Islander health practitioners, optometrists and psychologists had a median age of between 41 and 45 years of age and Chinese medical practitioners had a median age between 46 and 50 years, the

<sup>12</sup> [Australian Health Practitioner Regulation Agency](http://www.ahpra.gov.au), December 2012 quarterly registration data, accessed on individual board websites at [www.ahpra.gov.au](http://www.ahpra.gov.au), viewed on 20 January 2013.

<sup>13</sup> *ibid.*

oldest of the allied health professionals. Registration data also shows that allied health professions tend to be female dominated with the exception of chiropractors, which is a very male dominated profession. There is little data available for non-registered allied health professionals.

### Current status

The above workforce demographics assist us to understand the current state of the health workforce and the current challenges in delivering services to the community. The nursing and midwifery workforce accounts for approximately 60% of the health workforce and plays a major role in direct patient care. The medical workforce is the next largest at approximately 16% of the workforce and is tasked with both frontline primary care and acute care. Overall, medical practitioners, nurses, midwives, and dental practitioners account for approximately 77% of the registered health workforce. Therefore, their distribution, work practices and ageing profile heavily affect the supply of health services.

### Age and gender

As can be seen above, the medical, nursing and midwifery, dental and some allied health workforces are quite aged compared with the median age of Australia's workforce<sup>14</sup> and the proportion of those aged 55 years or older rose from 15% in 2005 to 19% in 2010.<sup>15</sup> The ageing workforce not only impacts on the future supply of health professionals but also on the quantity of current working hours as older workers tend to work fewer hours. Labour force survey data shows average working hours of health professionals are reducing and research shows that the working hours of future graduates will continue to fall.<sup>16</sup> The increasing feminisation of the health workforce has been postulated to have a major impact on the total hours worked as some segments of the female workforce traditionally work fewer hours than their male counterparts due to family commitments. However the male workforce average weekly working hours have also been decreasing. The average weekly working hours for male doctors fell approximately four hours between 1999 and 2009, from 48.4 to 44.9.<sup>17</sup> This fall in male average hours has occurred across all age groups.

Given the ageing of the workforce and reduction in work hours from both genders, the increasing training, graduation and recruitment of the total number of health workers has in fact led to only a small net increase in the number of full-time equivalent (FTE) practitioners.<sup>18</sup>

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<sup>14</sup> Median age of the Australian workforce was 37 years of age in 2011. The median age is the age that divide the population into two equal groups, half that is younger and half that is older (ABS Labour Force, Australia, Cat no: 6291.0.55.003).

<sup>15</sup> Australian Institute of Health and Welfare, *Australia's health 2012*, Cat. no. AUS 156. Canberra: AIHW, 2012, p 494

<sup>16</sup> National Health Workforce Taskforce, *Health Workforce in Australia and Factors for Current Shortages*, National Health Workforce Taskforce, Melbourne, 2009, p38

<sup>17</sup> Health Workforce Australia, *Australia Health Workforce Series – Doctors in focus*, Adelaide, 2012, pg 15

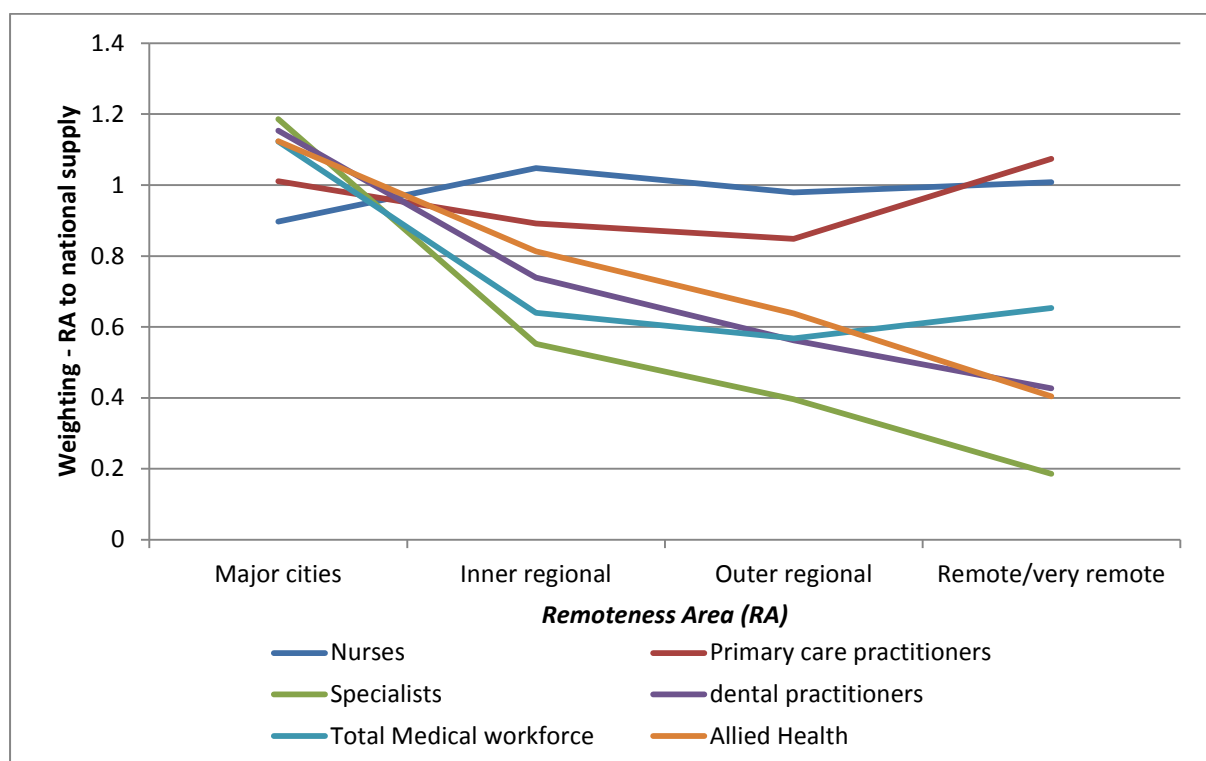
<sup>18</sup> Health Workforce Australia, *Health Workforce 2025 – Doctors, Nurses and Midwives – Volume 1*, Adelaide, 2012, p9.

### Distribution

It is widely recognised that the geographic spread of the health workforce does not reflect the distribution of the population. With the exception of nurses and midwives, the relative number of health professionals diminishes for communities located further away from major centres. Nursing and midwifery staff-to-population ratios actually increase in inner and outer regional areas before declining in remote and very remote areas and the midwifery staff-to-population ratio is the least in major cities.<sup>19</sup> Allied health, dental practitioners and medical specialists are in severe shortage in outer regional, remote and very remote areas.

The shortage of health professionals in rural and remote areas further exacerbates workload pressures for the current health workforce and has been a key focus for this review.

*Figure 2.3: Health practitioners per 100,000 population comparative weightings; Remoteness Area to national supply by health workforce*



Sources: AIHW nursing and midwifery labour force survey 2009, AIHW Medical labour force 2009, and AIHW Health and community services labour force 2006

The average age of the nursing and midwifery workforce in regional, rural and remote areas is older than in metropolitan areas. This indicates that while the current distribution is relatively even, the ageing of the nursing and midwifery workforces is likely to lead to a maldistributed workforce in the near future. Allied health professionals are rather unevenly distributed especially in the more rural areas.<sup>20</sup> It is important to bear in mind that allied health professions are diverse and

<sup>19</sup> Health Workforce Australia, *Health Workforce 2025 – Doctors, Nurses and Midwives – Volume 1*, Adelaide, 2012, p156.

<sup>20</sup> *ibid.*

some professions are small in number. It would be inherently improbable that these professions would be equally distributed across all regions. The role and scope of practice of different professions also needs to be taken into account. Professionals in regional and remote areas tend to provide a greater mix of services and different models of service delivery to meet demand.<sup>21</sup>

In summary, despite recent increases to raw numbers of entrants into Australia's health workforce, reductions in hours worked and retirements meant that there has in fact been only a small net increase in the number of FTE practitioners. Additionally, the workforce is currently unevenly distributed across geographic regions for many professions and this trend is likely to intensify.

## 2.3 Health workforce levers

As noted by the Productivity Commission in 2005, and reflected in the HWA modelling work described elsewhere in this report, Australia's health workforce arrangements are complex and interdependent. Along with the Commonwealth and state and territory governments, other players, including employers, universities, VET providers, professional registration boards and specialist colleges all have some capacity to influence the education, registration and employment pathways of the health workforce.

### The Commonwealth

The nature of the federated system of government has resulted in divided responsibility for health care between the Commonwealth and states. Section 51(xxiiiA) of the Constitution is the primary source of the Commonwealth's legislative powers for health, and allows for the Commonwealth to make laws with respect to 'pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorize any form of civil conscription)'. The Constitution also allows for the Commonwealth to make grants to the states that are subject to terms and conditions (Section 96); this is the basis upon which the Commonwealth funds states and territories for a range of activities, including public hospital services. Constitutional provisions are a fundamental consideration in the Commonwealth's policy responses to health workforce issues.

In 2010, the Commonwealth funded around 43% of health services, making it the largest funder of health services in Australia. Recent additional Commonwealth funding commitments through National Health Reform measures are likely to have increased this percentage.

The Commonwealth's capacity to influence the supply and distribution of the health workforce is exercised through a number of avenues. Adding to the complexity of the situation is that many of these are outside the health portfolio. For example, tertiary education and immigration policies and practices are also crucially important.

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<sup>21</sup> J Humphreys and J Wakerman, *Primary health care in rural and remote Australia: achieving equity of access and outcomes through national reform*, a discussion paper commissioned by the National Health and Hospitals Reform Commission, 2008.



### *Tertiary Education portfolio*

The Commonwealth funds university-delivered health education through Commonwealth supported places. Through its funding agreements with universities, the Commonwealth has the capacity to set targets for particular areas of study. However, from 1 January 2012, the Commonwealth moved to a demand-driven system, allowing universities (and students) to determine how many undergraduate students to enrol, and in what courses of study. Medical places are the exception – the Commonwealth continues to set a cap on the number of domestic medical places available (determined by the Minister for Tertiary Education on advice from the Minister for Health). This provides some control over the number of medical practitioners entering the Australian health training system, due to the extensive postgraduate training requirements for doctors and the current pressures on the clinical training system for all health professionals.

The Commonwealth also contributes funding to the VET sector, although state and territory governments are the primary funders.

### *Health portfolio*

The Commonwealth can place restrictions on access to Medicare provider numbers through the *Health Insurance Act 1973* (the Act) to achieve certain workforce aims, such as improving the distribution of medical practitioners in undersupplied areas. The Act includes provisions to limit Medicare benefits for services provided by medical practitioners who are not vocationally recognised (with a number of exceptions), and overseas trained doctors for a period of ten years which may be scaled if working in a district of workforce shortage.

The Commonwealth funds a large number of programs aimed at improving the supply and distribution of the health workforce, particularly in rural and remote Australia. These include infrastructure funding, rural education programs, programs placing individual obligations on funds recipients (for example, bonded medical places), and scaled incentive schemes providing greater incentives for health professionals willing to work in more rural areas. The Commonwealth delivers the vast majority of GP vocational training through General Practice Education and Training Limited (GPET), a Commonwealth-owned company, and can set the number of places available.

The Commonwealth's control over the parameters of the MBS and the PBS can also influence the structure and make-up of the health workforce. The Commonwealth controls which health professions are eligible for a provider number (for example, nurse practitioners), and which services are included on the MBS Schedule and thereby attract a rebate and which professions may prescribe drugs for which PBS benefits are available.

### *Immigration portfolio*

The Department of Immigration and Citizenship is responsible for determining the criteria for temporary and permanent entry of skilled professionals, allowing for the migration of overseas trained health professionals.

Free trade agreements entered into by the Australian Government restrict the capacity to limit or reduce the movement of nationals from some countries into Australia to work. This means that it is not possible to set overall caps on numbers or migration of health professionals. The World Health Organization's Code of Practice on the International Recruitment of Health Personnel (May 2010), to which

Australia is a signatory, requires ethical international recruitment practices including that migrant health personnel be hired, promoted and remunerated on objective criteria, such as levels of qualification, years of experience and degrees of professional responsibility.

### Commonwealth-state interface - COAG framework

Given the Commonwealth's Constitutional limitations, a significant amount of Commonwealth influence with respect to health is exercised using its funding power in agreements with states and territories, negotiated through COAG. Through the Intergovernmental Agreement on Federal Financial Relations and a number of subsidiary agreements, the Commonwealth provides funding to states and territories for a range of functions, including public hospitals and VET. This has been a significant area of activity for health workforce reform over recent years, including the introduction of the NRAS, efforts to improve clinical training capacity, and the establishment of HWA.

### State and territory governments

As outlined above, responsibility for health care is shared between the Commonwealth and the states and territories. The key roles of the states and territories with respect to the health workforce are listed below.

- As the co-funders and providers of public hospital and community-based health services, states and territories:
  - Determine the distribution of publicly funded services;
  - Are major employers of the health workforce, including medical, nursing, dental and allied health professionals; and
  - Provide the majority of clinical training placements.
- State and territory governments are responsible for primarily allocating funding to the VET, and own and operate a large number of registered training organisations (RTOs). These provide the training for health workers such as enrolled nurses, Aboriginal and Torres Strait Islander health practitioners, allied health assistants and personal care workers.
- State and territory governments are responsible for the regulation of health professionals within their jurisdiction. On 1 July 2010, a nationally consistent regulation scheme was introduced with the passage of parallel legislation in each state and territory: the *Health Practitioner Regulation National Law 2009* (the National Law) (see below).
- States and territories also fund and deliver a range of programs to address supply and distribution issues in particular areas and professions.

### Standing Council on Health

The Standing Council on Health (SCoH) is the Ministerial forum for intergovernmental negotiation on health issues. Ensuring a high quality and sustainable health workforce is listed as one of SCoH's priorities of national significance. Whilst sitting as the Australian Health Workforce Ministerial Council (AHWMC), it also has legislative responsibilities with respect to oversight of the NRAS and the Australian Health Practitioner Regulation Agency (AHPRA) (discussed below). SCoH is supported by the Australian Health Ministers' Advisory Council (AHMAC), which in turn is supported by the Health Workforce Principal Committee (HWPC), providing advice on workforce issues. Membership of the

HWPC is comprised of representatives from each state and territory health department as well as a representative from DoHA and HWA.

### Other key stakeholders

#### *Employers*

Employers of health practitioners across the public, private and not-for-profit sectors have significant impacts on the composition and size of the health workforce. The large number and variety of employers across the sector have resulted in complex wage and industrial conditions, all of which impact on workforce development. In particular, as state and territory governments are the major employer of health professionals within their hospital systems, there are often significant variations in industrial conditions between these jurisdictions, adding a layer of complexity to national workforce planning processes.

Further, the intersection between state and territory employment arrangements and the private health care system has impacts on particular workforce groups (e.g. nurses and midwives, medical specialists) and labor market conditions both nationally and within jurisdictions.

The not-for-profit sector (third sector) refers to organisations that are funded through a mix of government grants and contracts, fees for service, fundraising and philanthropy.<sup>22</sup> The role of the third sector in the provision of health services and employment of health practitioners is expected to increase with the greater focus on community based health care and launch of the *National Compact: Working Together*,<sup>23</sup> an agreement between the Australian Government and the not-for-profit sector to collaborate to deliver better policy and programs while strengthening the sector's viability.<sup>24</sup> This "third sector" is likely to become increasingly critical in meeting community health care needs, given the increasing need for aged care and disability services, much of which is delivered by a mix of not-for-profit organisations and private providers.

#### *National Boards and the Australian Health Practitioner Regulation Agency*

For those health professions included in the National Registration and Accreditation Scheme (NRAS), responsibility for professional registration, accreditation of courses of study, determining professional standards, and scopes of practice lies with the National Boards. The boards are established under the National Law, and members are appointed by AHWMC with a mix of practitioner and community members. The National Boards are supported by AHPRA, which was established to administer NRAS. Further discussion of the role of the National Boards can be found in Chapter 3.

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<sup>22</sup> I Sheppard, R Fitzgerald and D Gonski, *Inquiry into the Definition of Charities and Related Organisations*, Australian Government, Canberra, 2001

<sup>23</sup> Department of the Prime Minister and Cabinet, *National Compact: Working Together*, Australian Government, Canberra, 2011

<sup>24</sup> Productivity Commission, *Contribution of the Not-for-Profit Sector*, Research Report, Canberra, 2010

### *Universities and VET providers*

In general, universities are responsible for maintaining accredited courses and awarding degrees, powers that are granted through their establishment legislation (noting that courses leading to eligibility for professional registration under NRAS must be externally accredited, for example, medical courses must be accredited by the Australian Medical Council). This allows universities to determine the content and make-up of degree courses where professions are not under NRAS. Recent experience with several universities developing 'physician assistant' degrees, a health role not currently used in Australia except in a number of time-limited trials, demonstrates the autonomy of universities in determining what courses they offer.

As outlined above, from 1 January 2012, universities have the capacity to determine how many undergraduate students are enrolled in whichever courses of study, with the exception of medicine.

In contrast to the university sector, RTOs deliver vocational education and training and cannot accredit their own courses. Most VET sector programs are based on National Training Packages, which are a nationally endorsed set of standards, guidelines and qualifications for training, assessing and recognising a person's competencies. RTOs can also develop their own courses for skill needs not covered in the National Training Package; these must be accredited by the Australian Skills Quality Authority to be eligible for public funding. Part of the accreditation process includes an assessment of the viability and need for the course within the vocational area, requiring consultation with industry.

### *Medical specialist colleges*

Medical specialist colleges are responsible for delivering medical specialist education, and control entry into specialist training programs. Colleges also have legislative responsibilities under the *Health Insurance Act 1973* with respect to recognising an individual as a specialist (s. 3D) or a participant in an approved training program (s. 3GA) for the purposes of Medicare billing. They are also involved in the accreditation of new training settings and maintaining standards at existing training sites. The colleges therefore play a role in determining the supply of particular specialist practitioners.

Clearly the roles and responsibilities in training, regulating and employing the health workforce to support the health care needs of Australians are split across a range of players, and differ according to profession.

The Commonwealth's capacity to influence the supply and distribution of the health workforce (with some exceptions) resides primarily in its funding power and ability to influence workforce outcomes through legislative means. The Commonwealth also plays a key role in negotiating national outcomes through Commonwealth–state forums in areas where regulatory responsibility rests with the states.

## ***2.4 Identification of key health workforce issues and challenges***

The Australian health system has undergone extensive change over recent years. It is important to understand these trends and how they will impact on the future demand for health services and health practitioners. The changing demand on health services will have implications for health spending and government policy especially in relation to education, training and distribution of the health workforce.

Australia's health workforce has a traditional base of professions: medicine, dentistry and nursing; and allied health professional disciplines such as physiotherapy. These professional groups have well-established and strongly delineated roles in the delivery of services. Traditionally, services have been built around professional/discipline silos with often narrowly defined roles and responsibilities; and with clinical pathways and referrals built around disciplines. This can result in overlap of assessment processes and an experience for the patient or client which can be both confusing, alienating and inefficient from a system perspective. Patient service needs are often provided through multiple short or single discipline interventions. There has traditionally been a strong focus on providing services in an acute setting, in specific models of care; with siloed clinical governance and supervision.

This section of the review outlines these issues to inform the later discussion of Commonwealth health workforce programs. The aim is to allow current investments to be considered within the overall context of workforce development in an environment of competing pressures and increasingly scarce resources.

### Increasing demand for health services

As discussed previously, data shows that despite large increases in the numbers of people employed within Australia's health workforce, demographic factors mean that there has been only a slight increase in the number of full time equivalent practitioners, many of whom are due to retire shortly. In addition to these supply side pressures, the demand for health services is projected to increase, for a variety of reasons including increased chronic disease, greater consumer expectation and a treatment model built around short-term acute interventions. These health service pressures will require the health workforce to undergo reform to current practices in order to meet demand.

### *Ageing population*

Given decreasing fertility rates and mortality, Australia will experience further ageing of its population over the next three decades. Overall, the proportion of the population that is old (65 to 84 years of age) is expected to more than double between 2002 and 2042, and the proportion of the population that is very old (over 85 years of age) is expected to triple in the same time. The ageing of the population is projected to require a greater need for health services and hence increased health spending.<sup>25</sup>

As the population ages it is expected that they will utilise certain services more than others requiring greater supply of certain health practitioners. Older Australians use general practitioner (GP) services at twice the rate of younger people. Hospital admissions almost triple among older populations with length of hospital stays increasing with age, rising to eight days for patients aged 85 years and older. Demand for pharmacy services also increase with age with research showing that approximately 25% of people aged over 65 years used four or more medications concurrently, which increases the risk of drug interaction and hence adverse

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<sup>25</sup> Commonwealth of Australia, *Intergenerational Report 2002–03 – Budget Paper 5*, Commonwealth of Australia, Canberra, 2002, p. 22



events.<sup>26</sup> Older Australians will also utilise greater rehabilitation, subacute, disability and mental health services.

### ***Burden of disease***

The prevalence of many chronic diseases is increasing in Australia which will impose even heavier demand for health services and therefore health workers. The results of the 2007-08 National Health Survey indicated a high prevalence of chronic diseases among the Australian population, including cancer (2%), diabetes (4%), asthma (10%), long-term mental or behavioural conditions (11%), arthritis (15%) and heart disease (16%).<sup>27</sup>

The increasing occurrence of chronic disease has been correlated with earlier detection and improved treatments for conditions which may have previously led to an early death, as well as a number of poor lifestyle behaviours such as tobacco smoking, physical inactivity and poor diet. Chronic diseases include heart disease, stroke, cancer, depression and diabetes and are characterised by their long development period with multiple factors leading to their onset, and a prolonged course of illness. This often leads to other health complications such as functional impairment or disability. Early detection of chronic diseases is resulting in reduced mortality, with a corresponding need for care across a longer span of time.<sup>28</sup>

The increasing prevalence of chronic disease has implications not only for the number of health workers required in the future but also the skill mix and models of care required for optimum treatment. Multi-disciplinary and team-based care is becoming increasingly important in the management of many chronic diseases so that the patient is at the centre of his or her own care rather than a “command and control” model. Additionally, a significant proportion of chronic illnesses are preventable, indicating that there are considerable gains to be made both economically and for quality of life through greater concentration on health education and monitoring of high risk patients.

In other words, current trends indicate significant demand for specialised acute health services with suboptimal and costly results, when investment in primary care, health promotion and disease prevention efforts would produce better health outcomes and reduce cost.

### ***Increasing consumer expectations and higher disposable incomes***

There is a yawning gap in the degree to which health consumers have access to information about preventative health and health maintenance. More affluent health consumers are much more aware of the type of care available, the actions they can take and the results they may be able to expect from treatments. This has increased the demand for such services.

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<sup>26</sup> Australian Institute of Health and Welfare. *Older Australia at a glance: 4th edition*, Cat. no. AGE 52. Canberra: AIHW, 2007, pp. 105-115

<sup>27</sup> Australian Bureau of Statistics, *National Health Survey, 2007-08, Summary of Results*, Australia, Cat No 4364.0, ABS, Canberra. 2008

<sup>28</sup> Australian Institute of Health and Welfare. *Risk factors contributing to chronic disease*. Cat No. PHE 157. Canberra: AIHW, 2012, p.5.

Greater income coupled with consumer demand for preventative health care and treatment, including advances in surgery has led in more affluent populations to increases in expectation of health service quality, access and demand.<sup>29</sup>

However, more disadvantaged communities, particularly rural, remote and Aboriginal and Torres Strait Islander communities often lack access to information, frequently have minimal internet access and unreliable or non-existent transport to community facilities and services. This can lead to neglected or poorly managed chronic conditions which then become acute.

It is important to bear in mind that internationally and domestically, health models which place the patient at the centre of his or her own care, and engage health consumers meaningfully, are strongly evaluated as providing the best quality of care, especially for chronic conditions, as well as reducing the economic drain of escalating acute care admissions.

### Health workforce supply and future projections

In the context of increasing demand for health services and current shortages, a workforce projection study *Health Workforce 2025* (HW2025) was undertaken by HWA to assist in future workforce planning. The study aimed to model future health workforce supply and demand across a number of possible policy scenarios taking into account the ageing population and current service utilisation rates.

*Health Workforce 2025 – Doctors, Nurses and Midwives* (Volumes 1 and 2) were considered at the SCoH meeting in April 2011 and Volume 3, *Medical Specialties*, was considered in November 2012. Future iterations are intended to cover other health workforces including dental and allied health professions. A detailed summary of the *Health Workforce 2025* report – Volumes 1, 2 and 3 can be found at Appendix ii.

### Health Workforce 2025 study key findings<sup>30</sup>

HWA modelled various workforce scenarios as part of HW2025 such as:

- *Innovation and reform* – explores the projected impact of a number of possible reform initiatives including increased workforce productivity, decreased demand for health services and for nurses specifically, increasing workforce retention rates;
- *Immigration* – examines two scenarios that restrict the level of immigration of doctors and nurses to either 50% of current levels by 2025 (medium self-sufficiency) or to 95% of current levels (high self-sufficiency) by 2025.
- *Training* – calculated the number of graduates required for supply to meet demand in a given year according to the scenario modelled; and
- *Other impacts* – these include examining the effects of:
  - an under-supply of 5% in the medical and nursing workforce at the baseline year of modelling (2009), rather than supply meeting demand, the assumption used for all other scenario modelling;

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<sup>29</sup> Productivity Commission, *Australia's Health Workforce*, Research Report, Canberra, 2005

<sup>30</sup> Health Workforce Australia, *Health Workforce 2025 Volumes 1–3*, Health Workforce Australia, Adelaide, 2012.



- a 2% increase in demand beyond current predictions for health services such as may arise from the effects of an ageing population; and
- capping working hours (doctors only) at 50 hours per week to reflect an observed trend of a reduction in working hours for the medical workforce.

All scenarios were compared against a comparison or “do nothing” scenario. The comparison scenario shows that if health services continue to be delivered as is, with no change in policy, there will be a shortage of 109,490 nurses and a shortage of 2,701 doctors by 2025. The immigration scenario modelling shows that the Australian health workforce has become significantly reliant on the migration of doctors and nurses to Australia as well as on international students graduating from Australian universities who eventually settle in Australia.

As with any modelling, there are limitations and caveats, and various criticisms of the models have legitimately been made. However, given the previous lack of collated information, it is generally conceded that the HWA work represents a substantial advance in providing data as a foundation for planning.

Projected training requirements vary depending on which changes to policy settings being proposed. But there are clear practical constraints on the capacity of the system to provide clinical training, which means that substantially increasing the numbers of students in training in a given health profession may not be feasible. The larger numbers of clinical placements required are likely to be unobtainable in some circumstances.

HWA modelling suggests that the policy levers that have the most significant impact on health workforce service delivery are innovation and reform measures, which potentially lead to significant productivity gains and lowering of demand for services.

Productivity gains can be made through workforce reforms such as changing models of care, adjustments to practitioners’ skills mix, health professionals working to their full or expanded scope of practice, and technological changes, such as utilising ehealth or telehealth innovations.

Lowering demand could be achieved through better health promotion and prevention programs. Options for improving workforce retention (nurses only) include improving the workplace environment (such as provision of adequate equipment and resources), involvement in decision making, leadership support and the ability to practise to the full scope of practice.

Figure 2.4: Outcomes of innovation and reform scenarios – projection for doctors

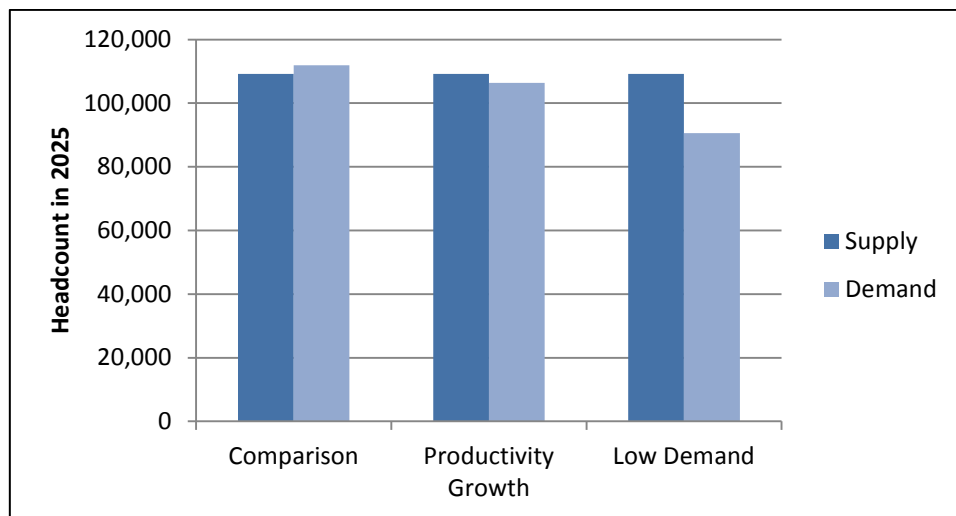
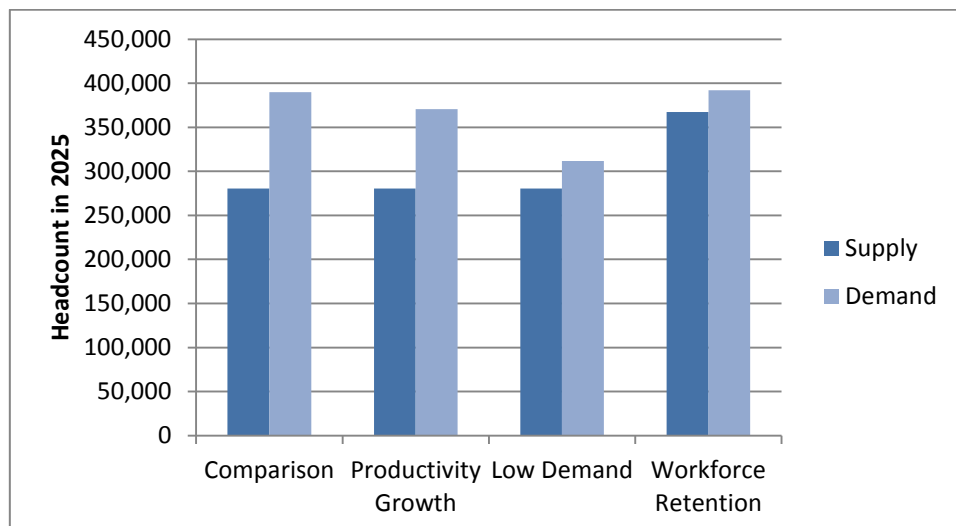


Figure 2.5: Outcomes of innovation and reform scenarios – projections for nurses



Given significant attrition in both nursing education and in nursing careers, increasing the number of nursing student places alone will not address the nursing shortage. As demonstrated in Figure 2.5 above, measures to improve workforce retention projected a significant impact in reducing workforce shortages.

Workforce retention increased dramatically in 2007-08, with speculation that this was caused by the impact of the global financial crisis on nurses' retirement plans.

Whatever the cause, a continuation of these exit rates could cause a decrease of 77% in the shortage forecast by the HWA. The best case scenario using this 77% reduction is a shortage of around 25,000 nurses. The reality is likely to be somewhere between this figure and HWA's more extreme projection. HWA will continue to update its 2025 projections as more data becomes available, nevertheless this is still a large projected shortfall regardless of the scenario modelled.

This volatility in the forecasts illustrates the difficulty of making reliable predictions in the area of workforce, and the many challenges facing policy makers seeking to make investment and planning decisions in this area. The consequences of investment decisions made on the basis of poor or inadequate data are considerable.

There has been much academic debate as to whether there is in fact a shortage of doctors in Australia, which is not surprising given the substantial increase in domestic graduate numbers outlined earlier. The *Too Many GPs* research report states that over-servicing by GPs is showing up in high bulk-billing rates and is an indicator of over-supply in Australia (with the exception of some remote areas).<sup>31</sup> The report has some useful observations and has prompted debate. It needs to be noted that HWA has disputed some aspects of the methodology of the *Too Many GPs* report.<sup>32</sup> While new research and an alternative perspective is useful, the majority of stakeholders consulted during this review consider the HWA data at least a useful starting point for workforce planning.

HWA modelling indicates that increased demand and decreasing working hours for doctors is likely to increase the projected workforce shortage. The report found that there was a maldistribution of doctors across regional and remote areas. The modelling also indicates that the maldistribution of doctors is even more highly problematic in the case of medical postgraduate training (specialist training) which will need to be increased in line with increasing medical graduate numbers and graduate demand. If the availability of advanced training places is kept fixed at the number required for current need then there will be an increased pool of pre-vocational doctors that are unable to move through training. However, if training places are set according to increasing demand then the specialist workforce will expand at a greater rate.

Workforce data showed the numbers of medical specialists is increasing, but the workforce is not evenly distributed. There is a growing trend towards specialisation and sub-specialisation, and an insufficient number of generalists. The specialties estimated to be in shortage by 2025 are obstetrics and gynaecology, ophthalmology, anatomical pathology, psychiatry, diagnostics radiology and radiation oncology. The specialties of cardiology, gastroenterology and hepatology and surgical specialties are currently meeting demand for health services, however projections indicate that there will be an increasing number of these specialists, exceeding projected demand by 2025.<sup>33</sup>

### The policy environment and the shift to primary care

It is important to recognise the implications of wider changes to health policy for the development of the health workforce. In particular, the national health reform process has led to a shift in focus away from acute care and toward more coherent delivery of joined up primary health care with a focus on the prevention of chronic

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<sup>31</sup> Dr Bob Birrell, *Too Many GPs*, CPUR Research Report March 2013, Centre for Population and Urban Research, Monash University, accessed at <http://artsonline.monash.edu.au/cpur/files/2013/03/Too-many-doctors-rapson-Mar-2013.pdf>

<sup>32</sup> HWA, *Response to Dr Bob Birrell's report "Too many GPs"*, media release, March 2013, accessed at <http://www.hwa.gov.au/sites/uploads/HWA-Response-Birrell-report-FINAL-5-March-2013.pdf>

<sup>33</sup> HWA, *Health Workforce 2025*, Vol 3 p. 9

disease. This is entirely rational, both from the point of view of community wellbeing, and from a budget and expenditure perspective, with, ideally, an emphasis on early intervention and preventative health initiatives rather than expensive acute and crisis care.

General practice has traditionally been the initial 'gateway' to the health system. Recent initiatives have shifted responsibility for even more health services to the primary care setting. Regionally based agencies such as Medicare Locals have an expanded role and an overarching responsibility for health care planning in their communities.

Over the past nine years, since 1 July 2004, general practices have had access to Medicare rebates for the development of chronic disease care plans. Rebates are also available for allied health sessions that are delivered as part of those plans. An important development in primary care in the 2010 budget was for the first time Medicare rebates became available for nurse practitioners and eligible midwives. The Practice Nurse Incentive Program (PNIP), which commenced in January 2012, provides up to \$125,000 a year to eligible general practices to employ practice nurses working to undertake activities such as immunisation, wound management and cervical screening, as well as care coordination for clients with chronic conditions. PNIP is discussed in more detail in Chapter 7.

Nationally and internationally, it has been increasingly recognised that people with chronic and aged related diseases are being admitted and treated in acute care where they may be more appropriately, safely and efficiently cared for in the community. Hospitalisation may have secondary impacts, such as hospital-acquired infections, falls, reduced strength and mobility. Hospitalisation of patients with chronic diseases results in pressure on 'beds' for clients who require admission for acute conditions, to have surgery or to have diagnostic tests performed.

Increasingly, jurisdictional health departments have developed programs to reduce 'unnecessary admissions and readmissions' of these clients. For example, NSW has a chronic care program (Connecting Care) and Victoria has the Hospital Admission Risk Program (HARP). These programs enhance the connection between general practices/primary care and the acute care sector, especially at client 'transition' points: on discharge from an admission or following assessment on presentation at emergency departments. The overall aim of these programs is to improve interdisciplinary primary care in the community, empowering clients and their carers to manage their own health and to trigger early intervention strategies which would reduce the likelihood of admission to the acute sector.

At the national level, the Royal Australian College of General Practitioners (RACGP) is advocating that the new care model referred to as the 'patient-centred medical home' needs to be seriously explored in Australia. This is evidence that major stakeholders are interested in developing enhanced primary care models to better meet community needs in the rapidly changing health care environment.

### Box 2.4: The medical home model<sup>34</sup>

The patient-centred medical home is described as a health care setting to which patients feel they “belong”, providing more structured, long-term care rather than episodic treatment of disease.

The underlying concept of this patient-centred medical home system is that the GP and the practice develop a relationship with the patient. It can also be described as a “partnering” relationship – in which the GP and other health professionals work with the patients, and quite often their families, helping them to manage and organise their own care.

The model has an emphasis on understanding and respecting each patient’s needs and preferences, as well as their culture and values. The core principles of this model revolve around the provision of care that is:

- patient-centred;
- comprehensive;
- team-based;
- coordinated;
- accessible; and
- focused on quality and safety.

The model has been derived from experiences in the United States, where a growing body of evidence is beginning to be compiled about this model of service delivery.

In the Australian context, the debate around this model is examining both its clinical merits as well as potential funding systems to support its delivery. RACGP representatives have also raised issues about how existing structures, such as Medicare Locals, could design activities to support this type of comprehensive approach to primary care and champion this approach.

The Commonwealth has recently flagged its interest in working with stakeholders such as the RACGP and General Practice Registrars Australia (GPRA) to explore evidence-based approaches to implementing this type of system.

Despite these moves, the provision of acute care in the Australian hospital system remains, necessarily, the focus of intense community concern; and the health care costs of the acute sector have also continued to escalate.

### Increased skills utilisation and productivity - national industry perspective

It can be argued that health industry productivity has been largely driven by advances in technology, such as enhanced diagnostic tools, better prostheses, more reliable devices and more effective medicines,<sup>35</sup> rather than through reform in the way the services are delivered in terms of workforce. Additionally, as has become evident during various consultations and roundtables in the course of this review, disciplinary demarcations have meant that the benefits of advances in technology have not been fully realised. Contemporary workforce structures have not proven to be particularly responsive to changing population needs nor in some cases to technological advances.

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<sup>34</sup> Royal Australian College of General Practitioners, *Laying foundations for the medical home – RACGP Submission to the Minister for Health, Federal Budget 2013-14*, March 2013.

<sup>35</sup> Productivity Commission, *Impacts of Advances in Medical Technology in Australia*, Productivity Commission Research Report, Aug 2005, pp. 104-106

Because of its traditional professional base and heavy reliance on public funding, the health industry has taken longer than other industries to face the realities of the need for changes in work practices and management reform. With some notable exceptions, the solutions generated have focused heavily on producing more of the existing workforce to meet demand, paying financial incentives to try to encourage rural distribution of the health workforce in both education and practice programs. Only relatively recently it appears, has the focus shifted to considering innovative responses through expanded practice and skill redefinition.

The health industry is one of Australia's largest, with around 1.2 million people employed (if those in the social assistance sector are included). The health and social assistance sector is also a highly educated sector, with more than 77% having post-school qualifications, compared to other industries at 66%.<sup>36</sup>

Health is competing for its slice of the financial pie – 8.7% of GDP in 2008 and increasingly competing for new workers with other industries (such as the mining industry).<sup>37</sup> As Australia ages, to restate the obvious, there will be increasing demand for health workers.

Skills Australia (now the Australian Workforce and Productivity Agency), a statutory authority, was set up in 2009 to research and assess skill needs across industry, and to inform Governments on policy and on the needs of industry around skills with the aim of enhancing productivity across all industries in Australia.

The Skills Australia report *Better use of skills, better outcomes: A research on skills utilisation in Australia* (April 2012) examined best practice local initiatives across different industries. The report notes that skills utilisation has emerged as an important policy issue both domestically and internationally, and that skills utilisation is a driver for increased productivity and workforce retention.

Skills utilisation has been shown in Australia to be a driver where the labour market is tight and employers are keen to maximise the skills of their workforce, and where skilled workers are looking for job satisfaction. Skills utilisation is important to maximise the contribution that people make to the workplace and the extent to which an individual's abilities are harnessed to optimise organisational performance. Further, Skills Australia notes that better utilising the skills of workers increases job satisfaction with better retention.<sup>38</sup>

Many senior stakeholders within the health sector will freely concede that it is not feasible for the health sector to see itself as protected from the need to find increased productivity and efficiencies in the way services are delivered. Lessons to be learnt from other industries in approaching innovation and increased skills utilisation may assist the health sector in breaking down traditional professional barriers and silos which impede innovation.

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<sup>36</sup> Skills Australia, *Industry Snapshot 2010: Healthcare and Social Assistance*, information paper, Skills Australia, Canberra, p. 1

<sup>37</sup> The World Bank, [Health Expenditure, total \(% of GDP\)](http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS), accessed at <http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS>

<sup>38</sup> Skills Australia, *Better Use of Skills, Better Outcomes: A research report on Skills Utilisation in Australia*, April 2012 pp. 1–2



### Health workforce program and policy implications

Even if substantial reform is undertaken, it is likely that the increasing demand for health services will result in a shortage of doctors and nurses, and a likely shortage of dentists and some allied health professionals. This has consequences for government policy in terms of training, immigration, role reform and incentives used to encourage a more even distribution of health professionals across Australia. A number of training and support issues were highlighted in *Health Workforce 2025* which will require government action.

The HWA modelling indicated the most effective policy intervention for meeting the increased demand in health services was adopting a process of reform and innovation to increase the productivity of the future workforce to meet future demand. Along with the use of technology, increased productivity can be gained through role re-design which will allow health practitioners to work at the fullest extent of their scope of practice, encourage greater role flexibility and multidisciplinary learning. Enabling practitioners to utilise more varied and transferable skills will also assist to retain the health workforce.

It is critical that workforce innovation results in not only improved productivity, improved retention and job satisfaction but also that the safety and quality of care is not affected. This requires national coordination across stakeholder groups including professional bodies, industrial bodies, employer groups and professional registration boards. Health professionals themselves must also be consulted and supported through any process of change. While the focus of this review is primarily on existing Commonwealth programs it is important that this pressing need for innovation is acknowledged and that sensible, evidence-based change is embraced in the further development of the initiatives discussed in the chapters to follow.



## Chapter 3: Ensuring a capable and qualified health workforce

The provision of safe and appropriate health care to the Australian community is dependent upon ensuring a capable and qualified health workforce. This is supported by the delivery of high quality education and training, and the application of consistent professional standards.

This chapter outlines the quality framework applying to health professionals, and describes, in broad terms, the Australian health education and training system. It then discusses the Commonwealth programs administered by the Health portfolio that form part of this system and investments in clinical training for health professionals, and vocational training for medical practitioners.

The Commonwealth's role in planning and investing in health education has an increasing focus on delivering education and training that matches the nature of demand and reflects the way health services are delivered in both clinical and community settings. For this reason, a significant proportion of the Commonwealth's investment in health education programs is directed towards those programs that are specifically targeted to rural areas, for example, the Rural Health Multidisciplinary Training program. These programs are dealt with in Chapter 4.

This chapter also examines the use of health education scholarships as a mechanism to promote the growth and sustainability of specific sectors of the health workforce.

### 3.1 *Quality framework for the health workforce*

Prior to the introduction of the National Registration and Accreditation Scheme (NRAS), arrangements for the regulation of the health workforce differed between jurisdictions and between professions. Flowing from the Productivity Commission's 2005 research report *Australia's Health Workforce*, the Council of Australian Governments (COAG) agreed to establish NRAS in March 2008.

NRAS commenced on 1 July 2010 with the passage of parallel legislation in each state and territory: the *Health Practitioner Regulation National Law 2009* (the National Law). The scheme initially included practitioners in ten health professions – chiropractic, dental practice, medicine, nursing and midwifery, optometry, osteopathy, pharmacy, physiotherapy, podiatry and psychology. A further four professions were included from 1 July 2012 – Aboriginal and Torres Strait Islander health practice, Chinese medicine, medical radiation practice and occupational therapy.

National registration is intended to provide consistent standards for training, registration and professional conduct across Australia, and transparency through a national public register of practitioners. There is a national registration board for each participating health profession which develops the registration standards, guidelines for best practice and registration procedures, accredits training courses and develops the criteria used to assess applications from overseas trained practitioners. Under the National Law, the National Boards are overseen by the Standing Council on Health (SCoH). The responsibilities of the National Boards include:

- Registration of health professionals, including specialist registrations;
- Accreditation standards for courses of study leading to professional registration, including the requirements for clinical training;
- Developing registration standards, such as scope of practice, continuing professional development, insurance, and recency of practice, for the approval of SCoH;
- Developing policies, guidelines and codes for the guidance of their profession; and
- Investigating and acting on breaches of professional standards and conduct.

In most professions regulated under NRAS, the accreditation function of the National Board is undertaken by an external accreditation authority, such as the Australian Medical Council (AMC) or the Nursing and Midwifery Accreditation Council.

It should be noted that NRAS itself is not the only regulatory arrangement for Australian health practitioners. Health practitioners covered by NRAS are also bound by jurisdictionally-based drugs and poisons legislation, the scopes of practice determined by their employers and codes of conduct enforced by the relevant professional associations. There are also a number of allied health disciplines that are not part of NRAS, some of which have expressed a strong interest in being included in the scheme.

The introduction of the national scheme was intended to assist health professionals to move around the country more easily, reduce red tape, provide greater safeguards for the public and promote a more flexible, responsive and sustainable health workforce.

Perhaps inevitably, with the establishment of a new organisation and the need to merge fragmented legacy databases from jurisdictions, delays and administrative issues were experienced at the outset. This has left residual concern within some regulated professions. Discussions with professional representative organisations and education providers generally indicated support for NRAS as a substitute for the previous state and territory registration and accreditation boards, panels and agencies. However, concerns clearly remain about delays, rigidity and obstacles to the re-entry of health professionals to the workforce.

Unanticipated issues have arisen which may be impeding the ability of some health practitioners to provide the full range of care allowed within the relevant professional scope of practice. These include the application of national registration standards and arrangements for prescribing.

Other issues to be considered within the context of the new scheme include collateral impacts on unregulated professions, the collection and availability of data, and the potential for the intensification of professional demarcation barriers.

### Health profession national registration standards

Attraction and retention of already qualified health practitioners is important not only to the delivery of quality care to clients but also to the sustainability of the health workforce through mentoring and support for new and less experienced practitioners.

The health workforce grapples with an ever-changing environment of client needs including increased acuity of illness, growing prevalence of chronic health conditions, and an ageing population and workforce. To support this, a framework has been developed by each health profession's National Board comprising registration

standards for recency of practice and continuing professional development with complementary policies for re-entry to practice.

In some instances, a national approach has seen the introduction of standards into jurisdictions where none previously applied, with occasional unintended consequences. For example, the introduction of requirements for recency of practice in the nursing and midwifery profession and the associated re-entry policy of the Nursing and Midwifery Board of Australia have led to flow-on issues in New South Wales. In this jurisdiction, which did not previously have any requirement to maintain recency of practice, there was only one pre-existing re-entry course which has become over-subscribed.

Also, the introduction of a requirement to undertake degree level study for nurses and midwives who have been absent from the workforce for greater than ten years has created a significant disincentive for some individuals returning to the workforce. This is particularly noticeable when compared to other health professions without such requirements. Some experienced former nurses, particularly those with family responsibilities in rural areas, who are seeking to return to the workforce describe the new regulatory regime with a sense of great frustration.

As another example, psychology interns in some rural areas describe barriers to meeting the newly imposed requirements for general registration without undertaking clinical placements outside of their region. In common with other rural health practitioners, this can be a significant challenge to students who are studying part-time, with impacts on women with family responsibilities and other key demographics.

The introduction of a national scheme has also highlighted some inconsistencies between professions in certain registration standards, including requirements of recency of practice and continuing professional development. For example, the recency of practice standard for nursing and midwifery requires members of that profession to practise for a minimum of three months (full-time equivalent) in the previous five years to maintain registration. The standards for some professions such as medicine and physiotherapy, while including a requirement for recent practice, do not stipulate minimum levels.

Whilst all participating health professions commend the promotion of improved quality of care provided to the Australian community through national requirements for each of the regulated professions, some practitioners (particularly those outside metropolitan areas) have described difficulty in meeting the registration requirements around continuing professional development (CPD). In some instances, it was suggested that this may be due to a lack of CPD activities using flexible delivery arrangements.

The Government has provided funding for enhancements to flexible learning arrangements, particularly through the Rural Health Education Foundation (RHEF) which manages the new Rural Health Channel on the VAST digital network. Additionally, it is hoped that the Government's National Broadband Network initiative will further enhance the opportunities provided by the Rural Health Channel, which has significantly expanded the reach of digital health education content.

The Rural Health Channel is a nationally available free-to-air health TV channel and began broadcasting on 21 May 2012. The Rural Health Channel broadcasts professionally accredited programs as well as health education information from

providers such as government, professional organisations and health associations. This service provides an effective, regular and targeted communication to health practitioners in rural and remote Australia. This service was well accepted by rural and remote stakeholders spoken to in the course of this review.

In summary, whilst the differing clinical requirements of the health professions are recognised, the current regime runs the risk of escalating rigidities, particularly presenting barriers to re-entry and for ongoing registration of rural practitioners. To this end, continued Government investment in technology enabling remote education, training and supervision is highly valuable.

### Prescribing arrangements

A range of health professionals currently prescribe medications in Australia, including doctors, dentists, midwives, nurses, optometrists, Aboriginal and Torres Strait Islander health practitioners and podiatrists. However, authority to prescribe is determined by state and territory drugs and poisons legislation, and there are differences between the jurisdictions in terms of the professions authorised to prescribe, and the conditions under which they can do so.

This creates a barrier, for some professions, to the benefits of workforce flexibility and mobility that have been delivered with the introduction of national registration.

As an example, the lack of harmonisation between state-based poisons legislation was raised by stakeholders in relation to Aboriginal and Torres Strait Islander health practitioners. In the Northern Territory, the *Poisons and Dangerous Drugs Act* allows for Aboriginal and Torres Strait Islander health practitioners to possess and supply medications if they have been approved to do so by the Chief Health Officer. However, there are no similar provisions in the other states or the ACT.

Health Workforce Australia (HWA) has been undertaking some work in this area with a view to advancing a nationally consistent approach to prescribing by health professionals other than doctors. The *Health Professionals Prescribing Pathway* (HPPP) project is aiming to establish a common framework for all non-medical prescribers, covering prescribing models, education and training, registration, accreditation and safe prescribing practices.

In conjunction with the HPPP project, the National Prescribing Service has recently developed a *Prescribing Competencies Framework* which forms the standard for prescribing education.

HWA released the draft pathway in January 2013.<sup>39</sup> Once finalised, HWA intends to seek endorsement of the HPPP from the SCoH.

While national consistency in non-medical prescribing cannot be achieved without changes to state-based drugs and poisons legislation, the work of HWA on developing a national prescribing pathway is a step in the right direction to support further reform in this area.

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<sup>39</sup> Health Workforce Australia, [Draft Health Professionals Prescribing Pathway](https://www.hwa.gov.au/sites/uploads/20130116_draft_Prescribing%20Modeldiagrams_v15.pdf), January 2013, accessed at [https://www.hwa.gov.au/sites/uploads/20130116\\_draft\\_Prescribing%20Modeldiagrams\\_v15.pdf](https://www.hwa.gov.au/sites/uploads/20130116_draft_Prescribing%20Modeldiagrams_v15.pdf)

### The unregulated professions

Several unregulated professions have made strong representations in the course of this review, expressing a desire to be included in NRAS, and raising concerns about the decision of Health Ministers to limit consideration of national registration for any additional professions. They perceive that this has had an unintended consequence of stratifying the allied health professions into those which are nationally regulated, and those that are not; with associated concerns about loss of professional status.

An impression has been created that some professions receive greater support from Government. This was an issue raised by the Australian Association of Social Workers during the consultation process for this review, who was of the view that some agencies, including some Medicare Locals, were contracting only with registered professions to deliver services which had previously been delivered, for example, by social workers.

The Department has confirmed that mental health programs including the *Access to Allied Psychological Services* (ATAPS) and the *Mental Health Services in Rural and Remote Areas* fund services provided by both nationally regulated and unregulated mental health professions including psychologists, social workers, nurses, occupational therapists, and Aboriginal and Torres Strait Islander health workers. If a de facto situation has arisen that the registration status of a profession is being used to determine eligibility for service provision in a way that it was never intended, it may be timely to clarify this with Medicare Locals and other service providers.

### Collection and availability of data

The introduction of a national system has enabled the collecting of detailed demographic information as well as information about geographical location and area of professional practice. The publication of standardised reports by each health profession's national board on a quarterly basis has overcome some of the past difficulties arising from a lack of available data. However, on a cautionary note, the Australian Institute of Health and Welfare (AIHW) has voiced concerns about the quality of much of this data and would prefer that any barriers to direct interrogation of AHPRA data by AIHW should be removed. Given the expertise of AIHW this would seem a far less costly option than AHPRA continuing to build up its own data expertise; with consequent benefits in reducing the rise in registration costs.

Unlike the medicine, nursing and midwifery professions (which have a very substantial basis in the public hospital system), many allied health practitioners operate in the private sector using a small business model. This has limited the ability of health workforce planners and professions to obtain reliable information about their geographical location and professional areas of practice, and to design and target workforce measures to address gaps in service delivery, particularly outside of metropolitan areas.

Further discussion regarding the collection and analysis of health workforce data is included in Chapter 9.



## Recommendations

Recommendation	Affected programs	Timeframe
<b>Recommendation 3.1:</b> The Commonwealth via the Standing Council on Health (SCoH) should engage with the national health professional boards to develop sensible and more consistent requirements for continuing professional development, recency of practice and re-entry to practice. Ideally, this should be undertaken for all registered professions and focus on maximising access to health services while maintaining safety and quality for the community. Professional re-entry requirements in particular, should be subject to periodic review for unduly onerous requirements creating barriers, particularly for the regional workforce.	Nil	Medium term
<b>Recommendation 3.2:</b> The Commonwealth should seek that SCoH bring forward options for a common legislative framework for prescribing of medicines by non-medical health professionals to promote workforce productivity, flexibility and mobility.	Nil	Medium term
<b>Recommendation 3.3:</b> The Commonwealth should identify and address any possible barriers to unregulated professions participating in Australian Government programs, where appropriate.	Allied health programs and scholarships.	Short term

## 3.2 Health education and training

The training of the health workforce occurs in both the vocational education (VET) and tertiary sectors. While many health professionals, including medical practitioners, registered nurses and allied health professionals, are educated within the university sector, other important categories of health workers such as personal care assistants, enrolled nurses, allied health assistants and Aboriginal and Torres Strait Islander health practitioners gain their qualifications through VET courses, ranging from certificate to diploma level (from a few months to a year or more in duration).

Responsibility for, and influence over, health education and training is shared across a range of players, including Commonwealth and state/territory governments, universities and other tertiary education providers, registration and accreditation boards, and professional colleges.



The Commonwealth provides funding for university-delivered health education through the provision of Commonwealth Supported Places (CSP), administered by the Department of Industry, Innovation, Climate Change, Science, Research and Tertiary Education (DIICCSRTE). The Commonwealth, through DIICCSRTE, also contributes funding to the VET sector, although the allocation of funding is the responsibility of state and territory governments.

As mentioned earlier, prior to 1 January 2012, the Commonwealth set targets for the number of undergraduate places a university could offer. The Commonwealth has now moved to a demand-driven system, allowing universities to determine how many undergraduate students it wishes to enrol, and in what course of study. The only exceptions to the new arrangements are that the number of medical places and postgraduate places will remain capped. The impact this change will have on the future supply and mix of health professionals is not yet known.

Further information on the history of the Commonwealth's involvement in the education and training of the health professions is provided in Appendices iii to v.

### Clinical training

A clinical training component is a significant part of the education and training requirements of health professionals. While all university-based health qualifications include an undergraduate clinical training component, some disciplines also require postgraduate clinical training as a condition of registration, most notably medicine.

Requirements for clinical training are set by the accreditation authorities operating under the National Boards. The accreditation authorities for some disciplines, for example nursing and midwifery, specify minimum numbers of hours for clinical training as a requirement for accreditation.

Through the National Partnership Agreement on Hospital and Health Workforce Reform, the responsibility for funding undergraduate clinical training is now shared between the Commonwealth and the states and territories, where it was previously left to states and territories to fund indirectly through public hospitals. Since 2006, states and territories have committed to providing clinical training for both Commonwealth-funded medical students and interns.

Most undergraduate clinical training and medical internships have traditionally been delivered within the public hospital sector, although delivery within other settings has become more common in recent years. It is the responsibility of the training provider to arrange clinical training opportunities for their students/trainees.

In the past, there has been no cost accruing to universities for the clinical training provided through public hospitals. The clinical training of professional entry health students has long been viewed by health professionals as part of their professional responsibilities in growing the future professional workforce. Health students, to varying degrees, also contribute to providing health care within the hospital or other health service setting.

*The National Health Reform Agreement 2011* requires that the Independent Hospital Pricing Authority (IHPA) provide advice to the SCoH on the feasibility of transitioning funding for teaching, training and research (TTR) to an activity based funding system by 30 June 2018. IHPA has convened an advisory body consisting of jurisdictional, clinical and academic representatives – the Teaching, Training and Research Working Group (TTRWG). The TTRWG will assist IHPA with developing a work

program on approaches to the classification and costing of TTR activities undertaken within public hospitals. It is expected that significant progress will be made on identifying the types of TTR that need to be funded in public hospitals, the cost drivers of this activity and the methods for counting and costing these items.

This has the potential for a dramatic impact on the relationship between the Commonwealth and state and territory jurisdictions with regard to the funding of clinical training, with corresponding implications for the training institutions, notably the universities.

### *Capacity constraints*

Concerns about the capacity of the health sector to support the clinical training needs of an increasing number of undergraduate health students have been expressed over a number of years, and were consistently raised by stakeholders during the course of this review. There are now over 16,000 medical students studying in Australian medical schools, with 3,770 commencing in 2011. This is over double the numbers of a decade ago.<sup>40</sup> Pressure on clinical training capacity is not limited to medicine, but also applies to the nursing, dental and allied health disciplines; in 2011, there were 16,338 students who commenced courses that led to qualification for initial registration as nurses or midwives, compared to 10,950 students in 2005.<sup>41</sup>

The pressure on clinical training extends beyond university-based clinical training required for entry into health professions, and impacts clinical training provided as part of internships and graduate entry positions and programs. For medicine especially, the training pathway is long and involves a number of distinct phases. It typically takes around 12 to 17 years to train a medical specialist in Australia, assuming no gaps in training. Any increases in the undergraduate medical student population therefore can take most of two decades to work its way through the system, with consequent difficulties for planning.<sup>42</sup>

The pressure on clinical training for health students other than medicine is likely to continue under the demand-driven system of funding higher education, as from 2012 providers have been able to enrol as many eligible undergraduate students as they wish. There is a clear tension between higher education reforms to expand participation, and the ability of the health system to provide high quality clinical training for increasing numbers of health students, especially when such clinical training capacity is already under significant pressure.

Stakeholders consulted during this review also noted that the current increase in demand for clinical training is coming at a time when state and territory Governments are seeking to make savings, and indeed, to maximise the extent to which budgetary burdens are borne by the Commonwealth. This has implications for the capacity of public hospitals to offer additional clinical placements to meet demand.

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<sup>40</sup> Medical Training Review Panel (MTRP), *Fifteen Report*, Commonwealth of Australia, 2012, p. iii

<sup>41</sup> Department of Industry, Innovation, Science, Research and Tertiary Education (DIISRTE) Higher Education Statistics Data Cube (uCube), 2012

<sup>42</sup> It should be noted, in passing, that many countries are seeking to grapple with the extended length of current medical education models and in some cases are looking for ways to compress at least undergraduate medical education.

The complexity and diversity of the arrangements for clinical training adds to the challenge of meeting the increasing clinical training burden. Requirements, such as the length of training, differ between professions and between individual universities. Clinical training is delivered across a range of settings; hospitals may have relationships with multiple universities (and universities with multiple hospitals or other health care settings), and clinical supervision may be provided by a university employee or an employee of the service provider. There are also multiple streams of funding for clinical training, and a mix of costing models and payment arrangements, from pro bono provision through (increasingly) to paid placements.

### *Health Workforce Australia's clinical training program*

Clinical training capacity has been the subject of considerable COAG reform activity. Under the 2009 National Partnership Agreement on Hospital and Health Workforce Reform, the Commonwealth and states agreed to share the responsibility for funding undergraduate clinical training, which was previously left to states and territories to fund indirectly through public hospitals. Commonwealth funding for this purpose is held and administered by HWA.

HWA's Clinical Training Funding program provides funding to increase capacity across the health system to expand the number of training places, with special emphasis on new and underserved areas, for example, rural and remote areas, primary care, mental health, aged care, dental and private sector settings.

This is a key component of HWA's work, comprising 70% of HWA's total funding allocation (\$547 million over four years). Through this funding stream HWA is:

- Supporting growth in clinical training places with a focus on improving access to clinical training for rural students and increased training opportunities in rural settings;
- Expanding training capacity by investing in the use of simulated learning technologies for use, where appropriate, within health professional curricula;
- Improving the management and coordination of clinical training placements across training providers; and the public, private, non-government and education sectors through the establishment of Integrated Regional Clinical Training Networks; and
- Supporting and recognising the role of clinical supervisors through the delivery of a Clinical Supervision Support Program.

In a number of cases, organisations funded by DoHA through its health education programs are also receiving grant funding through HWA. Under current arrangements there is no requirement for funding support between HWA and DoHA to be standardised and in some cases DoHA expresses the view that there is a lack of visibility, as a result of the reporting requirements under HWA's governance structure, about exactly what has been funded through HWA's clinical training reform stream.

There has also been concern expressed that the HWA funding of additional clinical training places has escalated the already existing pressure for service providers to charge for the provision of clinical placements, where previously no such fee was imposed. While this was already an emerging trend, as one stakeholder bluntly put it, a market has now been created and there may be a reduction in the availability of public sector clinical placements in favour of those funded by HWA. These concerns

have also been expressed within the context of the 2011 Higher Education Base Funding Review<sup>43</sup>, which noted that this could have a significant impact on clinical costs for universities.

A recently published study has sought to quantify the economic value of this component of clinical training. Oates and Goulston (2012) conducted an analysis of the total costs of medical education at Sydney University, incorporating the teaching by government-employed health providers and honorary teachers along with that provided by university-employed staff. The study found that in 2010, 38% of the total cost of medical education (or \$38,326 per student per year) was not paid for directly by the university.<sup>44</sup> While this study represents a single medical school, the principle of including the cost of face-to-face teaching for which a university does not pay would apply to many other medical schools. The future consequences for universities, and for students, of a direct cost recovery model by all parties involved, are likely to be reasonably dramatic.

Work by the IHPA may or may not substantiate the current market prices set for clinical training in the public sector, lately influenced by HWA's clinical training program. Responsibility for funding costs over and above the IHPA costing (if activity based funding is found to be feasible for TTR) will be a question for future exploration, beyond the scope of this review. Nevertheless, clinical training costs do not merely impact on education provision at the tertiary level. Pressures from large numbers of graduating medical students needing to complete internships (primarily a clinical training year with minimal unsupervised service delivery) have required the Commonwealth to contribute funding in 2013, to cover the shortfall in places (see Box 3.1 below).

While the move to a demand-driven system of university places (outside medicine) will assist in responding to Australia's future health workforce needs, its impact on the clinical training system will require close monitoring, given the extensive clinical placements required as part of a health professional's training. It is likely that expanded use of simulated learning environments will need to be part of the solution in meeting future demand for clinical training.

### Intern training

In the decade to 2010, the number of commencing medical students increased by 109%,<sup>45</sup> with graduate numbers also expected to double from 1,608 students (international and domestic) in 2005 to 3,935 projected to graduate in 2015.<sup>46</sup> The dramatic increase in medical students in recent years had raised concerns that the states and territories would be unable to build internship training capacity at a rate sufficient to match and that, at some stage, there would be too many graduates and not enough internships.

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<sup>43</sup> Higher Education Base Funding Review, [Final Report](#), October 2011, accessed at [www.innovation.gov.au/HigherEducation/Policy/BaseFundingReview/Documents/HigherEd\\_FundingReviewReport.pdf](http://www.innovation.gov.au/HigherEducation/Policy/BaseFundingReview/Documents/HigherEd_FundingReviewReport.pdf)

<sup>44</sup> R. Kim Oates and Kerry J. Goulston, "[The hidden cost of medical student education: an exploratory study](#)", *Aust. Health Review*, 2012. accessed at <http://www.publish.csiro.au/paper/AH12151.htm>

<sup>45</sup> MTRP Fifteenth Report, Table D1, p. 183

<sup>46</sup> *ibid.*, Table 2.21, p. 37

This has been further complicated by increasing levels of international student enrolments, with many universities keen to continue increasing their overseas student cohort. It has been well publicised that this is placing stress on the demand for clinical training and internship availability. As domestic students cannot be charged full fees for a medical degree (under current policy settings), the market for overseas full-fee paying students, whose numbers are uncapped, has become important for many Australian medical schools, keen to ensure their viability. In 2011, 15.4% of students enrolled in Australian medical schools (2,535 of 16,491) were from overseas.<sup>47</sup> In 2010, students from Canada, Singapore and Malaysia comprised 64.7% of all commencing overseas medical students.<sup>48</sup>

There has been a substantial increase in the overall number of intern training positions, from around 1,500 in 2004 to 2,753 in 2011.<sup>49</sup> Despite this growth, current accreditation requirements have been raised as a barrier to the implementation of more innovative solutions to expanding intern capacity, particularly in the rural and private sectors (discussed below).

The Australian Medical Council is in the process of implementing new national standards for the accreditation of intern positions. This is likely to improve the consistency between jurisdictions in the accreditation of new intern places in the medium term. In addition, stakeholder discussions are ongoing in relation to the adoption of a new national process for intern selection. These two changes have the potential to streamline current arrangements.

In terms of supply, state, territory and Commonwealth governments have committed to supporting the development of additional intern places and have undertaken to provide an intern place for all Commonwealth-supported students. Some jurisdictions have accredited internship positions in non-traditional settings (such as GP practices and private hospitals) which are based on the premise that the key learning objectives can be achieved in other settings. It is likely that the number of such positions will need to expand to help cope with the increasing demand for internship places. There has even been consideration of Australian internships being conducted overseas.

This issue is still developing and the short to medium term outcomes for supply and distribution are still unclear. Before the supply of interns can increase (via additional medical students) accredited internship places must be available for them. The complexities of maintaining educational quality while accrediting sufficient numbers of new intern positions to meet projected needs has been raised as a major challenge both during this review and in other forums.

The situation as 2014 draws near is unclear. As yet unpublished data indicates that an additional 191 domestic and 46 international medical students will graduate in 2013 than did last year. It is too early to determine the exact number of additional internship places which will be required nationally but it is likely to be more than states and territories will bring online this year and the issue of an internship shortage is once again likely to be raised in the community.

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<sup>47</sup> *ibid.*, Table 2.15 p. 31

<sup>48</sup> *ibid.*, Table 2.9, p. 26

<sup>49</sup> Higher Education Base Funding Review, [Final Report](#)



### Box 3.1: Additional Medical Internships 2013

Due to the increase in medical graduates in 2012, the Australian Government proposed a shared solution to work with the states and territories as well as private hospitals to ensure that all eligible medical graduates would be offered an accredited internship commencing in 2013. The Australian Government offered to fund up to 100 internships in private settings (and to provide accreditation funding) providing states and territories fund the remaining positions that might be required.

Subsequently, agreement was reached with the governments of Western Australia, Queensland, New South Wales, the Australian Capital Territory and Northern Territory, in late October and early November 2012. This became known as the Additional Medical Internships 2013 initiative (AMI 2013).

As a result of this collaboration, there are an extra 60 doctors working in Australian hospitals in 2013, of whom 19 are employed in private hospitals in Mackay (noting some public sector rotations in Mackay), Brisbane, Sydney and Perth. This reflects the willingness to participate and flexibility displayed by private sector hospitals, several of which have benefited through achieving accreditation for intern training which will allow them to utilise a future intern workforce to provide services to the Australian community.

A major issue last year was the inability of jurisdictions to specify how many internships were required at any given time to place all potential applicants. The SCoH and Australian Health Ministers' Advisory Council have continued to address this by considering issues such as a national application and allocation system, data standardisation and sharing, a unique student identification number and national agreement of internship priority. However, recent discussions between jurisdictions indicate that no system will be fully in place in time to resolve all outstanding issues for the intern application and allocation system for 2014.

The issue is made more complex as some jurisdictions alter their internship allocation priority, with some states and territories prioritising overseas nationals graduating from in-state universities over domestic students from out-of-state universities. The ultimate effect of these changes will not be clear until 2014.

Current data would suggest that this problem will recur over time until the number of graduates plateaus. Information on projected graduate numbers from 2013 to 2016 shows only a constant increase with no firm peak established. However, while the overall demand for clinical training/internships will remain high, the demand for creation of *new* positions will reduce after 2015.

*Table 3.1: Projected medical graduate numbers*

Year	2013	2014	2015	2016
Expected total number of graduates	3,623	3,762	3,935	3,970
Expected difference in graduate numbers between years	111	139	173	35

Source: MTRP Fifteenth Report, Table 2.21

These developments in the public health sector will inevitably mean a renewed focus on the provision of intern places in the private sector and community or general practice.



### *Engaging the private health sector*

The role of the private sector in delivering clinical training was discussed with stakeholders as part of the consultation process for this review.

Private hospitals accounted for 40% of admissions to Australian hospitals in 2010-11.<sup>50</sup> Of all elective admissions involving surgery in 2010-11, about two-thirds occurred in private hospitals.<sup>51</sup> This indicates that not only is the delivery of acute health care a shared responsibility amongst public and private service providers, but that the development of a well-qualified and highly skilled workforce is critical for both the public and private sectors.

As noted above, a large proportion of clinical training has historically been provided pro bono or through in-kind arrangements. However, private sector stakeholders expressed concerns that this has led to significant variation between jurisdictions and education providers, such that it is disadvantaging the service providers.

Private sector stakeholders also identified a perceived bias towards public sector providers within the HWA Clinical Training Funding program, with the implication that the private sector is unable to provide the same quality of training. The private sector decries this view, noting a long tradition of clinical training for nursing, midwifery and allied health students, and the growing role of the private sector in providing clinical training for undergraduate medical students, junior doctors and medical specialists.

Much like their public sector compatriots, private sector health care providers expressed some concerns about the administration of clinical training for undergraduate health students. In recent years, private hospitals say they have been asked to accept greater numbers of students although there is not always a commensurate increase in the level of supervisory support provided by the universities. This is commonly accompanied by allegations of a lack of clarity on the part of some educational institutions about the level of support required by students, which will vary significantly according to the education level achieved by the individual.

Some stakeholders perceive the development of formal contractual arrangements with universities and vocational education and training providers as a mechanism to more clearly define the roles and responsibilities of all parties, thereby providing students with more appropriate professional experience.

The private health care providers consulted as part of this review agreed that there is a significant level of untapped capacity in their sector for the clinical training of all health professions. A key to accessing this potential is to recognise the high quality care provided by some private sector medical facilities, and that this reflects the provision of high quality, meaningful and supported professional experiences for students at all points in the health education pipeline. However, unlike the public sector, private health care providers are not funded to support education and training for undergraduate students, a cost that would need to be considered in any proposal to utilise these settings.

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<sup>50</sup> AIHW, *Australian hospitals 2010-11 at a glance*. Health services series no. 44. Cat. No. HSE 118. Canberra: AIHW, 2012

<sup>51</sup> AIHW, *Australian hospital statistics 2010-11*. Health services series no. 43. Cat. No. HSE 117. Canberra: AIHW, 2012

### Prevocational training

Prevocational training is the period of clinical education and practice in which doctors and other health professionals develop competencies, usually after (or in the final stages of) completion of their basic academic qualification. Prevocational training is a requirement for medicine and many of the allied health professions including psychology, pharmacy, optometry and radiation oncology. While there is significant investment by the Government in prevocational medical education and training, other specialised areas of the health workforce are supported in ways which best fit their traditional models of training.

The Australian Government's major contribution to prevocational medical training to date has been its support for the Prevocational General Practice Placements Program (PGPPP) which is designed for individuals in any postgraduate year who are not enrolled in a specialist training program. The program offers general practice placements for 10 to 13 weeks at a time with a view to encouraging participants to take up a general practice career and to improve junior doctors' knowledge of general practice. The aim is to ensure that once they are vocationally qualified, doctors will be better informed about the role of general practice and its integration with other specialties and the broader health system.

#### Box 3.2: Background to broader general practice education and training arrangements

Up until the late 1990s, GP training, with Commonwealth funding, was solely managed by the Royal Australian College of General Practitioners (RACGP) through 21 regional providers. At the same time, a growing awareness arose of the need to consider the future of the GP education system as a whole, and to ensure that the system was capable of meeting the needs of the Australian community, especially in rural areas.

Following a Ministerial Review of General Practice Training in 1998, the Minister for Health announced a package of reforms involving significant changes to the structure and delivery of general practice vocational training in June 2000, including:

- establishing a government-owned company which would hold the funds for all postgraduate general practice vocational training; and
- the regionalisation of the management and delivery of training, with encouragement for a wider range of training providers to participate under a contestable GP training model.

General Practice Education and Training Limited (GPET) was founded as a company under the *Commonwealth Authorities and Companies Act 1997* in March 2001 to implement the regionalised and contestable GP vocational training program known as the Australian General Practice Training Program (AGPT).

The Department is the sole funder of the AGPT, which is a national three to four year general practice vocational training program with a regionalised focus. The program supports individuals to obtain fellowship from either the RACGP or the Australian College of Rural and Remote Medicine (ACRRM), noting that both colleges are represented on the GPET Board.

While registrars are training they are also providing primary care services to individuals and communities.

In January 2002, GP training under the regionalised training program commenced. GPET has subsequently reduced the number of regional training providers (RTPs) from 21 to 17 and in 2010 took over the management of the PGPPP from RACGP and ACRRM.

GPET sub-contracts with the 17 RTPs, who are themselves independent entities, who manage the distribution of places at the local level and coordinate educational delivery to registrars amongst general practices in their region.

The PGPPP offers additional general practice training to that offered in the standard internship program. In particular, the opportunity exists for students to experience general practice in a variety of non-standard settings, such as Aboriginal medical services, drug and alcohol services and community-based facilities. Placements can also occur in outer metropolitan, regional, rural and remote areas. There is a requirement that at least 50% of placements must occur in regional, rural or remote locations.<sup>52</sup>

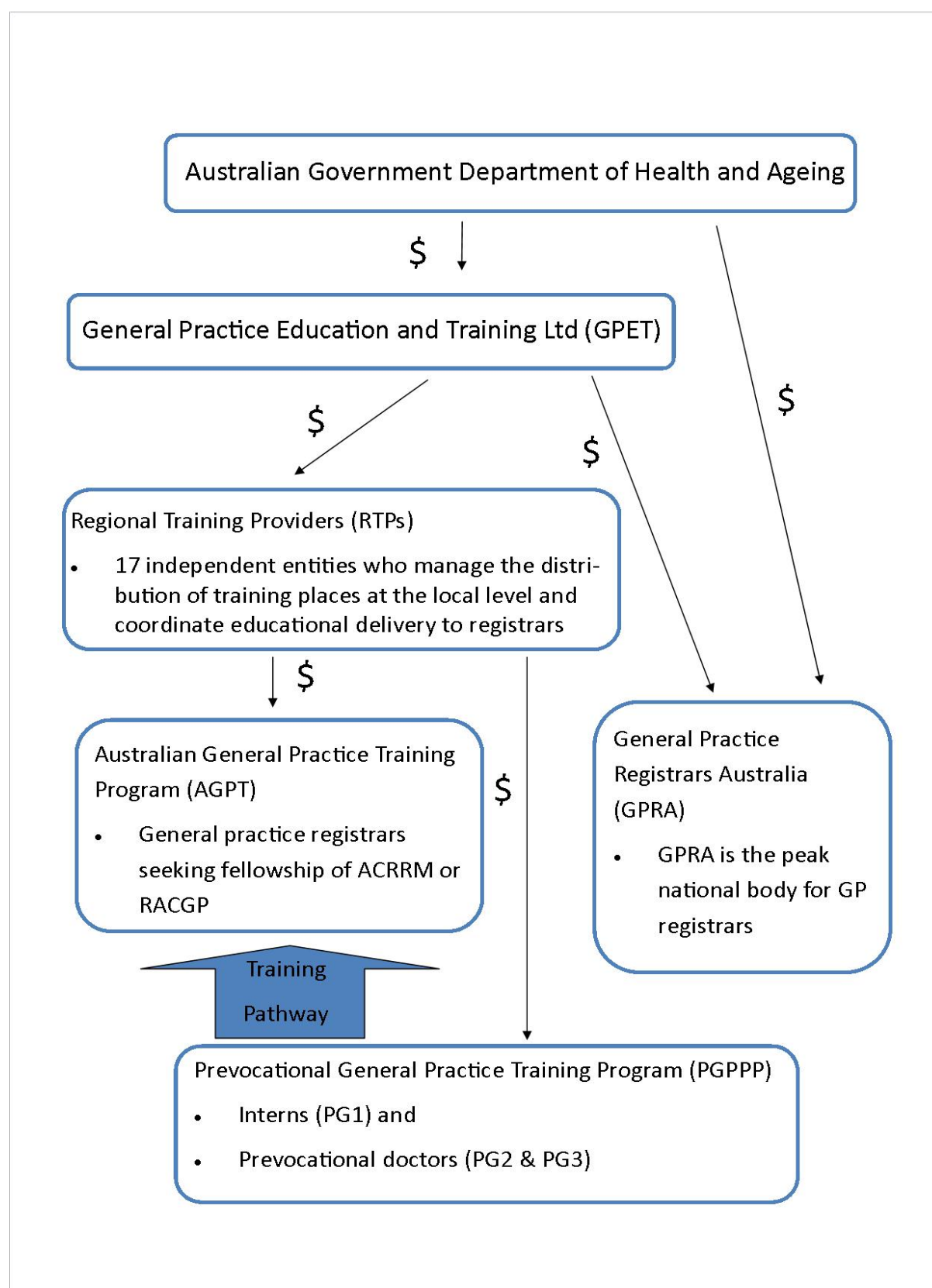
PGPPP was originally designed to influence the distribution and supply of general practitioners by improving understanding of the role of general practice and encouraging individuals to take up this career rather than another specialty or a hospital career. While the value of providing interns with primary care training experiences is strongly supported by stakeholders, there has been debate as to whether PGPPP, in its current form, is the most appropriate strategy for the Australian Government to invest in building intern training capacity.

PGPPP was introduced at a time when uptake of vocational training places on the AGPT was low. It was reasoned that the greater exposure a junior doctor could have early on in his or her training to general practice, the more likely he or she would be ultimately to pursue a career as a GP (see Figure 3.1 below).

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<sup>52</sup> Defined as RA 2 to 5 locations under the Australian Standard Geographical Classification – Remoteness Area (ASGC-RA) system. Further discussion of ASGC-RA is included in Chapter 4.

Figure 3.1 General practice training funding arrangements



PGPPP has also been utilised as one of the solutions to building prevocational training capacity. Moving interns out of hospital settings, even for a short period, is a way of freeing up additional placements in settings which provide necessary training experiences for interns to obtain registration. However, GPET reports that reluctance of jurisdictions to release trainees, even with backfilling costs met, was one of the reasons GPET did not meet its PGPPP targets in 2011.

In the current environment, demand for vocational training places is increasing (see data under specialist training below). The impact of higher numbers of students, it has been argued, is an opportunity to rethink the purpose of the PGPPP – insofar as the original aim of the scheme was to provide an early pathway for recruitment into GP training in an era when GP training was undersubscribed. In 2011, 1,427 doctors applied for the 1,000 entry training places on the AGPT for 2012. This surpassed the previous record of 1,235 applicants for the 2011 training year.<sup>53</sup>

While demand for AGPT places is high, there are indications that undertaking PGPPP placements has not necessarily articulated into graduates choosing to enter general practice training. It appears that only 25% of doctors (171 of the 692 in 2012) who had undertaken a PGPPP placement later accepted a place in the AGPT program.

GPET has recently engaged consultants to review the costs and funding model of the PGPPP. This project is currently underway with the aim of assessing costs of and developing a new standardised funding model, taking account of regional variations. Additionally, GPET aims to ensure that there is an equitable distribution of funds across their RTPs with the view to reducing costs over time.

The consultants are reviewing the details of funding of samples of PGPPP places from each RTP. This includes assessing actual costs of, for example, backfilling funding to hospitals, payments to practices, placement costs, regional differences, supervisor costs, etc. The intent is to identify similar costs borne by all RTPs, along with any regional variations. GPET expects that the new model will apply a standard base cost with regional weightings, similar to the AGPT funding model.

The present cost of PGPPP places (at an average cost of \$54,500 per three month rotation or \$218,000 per year) does not compare well with other investments in the training pipelines, such as the AGPT with an annual cost per participant of \$60,000 or the Specialist Training Program (STP), which provides an annual salary contribution of \$120,000 per registrar (including a rural loading). While a secondary benefit of the program involves freeing up intern places in hospitals, the current levels of funding for placements could create more than the current 240 (approximately) internship places funded. In fact given the raw cost of intern salaries and/or maximum on-costs (superannuation, indemnity etc.) a conservative estimate would allow the number of intern places to double if funding models were reshaped.

While this possibility is clearly attractive, there are also risks. One identified risk would be the potential loss of financial and human capital to the practices currently hosting junior doctors. There are various payments made to the practice during the 10 to 13 week rotation, the PGPPP also permits a relationship between the student

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<sup>53</sup> General Practice Education and Training Ltd, *Annual Report to 30 June 2012*, Canberra

and supervisors to develop, which may assist in future recruitment as a registrar and ultimately practice partner.

The current challenge is to develop a system that maintains the benefits of prevocational training in private general practice and community settings while establishing a more cost-effective and sustainable funding base for this activity. One element of such a proposal in the form of a new rural training pathway is outlined in Chapter 4. The Commonwealth has already set a precedent in funding intern positions in 2013, mostly in private settings, to address the unmet demand from Australian trained graduates (as described earlier in Box 3.1). An imperative of any expansion in clinical training capacity must include funding only for genuinely new positions.

If any such proposal were implemented, it would produce understandable concern about the potential loss of funding for metropolitan intern placements. Accreditation and supervision arrangements which are already in place should be retained and may be better supported as part of longer term placements for junior doctors integrated with the AGPT (see Box 3.3 below). Approximately 50% of PGPPP placements (up to 488 from 2012 onwards) may be located in metropolitan areas. Conservatively, this could provide at least 100 better integrated, well-structured internship positions, with priority given to students who wish to undertake later specialist training as a GP.

As part of this process, it would also be timely to investigate the consolidation of all Commonwealth investments in prevocational medical training into a single coordinated funding platform. Such an arrangement could incorporate historical funding agreements such as that between the Department of Veterans' Affairs and Ramsay (Greenslopes and Hollywood Private Hospitals) for clinical training positions. Given that approximately 110 junior medical officer positions (some of which may be interns) are funded under this arrangement, this represents a strong potential to develop better networked arrangements for prevocational training in the private and community sectors.

### Box 3.3: Case study of the community-based intern education project

#### *Background*

There have been significant increases in the number of medical graduates entering the hospital system to undertake intern training in recent years. This has resulted in pressure on service delivery capacity due to increasing costs, supervision and training load.

#### *Aim*

The aim of the project is to determine the feasibility of offering medical graduates who have expressed an interest in a career in general practice an alternative pathway to a hospital-based internship. This will be achieved by piloting an intern program that is community-based and provides a pathway into general practice vocational training through the Australian General Practice Training program.

#### *Program Model*

The pilot project will involve up to 24 community-based internships, which will be provided in an agreed mix of supervised training undertaken by junior doctors in their first postgraduate year. The training will



be based primarily in accredited general practices, and provide experience in the local, regional or rural hospital settings and relevant community health services.

The pilot will be run by GPET in conjunction with a small group of RTPs. It will be delivered to meet the requirements of the relevant boards and authorities, including the Australian Medical Council, the Medical Board of Australia, the postgraduate medical education councils, the colleges and other key stakeholders. This will ensure that interns meet the mandatory requirements to enable the granting of unconditional registration at the completion of the internship.

University of Melbourne Commercial tendered successfully to deliver the pilot program. In 2013, the university will undertake a community-based intern training feasibility study. This will involve a scoping and feasibility study; consultation, model design and selection of training providers; and finalisation of the pilot program and preparation for full implementation. Subject to the findings of the feasibility study and the decision of the GPET board, the pilot intern placements will commence in the first half of 2014.

### Vocational training

Once an intern has achieved general medical registration they have the option of training to become a specialist (including a GP). The Government supports several training initiatives to influence the supply and, especially, the distribution of specialists and GPs.

#### *General practice training*

During the past 30 years GP shortages, particularly in rural and remote areas, have been a regular subject of media reports and action by Governments. Several major measures have been taken in recent years to increase GP numbers and encourage doctors to pursue a rural career, thereby alleviating the main issue of access.

At the risk of labouring the point, while there is some concern over the absolute numbers in Australia, of greater immediate concern is the distribution of doctors throughout the country and the relatively low level of services provided in rural and remote areas.

In the case of GPs, in 2006-07 there were 97 per 100,000 people in urban areas in Australia. This figure dropped through regional and rural areas until in remote areas, the figure was 68.2 per 100,000 of population and 47.1 per 100,000 people in very remote areas.<sup>54</sup> Significant government resources are directed towards countering this imbalance.

The recent expansion in training places has also coincided with substantial increases in applicants indicating that there is strong demand and interest in general practice as a career, notwithstanding the rural/regional training requirements. With the increases in training places made by the government (almost doubling to 1,200 places per year by 2014), and the requirement that at least 50% of this training must occur in ASGC-RA 2–5 locations, the AGPT is a key element in improving the distribution of GPs in rural and regional areas.

Stakeholders have advocated for an increase in the overall number of placements on the AGPT on top of current growth, with a suggested expansion of up to 600

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<sup>54</sup> Department of Health and Ageing, *Report on the audit of health workforce in rural and regional Australia*, Commonwealth of Australia, 2008

additional places to a total of 1,700 per annum.<sup>55</sup> While the current training capacity seems to be leading towards a shortage of vocational training places (see Table 3.2 below), it is important to acknowledge that the Government's focus has been filling places on, what was until recently, an undersubscribed training program.

While the potential to expand vocational training, including funding limitations, is addressed further under the specialist training section of this chapter, it is important to note at this point that the Commonwealth's control of GP training places represents an important mechanism to influence the future mix of the medical workforce.

Stakeholders have presented strong arguments during this review that increasing the number of GPs and "generalists" needs to be a key priority in workforce planning and future funding for vocational medical training. This is supported by the findings of HWA's HW2025 Volume 3 report, which identified both an insufficient number of "generalists" and that the general practice workforce is highly reliant on overseas trained doctors, which may not be sustainable.<sup>56</sup>

There are instances where regional training providers are working well with other regional medical education providers, such as universities delivering the Rural Clinical Training and Support (RCTS) program, to deliver vertically integrated training with good prospects of developing sustainable teaching practice environments.

A case study of this type of arrangement is contained in the 2008 Urbis evaluation of the Rural Clinical Schools (RCS) and University Departments of Rural Health (UDRH) programs. It describes an innovative partnership between the Australian National University Rural Clinical School and the Coast City Country GP Training consortia in delivering both university medical education and GP training, sharing teaching resources and access to primary care settings under a formal partnership.<sup>57</sup> Clearly these sorts of arrangements can be established if goodwill and flexibility exists on both sides.

However, feedback from some stakeholders suggests that these types of arrangements are not being consistently adopted nationally, are not always maintained, and that there are competitive pressures between GP training providers and other institutions, with little incentive for GP registrars to become involved in teaching. Promoting vertically integrated training is part of GPET's charter and this is an area that requires further work in some cases to ensure training is delivered with maximum effectiveness in primary care settings. As noted earlier, the RTPs themselves are independent entities, with local boards and obligations under the *Corporations Act 2001*, who may be organisationally resistant to direction from GPET and (it is alleged by local stakeholders) may be more strongly motivated by the need to comply with corporate governance requirements than the desire to collaborate with other regional institutions.

The AGPT, and the PGPPP, have been successful in placing doctors in training in rural and regional areas. For the AGPT, this has had the added benefit that all registrars provide Medicare eligible services while they train. There is also some

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<sup>55</sup> A. Bracey, "Plea for more GP training". *Medical Observer*, 26 March 2013.

<sup>56</sup> HWA, *HW2025 – Medical Specialties – Vol 3*

<sup>57</sup> Urbis Pty Ltd, *Evaluation of the University Departments of Rural Health Program and the Rural Clinical Schools Program*, Commonwealth of Australia, 2008

evidence that more GPs who have trained in rural areas are now staying on where they train, or in other rural areas. The regionalised model of delivering the AGPT has been a key element in ensuring that GP registrars have been well distributed across Australia.

However, there was some criticism of regional training providers not being open to allow registrars to train in new practices. In particular, some larger corporate practices believe that they are being shut out of the AGPT by particular regional training providers, which preferred to direct registrars to practices that had an established involvement in the AGPT program.

Ongoing educational support for GPs is available through the General Practice Procedural Training Support Program (GPPTSP) which provides funding and locum access to allow medical practitioners to attend further training and upskilling while not disrupting the provision of medical services in the area where they are posted.

Under GPPTSP, 25 obstetrics scholarships and 15 anaesthetics scholarships have been awarded to rural and remote GPs for the 2012 training year. Scholarship recipients commenced training from 1 January 2012. For the 2013 training year, 35 obstetric scholarships and 15 anaesthetic scholarships will be awarded to rural and remote GPs. This targeted program shows evidence of providing a valuable boost to service provision at locations where participants are based.

There has been high demand for this program as shown by the numbers of GPs applying for the scholarships, which are oversubscribed. With the growing focus on rural generalism, and training GPs to have a range of procedural skills, demand for this program is likely to increase. A relatively small investment in a program like this may result in substantial gains in service delivery in rural and regional Australia.

Some GPs participating in the program have experienced difficulty in gaining training posts, especially when they are competing against specialist trainees on the relevant college training program. As the administration of the program is managed by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and the Australian College of Rural and Remote Medicine (ACRRM), it may be necessary for colleges to play a greater role in assisting successful applicants to access appropriate positions in order to participate. Some colleges already provide such a service as part of their fellowship programs and for registrars participating in the STP.

During the course of this review there have been some suggestions that further administrative reform of the management of the AGPT should be considered by the Government, including proposals for the possible incorporation of GPET functions within the Department of Health and Ageing (DoHA), with the replacement of GPET with an advisory board. The advantages and costs of such proposals need to be carefully considered in the context of the major reforms to GP training over the last decade or more. GP colleges, the AMA and other stakeholder groups are likely to view any such proposal as a backward step.

**Specialist training**

Predominantly, the supply of new specialists comes from within the Australian training pathway. In 2010, of the 1,538 doctors (except general practitioners) who became fellows of their respective colleges, only 411 were international medical graduates.<sup>58</sup>

The distribution of specialists tends to group around urban areas, particularly capital cities. In 2005, urban areas supported 122 specialists per 100,000 of population and this figure dropped to 16 specialists per 100,000 people in very remote areas.<sup>59</sup> Specialists located in regional and rural areas often need to travel to undertake continuing professional development because the education they need will often not be available in their local area. Also, many types of specialists are reluctant to work rurally as there may not be a sufficient population base to support their specialty in private practice.

The admittance of doctors into specialist training programs is controlled by each individual professional college. From time to time allegations are made that some professional colleges limit entry to training programs for effectively industrial reasons, such as the protection of income levels or maintenance of prestige. Colleges have generally countered that the number of training places that they can offer is limited by the number of accredited training positions that are being funded by the state or territory governments.

The table below includes demands based projections from HW2025 for specialist training places (including GP training) in the coming decade.

*Table 3.2: Community demand scenario – demand for advanced training places versus available places<sup>60</sup>*

	2009	2012	2016	2020	2025
First year advanced training positions available	2,589	3,169	3,416	3,497	3,559
Doctors seeking first year advanced training positions	2,589	2,444	3,820	4,344	4,824
Difference between available first year advanced training positions and demand for positions	0	725	-404	-848	-1,265

The major concern in ongoing implementation of vocational training programs is that there are no clear linkages between the different initiatives investing Australian Government funding in medical education, particularly that which is rurally based. There is no requirement for universities, regional training providers involved in GP training or specialist colleges managing the Specialist Training Program or

<sup>58</sup> MTRP, Fifteenth Report, Table 4.39

<sup>59</sup> Department of Health and Ageing, *Report on the audit of health workforce in rural and regional Australia*, 2008

<sup>60</sup> HWA, HW2025 Vol 1

emergency medicine places to collaborate to ensure that career pathways are transparent for either students or graduates participating in these initiatives.

The impact of this lack of connection is that organisations tend to focus primarily on educational quality and student welfare at specific points of the training pipeline, without focussing on the end point in terms of workforce goals. While this focus on educational quality should in no way be diminished, an additional emphasis towards supporting vertically integrated rural positions and building partnerships between organisations at different levels of the training spectrum to assist with achieving distribution outcomes needs to become embedded within these programs.

The SCoH has recently acted to address this lack of coordination in the medical training system through the introduction of a National Medical Training Advisory Network (NMTAN), which was agreed in November 2012. HWA has been tasked with developing the network and released a discussion paper on its potential operation in February 2013.<sup>61</sup> Members of the network are expected to include governments, representative organisations of the medical profession, registration and accreditation bodies, medical colleges and universities, and consumer representative groups. It is proposed that the NMTAN will produce five-year rolling medical training plans across the whole medical training pipeline from university training through to vocational training. These will be informed by analysis of information and quality data sources to identify future workforce supply, and will consider employment demand.

The NMTAN has strong potential to improve the interconnectedness of the various stages of the medical training pipeline and the capacity to make evidence-based decisions. However it is likely to be a number of years before it is fully operational and the benefits can be felt.

### *Specialist Training Program (STP)*

The STP provides support to enable medical specialist trainees to rotate through an expanded range of settings beyond traditional public teaching hospitals. It is the only source of Commonwealth grants support for specialist training initiatives and could be considered to have both supply and distribution outcomes for specialists. In addition to establishing specialist training posts, the program also provides funds for a range of support activities, including clinical supervision and training infrastructure for private sector participants and developing support projects aimed at Specialist International Medical Graduates. The program will support 900 specialist training positions by 2014.

The STP has been highly successful in extending vocational training into new settings, particularly in the rural and private sectors. It has also demonstrated that specialist colleges can take a flexible approach to accrediting new positions and to supporting networked training arrangements involving multiple health care settings, sometimes in different regions. However, the program has been consistently oversubscribed during its national application rounds for new positions.

The following table shows the difference between STP applications and available places.

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<sup>61</sup> Health Workforce Australia, [National Medical Training Advisory Network: discussion paper](http://www.hwaconnect.net.au/nmtan/files/HWA-NMTAN-discussion-paper-a.pdf), Feb 2013. accessed at <http://www.hwaconnect.net.au/nmtan/files/HWA-NMTAN-discussion-paper-a.pdf>.



*Table 3.3: Applications for the Specialist Training Program*

Year	2011	2012	2013
New places available	464	82	150
Applications received	902	520	542

Source: DoHA administrative data, unpublished

There is clearly high demand for new specialist training positions across the different disciplines, perhaps reflecting that jurisdictions have not traditionally supported significant growth in specialist training outside the traditional metropolitan teaching hospitals.

Although widely regarded as a successful initiative, as discussed above there is no clear pathway for graduates interested in working in the type of settings supported by STP (i.e. rural and private) to enable them to plan to undertake placements in this program. This problem persists beyond STP and the lack of structured pathways into vocational training outside general practice is often cited as an issue by junior doctor representative groups.

Specialist registrar recruitment and selection is ad hoc and there is very strong potential that prospective graduates interested in training in non-traditional settings will miss out on the limited places offered by STP. The program has also generally only supported one year placements for registrars and, under its current structure, has somewhat limited potential to provide a genuine solution to the need to construct clear and coordinated training pathways for graduates interested in pursuing rural careers. While health care settings that successfully apply for an STP place gain a registrar, the impact on long-term workforce recruitment of trainees has not yet been demonstrated and is likely to be reduced by the relatively short-term nature of most STP posts.

The ability of the STP to provide higher numbers of longer term rural specialist training positions should be examined, subject to available funds and the maintenance of training standards. This would be based on the concept of trainees rotating back to metropolitan sites for advanced skill rotations, unlike the more traditional system through which metropolitan trainees rotate out for rural terms. Ideally, these positions should be linked with rural internships to provide a seamless, vertically integrated transition through the different levels of training.

It is important that the STP policy of only supporting new training posts is maintained to avoid the potential for cost shifting and that the allocation of new training places is linked to both geographic areas and those specialties predicted to be in shortage by HWA's HW2025 Volume 3 report. This situation would also apply to any extension of the STP model into prevocational training.

The major challenge in pursuing this approach is that by 2014, current funding for the STP will be fully committed. While there is the potential that a review analysing existing STP positions may free up some capacity, it will be difficult for the program to continue to extend specialist training into new settings without further resources. Regardless, it is recommended that a full evaluation of the STP should be carried out to inform its future direction and to ensure existing posts are meeting the objectives of the program. Indexation of funding should also be applied for future posts.



### *Supporting emergency medicine*

Funding from the 2011-12 Budget measure, *Building emergency department workforce capacity* is being used to support an additional 22 emergency medicine specialist trainees each year over four years; and a minimum of ten new private sector clinical supervisor/staff specialist training coordination positions nationally.

The Australasian College for Emergency Medicine (ACEM) is administering a number of critical elements of the program including:

- Delivery of 22 emergency medicine specialist training places each year for four years, reaching a total of 110 annually in 2015. Funding covers salary support of \$100,000 per post, plus a rural loading of up to \$20,000;
- Increasing the capacity for ACEM fellows to participate in structured training and supervision activities in public sector emergency departments nationally through the Emergency Medicine Education and Training (EMET) Program;
- Providing a more structured training and upskilling environment for overseas trained doctors working in Australian hospital emergency departments to access training that is not available at their normal workplace; and
- Providing support for GPs and other doctors to become better skilled in emergency medicine through the development of the ACEM Certificate and Diploma of Emergency Medicine qualifications.

Support for private sector training is delivered through the Emergency Department Private Sector Clinical Supervisor (EDPSCS) program. The EDPSCS aims to expand and enhance the postgraduate training capacity of private emergency departments by establishing and supporting new emergency medicine clinical training coordinator positions.

ACEM has established 30 agreements with public sector hospital networks, covering around 190 hospitals across Australia. Stakeholders are positive about this activity and would likely welcome an increase in its funding and scope. College reporting demonstrates high demand for public sector training support as well as benefits from the delivery of training services. However, the potential for cost shifting onto the Commonwealth needs careful consideration.

Other components of the program, such as supporting clinical supervision to build training capacity in the public and private sectors have yet to operate for sufficient periods to demonstrate their effectiveness. There have been some initial difficulties in recruiting key clinical supervisors and/or gaining accreditation for private sector hospitals to train emergency medicine specialists. This is a risk as there is limited capacity for other private operators to replace these hospitals.

### *Support for the specialist training of the radiation oncology workforce*

The delivery of a course of radiotherapy is highly technical and involves a team of health professionals including radiation oncologists, radiation therapists (radiographers) and radiation physicists.

The Commonwealth's Radiation Oncology Workforce Training measure aims to address the shortage of specialist radiation oncology staff. Component activities include contribution towards two types of training positions and associated clinical support:

- Professional year placements for radiation therapists;

- Three and a half year training placements for radiation oncology medical physics registrars; and
- Clinical preceptors (tutors) to support these registrars.

Annual funding rounds called cohorts usually commence prior to the end of the academic year. Allocation of funding is via a targeted non-competitive Expression of Interest process as only accredited facilities are able to take on trainee positions. Accredited facilities include both public (State and Territory Health) and private providers.

The program has generally met the targets for the radiation therapist placements, with a lower rate for the medical physics registrars. Participants have indicated that this has been largely due to the unavailability of senior staff to provide the clinical support required. However, numbers of senior staff will evidently not be bolstered in the long term without sufficient supply of junior practitioners to replace/increase the workforce.

HWA are developing a National Cancer Workforce Strategy (NCWS) that offers a course of action to address workforce issues for the cancer control sector. The Strategy will identify key reforms with potential national application, and HWA will provide funding for activities that support innovative cancer workforce models arising from the finalised NCWS. There may be value in examining the aims and operation of the Radiation Oncology Workforce Training measure within the context of the NCWS, once it is finalised.

### Inter-professional learning

Inter-professional learning (IPL) is a stated aim of most institutions which deliver health education. However, the degree to which it is implemented is not well known. What is clearer is that, where health education occurs in a rural setting, inter-professional learning is more prevalent, as much out of necessity as design.

Where students who need to be exposed to the same clinical training do so in a rural setting, resource limitations often mean that medical students will attend a lecture or a practical clinic with nursing students and in some cases with allied health students as well, such as physiotherapy or pharmacy students. The move towards IPL therefore presents opportunities for efficiencies in how training is delivered which could be applied in a broader range of settings.

Some institutions which coordinate clinical placements for health students in rural areas – particularly universities delivering the RCTS and UDRH initiatives – are happy to facilitate a greater degree of IPL by choice, perhaps reflecting a greater openness to team-based service delivery in rural and regional health care settings in which they operate. The university departments, particularly, promote IPL as they deal with a range of health students from the same location.

Placements in small communities, particularly in Aboriginal and Torres Strait Islander communities, also involve levels of IPL by necessity. For example, when established rural health professionals gather for an education session – perhaps from a travelling expert or through a satellite educational broadcast – that gathering will most likely be an inter-professional one.

There has been significant academic debate about what should be the ideal model of IPL. These issues are then often linked with discussions about common assessment processes under competency based frameworks. There has been a degree of

professional resistance to this concept, on the basis that it could lead to a break down in the recognition of different professional roles, e.g. between doctors, nurses and other health professionals.

Notwithstanding these issues, inter-professional education (IPE) in rural areas reflects the reality of health service provision in rural areas where the relative scarcity of health professionals can tend to break down the demarcation of roles which may be able to perpetuate in urban areas. However, with large urban universities and hospitals reporting increasing pressure on resources, inter-professional learning may become more of a reality across all settings and the benefits of this approach should be considered as part of the implementation of Commonwealth health education training programs.

Over the past number of years, with the dialogue for enhancing collaborative inter-professional practice between health professionals in service delivery, the education sector has also seen an emergence of IPE, albeit with no national consistency. HWA engaged a consultant to provide an overview of the current status of inter-professional programs in undergraduate university programs. The report, entitled *Interprofessional Education: a National Audit* was published in early 2013. The report provides a detailed profile and analysis of current activity and achievement in IPE in health across all relevant Australian universities, describes best practice in inter-professional education in Australian practice contexts, and identifies gaps, opportunities and recommendations for future development and deployment of IPE models in health nationally.

Informal indications are that although many universities have introduced inter-professional learning as part of the core curriculum, the mode of delivery is varied. Some institutions e.g. Curtin University commence IPE in first year student curriculum, whilst other institutions include IPE components only with clinical placements in later years. Edith Cowan University utilises the simulated learning environment in the early years to introduce inter-professional practice.

There is a divergence of opinion and little evidence nationally or internationally to the best approach – some believing that it is important to establish the ‘discipline entity’ in the initial years, whilst others believe that the concept of inter-professional practice should commence early in studies to ensure it becomes core to clinical practice. Evaluation of inter-professional programs is often limited to surveys of student experience and often IPE is driven by and dependent on a local champion, with sustainability an issue in some IPE programs. Additionally, there are expressed fears that inter-professional learning will lead to professional creep and that introducing inter-professional education into core curriculum will impact on the quality (and quantity) of discipline training and skill development.

The National Audit study listed seven recommendations for development and national capacity building. Key areas which impact on the quality and capacity of the health workforce include adoption of inter-professional practice (IPP)/IPE requirements in the accreditation standards of all Australian health professions and adoption of IPP/IPE in the continuing professional development requirements for ongoing registration. The remaining recommendations relate mostly to curriculum development and harmonisation of core competencies and information sharing. This review recommends that the benefits of IPL should continue to be explored within existing programs, particularly those funded under HWA’s clinical training stream.

*Recommendations*

Recommendation	Affected programs	Timeframe
<b>Recommendation 3.4:</b> The Commonwealth should continue to invest in clinical training initiatives to help ensure the future health workforce has the right training to meet community needs. This should include ongoing investments in the clinical aspects of undergraduate health education across disciplines, as well as targeted funding for vocational medical training. There are pressures on training capacity and it is critical that government investment is cost-effective and sufficiently flexible to allow resources to be directed towards identified priority areas.	HWA, AGPT, STP, PGPPP, RHMT	Short term – ongoing.
<b>Recommendation 3.5:</b> A new focus on collaboration between organisations involved in health education programs needs to be mandated as part of core program delivery. Specific requirements should be incorporated into funding arrangements, with effective collaboration included as a key performance indicator for each initiative.	AGPT, STP, RHMT (inc RCTS, JFPP, UDRH and DTERP) PGPPP, RVTS	Medium term – as agreements expire.
<b>Recommendation 3.6:</b> The Commonwealth (as well as Health Workforce Australia (HWA)) should engage more closely with the private health sector in developing and implementing health education training initiatives. This engagement should be planned and regular and occur at a senior level. This approach should help to enhance the potential for private sector training capacity to be utilised more fully and in a more structured and consistent way.	DoHA and HWA Health education programs.	Short term and ongoing – to commence post-Review.
<b>Recommendation 3.7:</b> The Commonwealth, in close consultation with General Practice Education and Training Limited (GPET) and other key stakeholders, should investigate reforms to the way in which support for intern training placements is delivered in general practice and community settings. While maintaining the focus on intern training in	PGPPP	Medium term

Recommendation	Affected programs	Timeframe
primary care is crucial, there may be an opportunity to work with GPET to invest a portion of the funds currently dedicated to the Prevocational General Practice Placements Program (PGPPP) in new models discussed in this review.		
<b>Recommendation 3.8:</b> Reforms to the Commonwealth's investment in junior doctor training will need to be targeted towards building a more integrated training pathway for new graduates, with a proportionate emphasis on rural training. This pathway should continue to provide structured opportunities for junior medical officers to experience general practice.	PGPPP	Medium term
<b>Recommendation 3.9:</b> The Specialist Training Program (STP) should provide indexed funding for its training posts.	STP, Specialist training component of the More Doctors and Nurses for Emergency Departments program.	Short term – indexation to commence as agreements with specialist colleges are extended.
<b>Recommendation 3.10:</b> While STP has been a well-received and apparently successful program, it is important that a full evaluation of the program should be carried out to verify that settings such as the mix of positions are optimal, and to inform the future development of the scheme.  In addition, existing STP posts should be reviewed by colleges (in discussion with the Department and other program stakeholders) to ensure they are meeting the objectives of the program. This may provide the opportunity to redirect funds to new training posts that may better meet emerging workforce priorities.	STP, Specialist training component of the More Doctors and Nurses for Emergency Departments program	Short term – review to commence by the end of 2013.

### 3.3 *Health education scholarships*

The Government currently provides health workforce education support through a number of scholarship programs. Whilst the eligibility and target groups vary between scholarships, they all have similar objectives such as supporting students to enter the health workforce, supporting existing professionals to maintain or upgrade their skills and qualifications and other forms of continuing professional development.

The majority of these scholarship programs in the Health portfolio are managed within Health Workforce Division, although scholarship programs have also been established in areas including Ageing and Aged Care Division and Pharmaceutical Benefits Division.

The existing programs vary in terms of the target recipients, eligibility and scholarship value. This can include differences in:

- the target workforce – for example, medical, nursing or allied health professions and/or particular groups within these professions, such as nurse practitioners or diagnostic imaging professionals;
- the level of training – for example, undergraduate, postgraduate, CPD or clinical placement support; and/or
- the training location – for example, rural areas or professionals in particular settings such as emergency departments or Aboriginal Medical Services (AMS).

Current Health Workforce Division scholarship programs and those offered by other divisions are outlined in Boxes 3.5 and 3.6 below.

#### **Box 3.5: Current Health Workforce Division scholarships**

##### *Nursing and Allied Health Scholarship and Support Scheme (NAHSSS)*

- The Australia College of Nursing administers the nursing component.
- The Services for Australian Rural and Remote Allied Health (SARRAH) administers the allied health component.
- 2012-13    \$30.2m

The NAHSSS provides scholarships to nursing and allied health students and professionals for undergraduate and postgraduate studies, CPD and clinical placements. The scheme aims to facilitate the entry of nurses and allied health professionals into the health workforce, encourage practice in geographic and other areas of need, and facilitate continuing professional development.

##### *Rural Australia Medical Undergraduate Scholarship (RAMUS) Scheme*

- Administered by the National Rural Health Alliance (NRHA).
- 2012-13    \$4.6m

The RAMUS scheme provides medical scholarships to students from a rural background with a demonstrated financial need and commitment to rural practice. The scheme also supports an Alumnus Program which enables contact and support mechanisms for former RAMUS recipients. The scheme is part of the Government's strategy to improve the sustainability of the rural health workforce.



### *Puggy Hunter Memorial Scholarship Scheme (PHMSS)*

- Administered by the Australia College of Nursing.
- 2012-13 \$4.45m

The PHMSS provides scholarships to Aboriginal and Torres Strait Islander people who are undertaking study in a health-related discipline at an undergraduate or Certificate IV level or above. The scheme aims to address the under-representation of Aboriginal and Torres Strait Islander people in health professions and with professional health qualifications.

### *Australian Rotary Health Indigenous Health Scholarships Program*

- Administered by Australian Rotary Health.
- 2012-13 \$0.48m

The program provides scholarships to Aboriginal and Torres Strait Islander students in all health-related disciplines. Fifty per cent of the scholarship funding is provided by a local Rotary Club with Governments (Commonwealth or state and territory) contributing the remaining funding. Scholarship recipients also receive mentoring and other support by the different Rotary Clubs around Australia.

### *Diagnostic Imaging – Enhancing the Rural and Remote Workforce Scheme (DI-ERRWS)*

- Administered by the Australian Institute of Radiography.
- 2012-13 \$0.25m

The DI-ERRWS aims to increase the rural diagnostic imaging workforce through the provision of National Professional Development Year scholarships and postgraduate scholarships. The scheme also aims to support the existing rural diagnostic imaging workforce through access to grants.

### *Medical Rural Bonded Scholarship (MRBS) Scheme*

- Administered by the Australian Government Department of Health and Ageing
- 2012-13 \$13.1m

The MRBS scheme aims to increase the number of doctors practising in rural and remote areas of Australia. The scheme provides 100 additional graduate and undergraduate medical school places each year to Australian medical students. In return for a scholarship while they are studying medicine at university, students agree to work for up to six continuous years in a rural or remote area of Australia once they have qualified and attained fellowship of a specialist college (including general practice).

### *Box 3.6: Scholarship programs managed by other divisions*

#### *Aged Care Education and Training Initiatives (ACETI)*

- Administered by the Australian Government Department of Human Services.
- 2012-13 \$13.7m

ACETI was designed as a retention and professional development strategy to maintain a skilled and sustainable aged care workforce. Incentive payments are provided to registered and enrolled nurses and personal care workers who undertake eligible certificate, diploma and degree courses.

#### *Aged Care Nursing Scholarships (ACNS)*

- Administered by the Australian College of Nursing.

- 2012-13     \$18.8m

ACNS assists registered and enrolled nurses working in the aged care sector to increase their skill set through undergraduate and postgraduate study as well as continuing professional development activities. Scholarships are also available to students intending to seek employment in the aged care sector following completion of studies.

### *Rural Pharmacy Scholarship Scheme (RPSS)*

- Administered by the Pharmacy Guild of Australia.
- 2012-13     \$1.2m

RPSS recognises the role of pharmacists in maintaining the health of all Australians, particularly in rural and remote Australia. RPSS provides financial support to encourage and enable students from rural areas to undertake entry level university pharmacy studies.

### *Aboriginal and Torres Strait Islander Pharmacy Scholarship Scheme (ATSIPSS)*

- Administered by the Pharmacy Guild of Australia.
- 2012-13     \$45,000

ATSIPSS aims to improve access to community pharmacy services by Aboriginal and Torres Strait Islander people by taking account of cultural issues in meeting health needs. The aim is to encourage Aboriginal and Torres Strait Islander students to undertake entry level studies at a university. Scholarships are offered preferentially to students who currently live, or have lived, in a rural or remote community.

### *Continuing Pharmacy Education/Professional Development Allowance*

- Administered by the Pharmacy Guild of Australia.
- 2012-13     \$0.6m

The Continuing Pharmacy Education/Professional Development allowance provides financial support to assist pharmacists from rural and remote areas to access CPD and professional development activities.

### *Rural and Remote Placement Allowance Scheme*

- Administered by the Pharmacy Guild of Australia.
- 2012-13     \$0.8m

The Placement Allowance Scheme recognises the role of pharmacists in maintaining the health of all Australians, particularly in rural and remote Australia. The Placement Allowance Scheme provides financial support to encourage and enable undergraduate pharmacy students to undertake clinical placements in rural and remote areas.

### *Rural Intern Training Allowance (RITA)*

- Administered by the Pharmacy Guild of Australia.
- 2012-13     \$0.3m

RITA complements the Continuing Pharmacy Education/Professional Development allowance. It provides financial support to assist intern pharmacists from rural and remote areas to defray travel and accommodation costs associated with undertaking compulsory intern training workshops, training days and examinations.

### Are scholarships the most effective way to build and support the health workforce?

There appears to be limited evidence to show whether the desired workforce outcomes are actually achieved through scholarship programs. There is insufficient Australian academic literature or research on the issue of whether scholarships affect an individual's choice to enter and/or to remain in the health workforce.

#### *Stakeholder feedback*

A number of stakeholders were consulted regarding scholarships during this review.

There were some common themes raised:

- Scholarships should support gaps in service planning and align with priority areas. It is important to identify and target these gaps;
- The effectiveness of scholarships should be evaluated;
- Scholarships provided by other stakeholders including state and territory governments should be identified to reduce duplication;
- There is an inequity of funding across disciplines and there should be greater consistency in the value of scholarships;
- “Oversubscription” of scholarships causes disillusionment; and
- There is a need for support programs to complement scholarship schemes.

In 2005 the National Nursing and Nursing Education Taskforce wrote a review of Australian scholarship programs for postgraduate study on specialty nursing areas for the Australian Health Ministers' Advisory Council. Whilst the report and recommendations specifically related to nursing, the report advised that the same principles are relevant to the whole health workforce.

Recommendations of the taskforce included:

- The facilitation of greater consistency in data collected by government and individual scholarship providers and to enable greater comparison between programs;
- Scholarship programs should be informed by, and be based on, the best available evidence, including current service need and workforce projections both local and national, and the effectiveness and need for programs reviewed at least annually;
- Australian, state and territory governments, in collaboration with the nursing profession, employers and education providers, should identify specialty areas to be targeted for scholarship support and develop strategies to ensure that the targeted uptake in those areas is achieved;
- Scholarship programs should be developed using a policy framework that is responsive to changing environments and service and workforce needs; and
- The Australian, state and territory governments develop and implement a common evaluation framework for scholarship programs.

Longitudinal evaluation is required in order to determine whether scholarships are effective in influencing individuals to join the workforce or to remain in the workforce. Without such evidence it is arguable that the funding that is currently spent on scholarship programs could be more appropriately spent on other forms of educational support, such as subsidising the cost of course fees or other training activities in areas of identified workforce need.

There is some evidence to suggest that students from rural areas are more likely to practise in rural locations on completion of their training. Targeted rural origin scholarships like RAMUS could therefore play an important distributional role. However it is not known:

- how long scholarship recipients are remaining in the health workforce or in particular areas of need;
- how the scholarships assisted in career choices, the education and training of recipients or the broader health workforce in the longer term; or
- whether the scholarship recipients would have undertaken the education regardless of whether they did/didn't receive the scholarship.

Available evidence suggests that a large number of nursing graduates leave the workforce within the first few years of practice. This could potentially mean that undergraduate scholarships, of up to \$10,000 annually, are not heavily influencing the recipients' future career choices and that the workforce is not greatly benefiting from this type of investment in terms of retention.

Some administrators, such as SARRAH for NAHSSS (allied health) and NRHA for RAMUS, undertake surveys of current scholarship recipients in terms of their career choices, but this does not extend to retrospective surveys of past scholarship recipients and definitive evidence of where graduates are currently providing health services.

The Medical Schools Outcomes Database (MSOD) project data is beginning to provide information on the locations being chosen by medical graduates and in future years should be able to provide information on RAMUS graduates as they progress through their vocational training.

Monitoring future practice choices of scholarship recipients may become easier with the introduction of student registration numbers under the NRAS. However, there is likely to be an unsuitable lag time in using such data to accurately inform future scholarship decisions. In the meantime, the Department may be able to fund scholarship administrators to undertake a survey of all past scholars to ascertain their current work situation. Such a survey should form part of a broader evaluation of current programs to ensure scholarship efforts are being appropriately targeted, achieving desired outcomes and are being efficiently and effectively administered.

### Options for reform

#### ***Redirection of the MRBS scholarships to RAMUS and NAHSSS rural allied health***

Critics have questioned the effectiveness of the MRBS and its ability to provide a return on a significant investment. The value of the scholarships is considerably higher (by \$16,000) than the standard undergraduate scholarship. It needs to be noted however that this in part is counterbalanced by the not insubstantial return of service obligations (RSO) and penalties faced by MRBS recipients, which do not apply to any other Commonwealth health scholarship.

Many MRBS participants, it is alleged, lack a positive connection to rural service and generally indicate an unwillingness to fully participate in rural life. The bonded element is experienced as stigmatising of rural practice, and requires complicated contractual arrangements which are expensive and administratively onerous, while being of questionable utility. The Department has suggested it is common for participants to make representations seeking a way out of their obligations, which for

some may include pursuing employment overseas. This obviously is undesirable in the light of the depth of need in rural and remote areas, and increased administration costs.

DoHA records indicate that to date fewer than 50 MRBS recipients have commenced their RSO period. While this is expected to increase as more students finish their training it does not represent a particularly positive return after more than a decade of investment in well supported scholarships (there are currently over 1,200 participants in the scheme).

It has been suggested that MRBS funds would generate greater value if the program was phased out and support redirected to other more targeted rural scholarship schemes.

The Commonwealth should consider phasing out the Scheme from 2014 and redirecting the funding to support an additional number of RAMUS places (up to 100) as data suggests that this scholarship scheme is both popular among rural communities and rural medical students. As RAMUS scholars, in order to be eligible, must have a significant rural background, available evidence is that they are most likely to return to their own community or a similar rural setting. This scheme lacks the element of stigma and coercion and is more likely to result in a genuine community engagement.

If the MRBS is phased out consideration should be given regarding the substantial penalties that are currently applied to participants, and whether they should continue to be applied to existing participants who will need to fulfil their contractual obligations. In view of the substantial taxpayer investment in their training it is suggested that the RSO requirement should be maintained for these students. However, if current penalties are applied they will include reimbursement of part of the government's investment, approximately \$250,000, together with a 12 year restriction on providing services under Medicare. The companion Bonded Medical Places (BMP) scheme (discussed in detail in Chapter 6), which does not include a scholarship but is limited to the provision of a university medical school place, allows the participant to buy out of their RSO, roughly equivalent to 75% of the government investment in their education, with no equivalent restriction on Medicare.

A portion of the remaining funds from the MRBS should be reallocated to support additional rural NAHSSS allied health scholarships. The current quota of scholarships available under the NAHSSS for allied health is oversubscribed and must cover multiple disciplines. Distribution of allied health professionals both in the public and private sector is limited in rural Australia and in remote areas can be non-existent. This leads to poorer health outcomes. As such, it is proposed that the NAHSSS allied health scholarships are expanded using the existing model of support, based on the principle that rural students are most likely to return to their home community or similar rural location upon completion of their education.

If the MRBS scholarship funds were redirected towards RAMUS and rural NAHSSS allied health scholarships, for every two MRBS scholarships it would be possible to fund two RAMUS scholarships and three allied health scholarships valued at \$10,000 per annum. This has the potential to significantly impact on the rural and regional health professional workforce of the future. Any such expansion of scholarships to allied health and dentistry would need to be subject to the same requirements for data and evaluation outlined above. Specifically, there is a need to

target support to the professions where shortages have the biggest impact on population health, and where evidence shows that scholarship support is most likely to make a real difference for disadvantaged populations.

### Risks

If this course of action were to be adopted, consideration would need to be given to the 100 university places that are currently allocated to the MRBS. If the scholarship is terminated three options will need to be considered. The places could either:

1. be withdrawn from universities;
2. convert to standard Commonwealth supported places (CSP); or
3. convert to places under the BMP, increasing the total number to approximately 800 students per annum, which is 4% of the total number (16,491 in 2011) of medical school places or 6% of CSPs (13,016 in 2011).<sup>62</sup>

### *Potential for further consolidation of the existing scholarship programs*

The consolidation of eight existing scholarship measures into the NAHSSS in 2010 produced some administrative savings and program efficiencies. There has been discussion during the review process as to whether further consolidations should occur, given that there are still numerous Commonwealth funded scholarship programs.

This could encompass some or all of the programs managed within Health Workforce Division and might extend to include all scholarship programs managed within the Department, including aged care scholarships and pharmacy scholarships.

### Benefits

Further consolidation of the scholarship programs, it has been argued, might:

- Lead to an overall reduction in administration costs due to economies of scale.
- Be more accessible to students and easier to promote. Student representatives have indicated that the current variety of scholarship initiatives can be confusing and hard to navigate, with multiple websites to search and a variety of organisations to contact.
- Enable a re-profiling of some of the current investment in scholarship initiatives to greater flexibility and targeted funding to ensure the most effective outcomes and better alignment with emerging workforce needs, including those identified in the *Health Workforce 2025* report.
- Facilitate consistency in the way that scholarships are administered and reported. Further consolidation would enable the Department to select an administrator with a good history in administration and reporting.
- Minimise the potential for duplicate funding, for example scholars receiving multiple Commonwealth-funded scholarships concurrently. For example, the terms and conditions of the NAHSSS allied component state that applicants who are in receipt of another scholarship funded through the Department are ineligible to apply for a scholarship under NAHSSS. However, due to privacy rights of the scholarship recipients, the NAHSSS allied component administrator is not able to contact any other scheme's administrator, such as the PHMSS, to determine if they share any common scholarship recipients.

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<sup>62</sup> MTRP, Fifteenth Report, Table 2.4



## Risks

However, further consolidation of the scholarship programs could also:

- Result in the scholarship programs being administered by an organisation that may not have sufficient knowledge or connections required for effective administration across the range of workforces. For example, the NRHA has established networks across the rural medical portfolio that enable them to administer the RAMUS more effectively than an organisation that does not regularly contact the relevant key stakeholders. These resources however, may not extend to the nursing or allied health professions, rendering effective managing of the NAHSSS more complex. The reverse is true for the administrators of NAHSSS.
- Cause stakeholder dissatisfaction. Several nursing and allied health stakeholders expressed dissatisfaction with the consolidation of the NAHSSS in 2010, because they considered that this removed expertise from the administration of the individual scholarship streams. A further consolidation that combined the larger scholarship programs (such as RAMUS, NAHSSS, MRBS and PHMSS) could generate greater concerns.
- Potentially result in a more complicated program through which the Commonwealth awarded scholarships, depending on how the consolidation model was implemented. For example, the NAHSSS funds undergraduate, postgraduate, CPD and clinical placement scholarships (four streams). For each stream, there are several sub-streams to accommodate targeted scholarships such as AMS scholarships or emergency department scholarships (total of 23 sub-streams). If the NAHSSS allied, NAHSSS nursing, PHMSS and the RAMUS were consolidated into one scholarship scheme, then there would be around 25 different scholarships sub-streams from which nurses, midwives, allied health and medical professionals and students would need to navigate to determine the correct scholarship to meet their specific needs.

This system may lead to confusion and dissatisfaction from applicants and key stakeholders unless the scheme was streamlined to establish a single program with broad eligibility criteria and identified priority areas.

Further, the potential administrative savings identified to date are likely to be very small. Most organisations receive less than 8% of the total value of the scholarships awarded towards all the administrative costs incurred in delivering the scholarship program. It is unlikely that consolidation of the scholarships will lead to a significant overall reduction in the cost of administration, although the promise of other benefits remains strong. These would include potential for greater consistency in program delivery, easier access to students and the ability to reprioritise the allocation of scholarships.

In particular, unless there is an appetite to merge the current funding streams between the health disciplines and targeted workforce areas (e.g. rural health and aged care) then the benefits of merging Health Workforce Division programs alone remain questionable. It would also be necessary to maintain branding of iconic schemes, like the Puggy Hunter Memorial Scholarships, and this would further complicate the introduction of any consolidated management model.

Any consolidation that involved consolidation of programs managed in other areas of the Department would require careful consideration and consultation with the

relevant divisions to determine if it would be an effective and efficient way to support the health workforce and to identify any concerns that would affect a consolidation.

Nevertheless, this review has identified significant overlaps between Health Workforce Division scholarships and similar initiatives in other divisions. In some cases the same workforce group is targeted, particularly in nursing. The Department is also supporting multiple funding agreements with the same stakeholder group, the Australian College of Nursing.

On balance, while there is certainly potential for improved outcomes and administrative efficiencies, further work needs to be undertaken in developing a model which would justify the disruption and stakeholder anxiety likely to result from consolidation of current scholarship schemes.

In the interim, there could be benefits realised from creating a single entry point where potential applicants can gain information on all Commonwealth-funded health workforce scholarships. This gateway could then direct potential applicants to the appropriate websites for each of the individual schemes. It is suggested that the administrators of each scholarship scheme could work together to develop such a portal, which would come together under uniform branding, but allow providers to continue to deliver their particular scholarship element.

The official Australian Government website for advice on [study in Australia](http://www.studyinaustralia.gov.au) ([www.studyinaustralia.gov.au](http://www.studyinaustralia.gov.au)) has a user friendly scholarships database which could form the basis of the single entry portal for health scholarships described above. Users of the database are able to search based on the type of course (VET sector, University etc), field of education and location (state or territory). A list of potential scholarships with brief descriptions and links to more information including eligibility criteria is then presented. The Study in Australia database contains a health delimiter but it would require a further filter option to sort the scholarships into medical, nursing, allied health and other subcategories i.e. psychology, physiotherapy.

### Inconsistencies between scholarships

There are variations across the schemes in regard to many aspects of the scholarships including:

- the value of the scholarships;
- the number and proportion of undergraduate scholarships available to each discipline;
- criteria for allocating scholarships including financial need; and
- the funding arrangements for scholarship schemes.

The rationale for the variations is limited and needs to be considered as part of an evaluation to enable greater consistency across each scholarship element.

### Value

There are discrepancies in the value of scholarships funded by the Department. For example, the NAHSSS nursing, NAHSSS allied health and the RAMUS all provide \$10,000 per year for undergraduate scholarships, whereas the PHMSS provides \$15,000 per year. Postgraduate scholarships for the general NAHSSS nursing and NAHSSS allied health are valued up to \$30,000 over three years. However, the NAHSSS emergency department postgraduate scholarships, which are considered

to be a Government priority area, are only funded at a total of \$15,000 for one year. Clinical placement scholarships vary greatly, with some as low as \$5,000 each (Tasmania Package for nurses) and others up to \$23,000 (emergency department for nurses). CPD scholarships for nurses are valued at up to \$1,500 each, but allied health CPD scholarships are valued at up to \$3,000 each. The discrepancy in the value of MRBS scholarships was discussed earlier.

Some stakeholders have commented that the Commonwealth scholarships are generous in comparison to the value of scholarships provided by state and territory governments or philanthropic organisations. The majority of non-Commonwealth postgraduate scholarships are valued at \$5,000 or less.

It would be beneficial for the value of the scholarships to be reviewed for appropriateness and consistency. Scholarships that are awarded for a similar purpose should have a similar value. CPD scholarships legitimately have a lower value, as the costs experienced by these students are generally less, but scholarships supporting university education should have their grant amounts aligned.

#### *Number and proportion of undergraduate scholarships available to each discipline*

Key stakeholders, including the Australian Nursing Federation, have asked the Commonwealth to consider the number of scholarships available to nursing and allied health students in relation to the number of scholarships available to medical students. Allied health stakeholders also raised this issue during review consultations.

Currently, around 8.5% of the total domestic medical student population in Australia receive a Commonwealth funded scholarship (through RAMUS, PHMSS, MRBS or Rotary) compared to only around 1.7% of the total domestic nursing and midwifery student population in Australia (through NAHSSS, PHMSS, or Rotary).<sup>63</sup>

It has been suggested that the disproportionate share of scholarships is inconsistent with the findings of the *Health Workforce 2025 – Doctors, Nurses and Midwives Report*, which predict a future shortfall in nurses nationally. However, the counter argument to this claim is that the medical scholarship programs are primarily targeted at improving rural medical workforce distribution, which was raised as the key issue for medical workforce development in the HWA report. Nursing, in particular, is not experiencing similar distribution challenges at present, noting that this situation may change as rural nurses begin to retire.<sup>64</sup>

Anecdotal evidence also suggests that there is a shortage of allied health professionals across Australia – particularly in rural areas. As discussed elsewhere in this review report there are challenges with the consistency of national allied health data. HWA is currently undertaking work to quantify any shortage in the allied health workforce.

The allocation of broad-based support for undergraduate scholarships needs to be reviewed to ensure this aligns with current evidence about where support is needed most. In some cases current funding at the undergraduate level may be more

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<sup>63</sup> Health Workforce Division data analysis, 2012.

<sup>64</sup> HWA, HW2025 – Vol 1

effective in generating workforce retention and distribution outcomes if it is redirected to support postgraduate training for committed graduates wishing to upskill particularly in light of the move to demand-driven, uncapped funding for CSPs in all professions except medicine under current Government policy. This could apply to either the development of advanced clinical skills or management and leadership abilities.

### *Criteria for allocating scholarships including financial need*

There are inconsistencies between the criteria under which different scholarships are awarded. It would be beneficial to have some consistency amongst the different schemes, allowing for the necessary differences in the target recipients.

The demand for undergraduate scholarships for all disciplines far exceeds the supply. It would be desirable if the scholarships could be awarded to students with the greatest financial need because they are at most risk of leaving their studies due to insufficient income to meet their living costs whilst studying.

Whilst most of the scholarship schemes that provide undergraduate scholarships use remoteness or income as eligibility or selection criteria, there is an inconsistency in how these are applied across the schemes.

- RAMUS, NAHSSS allied health and NAHSSS nursing all require the undergraduate applicant to provide details of income earned to assist with the selection process. PHMSS does not require this information, as the selection process is not influenced by the applicant's financial situation.
- RAMUS and NAHSSS allied undergraduate scholarships are restricted to rural students, whereas NAHSSS nursing uses remoteness as a weighting mechanism in the selection process. PHMSS does not consider remoteness in the selection process.
- The administrator of RAMUS reserves a number of scholarships for appeals. There is no appeals process for NAHSSS allied, NAHSSS nursing or PHMSS; however, the administrator of NAHSSS allied reserves a number of scholarships for students who are able to demonstrate exceptional circumstances.

Each year representations are received by the Department and the administrators from unsuccessful applicants who consider that their financial need is greater than other applicants. There are also objections from unsuccessful applicants that financial need should outweigh academic performance as a selection tool. A counter argument is that basing support only on financial need results in a higher than necessary proportion of scholars failing or deferring their course.

Whilst it is not possible to establish a 'perfect' selection system, it would be beneficial to introduce a standardised mechanism. This could be similar to that used for the RAMUS Scheme which assesses financial need using a similar method to the Department of Human Services.

### *Funding arrangements for scholarship schemes*

There is an inconsistent approach to the way annual funding allocations for each scholarship program are provided to the administrators. This results in some administrators holding a cash balance of up to \$24 million to pay for the future payments for awarded scholarships, whilst other administrators only hold sufficient cash balances to make the scholarships payments due that financial year. In some cases there appears to be an expectation that students will continue to receive

scholarships for the duration of their training, regardless of whether the various program guidelines stipulate that funding is provided on an annual basis and is subject to continued government funding in the out-years.

### *Duplication with state and territory scholarship schemes*

In some areas, particularly nursing and midwifery, Commonwealth scholarships are in competition with those offered by the states and territories (see Box 3.6 as an example). This type of duplication may result in students who are not accessing all of the support options available to them. In other cases there may be a duplication of resources and students may be receiving two separate scholarships from different sources for the same area of study or continuing education.

Prior to making any changes to the Commonwealth's current health workforce scholarship arrangements it would be prudent to undertake a comprehensive survey of the educational scholarships which are available for each health discipline across the states and territories.

#### **Box 3.7: New South Wales health scholarships**

New South Wales has a variety of allied health scholarships mostly targeted at rural areas.

Up to 50 NSW Rural Allied Health Scholarships, valued up to \$10,000, are offered each year.

NSW Metropolitan Allied Health Clinical Placement grants of up to \$750 are offered each semester. Grants provide financial assistance to allied health students from a rural or remote background studying at rural universities with the travel and accommodation costs of metropolitan clinical placements. Grants are awarded on the basis of the duration of the placement and the cost of travel associated with accessing the placement.

NSW Rural Allied Health postgraduate scholarships are available to permanent full-time or part-time allied health clinicians employed and currently working in a rural located public health service, to assist with educational expenses directly associated with postgraduate study. In 2012 the scholarships were valued at up to \$10,000 dependent on the course undertaken.

There are an even broader range of nursing and midwifery scholarships on offer which have more targeted eligibility criteria including Aboriginal Undergraduate Scholarships, Re-entry to Nursing Scholarships, Rural Undergraduate Scholarships etc.

### **Funding activities to support the scholarship recipients**

Whilst the majority of the schemes are limited to the provision of scholarships alone, RAMUS and Rotary are funded for additional activities, such as mentoring, conference placements or Alumni events which complement the schemes.

#### ***Mentoring***

- RAMUS is funded to ensure that each scholar has a mentor and for undertaking the administrative work associated with this activity, including payments to the mentor (\$175,050 in 2012-13 to support mentors for 587 students). The attachment to a mentor may be an effective means of linking participants with the rural workforce, ensuring they remain mindful of the purpose of the scheme in receiving support.
- Rotary is funded to cover the travel and accommodation costs of an administrative officer to visit individual Rotary mentors and provide them with



support required to be a mentor. The mentors themselves are not paid – it is a voluntary role (\$60,000 in 2012 to support mentors for 40 students).

The NAHSSS allied administrator has also asked for permission to implement a mentoring component, but has not been funded to do so to date.

#### *Conference placements*

RAMUS is funded to manage the Conference Placement Program to assist RAMUS scholars and alumni to attend selected conferences in Australia. In 2011-12, a total of 69 conference placements were awarded (\$79,874.61 funding in 2012-13).

#### *Alumnus scheme*

RAMUS is funded to maintain an Alumnus program for graduated RAMUS scholars as well as current and previous RAMUS mentors, including the provision of networking and communication opportunities (\$4,500 in 2012-13 for Alumnus program services).

It would be beneficial to evaluate fully the effectiveness of the mentoring, conference placements and the Alumnus activities for their impact on the retention of health professionals and, if effectiveness is demonstrated, these support activities should be rolled out to nursing and allied health students.

This issue is of particular relevance if there is a consolidation of the current scholarship schemes to form a single Commonwealth program.

### *Recommendations*

Recommendation	Affected programs	Timeframe
<p><b>Recommendation 3.11:</b> This review has identified inconsistencies in scholarship funding arrangements (in both administration costs and levels of support to recipients) that need to be rectified to ensure equity and value for money. To progress this issue, If the recommendations of this review are accepted, a detailed mapping of each of the health workforce scholarship schemes across the Department will have to be undertaken. This process should include an analysis of:</p> <ul style="list-style-type: none"><li>• the administrative costs of existing scholarship activities with a view towards establishing clear benchmarks for application across programs; and</li><li>• the financial and other value of various scholarships for both appropriateness and consistency across the various activities funded.</li></ul>	All scholarships including PHMSS, MRBS, NAHSS, RAMUS, SARRAH scholarships, Aged Care scholarships, Pharmacy scholarships.	Short term – review to commence from July 2013.



Recommendation	Affected programs	Timeframe
<b>Recommendation 3.12:</b> The Commonwealth should develop a health workforce scholarship internet portal. This should be the main source of information on scholarships funded by the department. It should have directions and links to other pages managed by scholarship administering agencies.	All scholarships	Short term – development to commence as soon as possible.
<b>Recommendation 3.13:</b> The Commonwealth needs to develop measurable health workforce objectives for all scholarship schemes and embed agreed outcomes in contracting, program reporting and post-project evaluation.	All scholarships	Medium term – embed outcomes reporting measures in agreements with program management agencies as they expire.
<b>Recommendation 3.14:</b> Detailed workforce data analysis needs to be undertaken to determine where scholarship funding may be most efficiently targeted to achieve workforce distribution objectives in future funding rounds. Such analysis needs to include evidence about the effectiveness of financial support for students suffering other disadvantage in choosing to enter and remain in training for particular health professions.	All scholarships	Longer term – informed by better outcomes data and analysis outlined in recommendations above.
<b>Recommendation 3.15:</b> As part of the further evaluation work recommended above, the Commonwealth should specifically consider whether continued investment in the Medical Rural Bonded Scholarship (MRBS) Scheme represents value for money in terms of the level of the scholarship in comparison to other programs, and the workforce outcomes desired.  Subject to more detailed data becoming available, this review recommends phasing out new scholarship funding and converting MRBS medical school places to standard Commonwealth funding places.  Scholarship commitments and return of	MRBS, RAMUS, NAHSSS	Medium to long term.  The award of new MRBS places could be ceased from 2014 and funding could begin to be redirected to other priorities. Existing scholarship commitments will need to be honoured for up to six years, depending on the length of degree

Recommendation	Affected programs	Timeframe
<p>service requirements for existing participants would be maintained under this scenario with the possible option of allowing some flexibility for students to buy their way out of the commitment.</p> <p>Any funding released from the reconfiguration of MRBS should be redirected towards the Rural Australia Medical Undergraduate Scholarship (RAMUS) Scheme and to the Nursing and Allied Health Scholarship and Support Scheme (NAHSSS) rural scholarships for allied health students.</p> <p>Given current funding levels, over time this change should substantially increase the number of scholarships that are awarded to support rural workforce outcomes. It would also allow funding to be redirected towards rural students with demonstrated financial need, and allow a greater proportion of funds to be provided to nursing and allied health than is currently the case.</p>		of individual participants.
<p><b>Recommendation 3.16:</b> The Commonwealth should undertake further policy analysis of possible models for consolidation of health workforce scholarship schemes within professional groups. The aim should be to reduce administrative costs and streamline reporting arrangements to maximise the number of scholarships available to each health profession.</p>	All scholarships	Longer term
<p><b>Recommendation 3.17:</b> The Commonwealth should consider changing the focus of its nursing scholarship funding towards postgraduate scholarships that are responsive to identified nursing workforce retention needs, informed through HWA workforce data and analysis. In the first instance the priorities should be mental health, aged care and palliative care. This would provide the ability to target those areas identified and would ensure that priority was given to students undertaking studies in nursing courses or specialties identified</p>	NAHSS, Aged Care Nursing Scholarships.	Medium term – implementation to commence from the 2014 allocation of new scholarships.

Recommendation	Affected programs	Timeframe
in the HWA data. Financial need should also be a relevant consideration.		
<b>Recommendation 3.18:</b> As part of any implementation of recommendation 3.15, listed above, the Commonwealth should explicitly consider increasing the number of allied health scholarship and support places with a priority given to rural training locations.	Allied health scholarships, such as those managed by SARRAH.	Longer term – subject to available funding.



## Chapter 4: Addressing health workforce shortages in regional, rural and remote Australia

The Commonwealth funds a range of rurally focused workforce programs and projects which fall into two broad categories – health *education* strategies for rural distribution and rural *retention* strategies for the existing workforce. The Commonwealth also administers legislative distribution mechanisms for overseas trained doctors (the ten year Medicare moratorium, defined and described in Chapter 6). Pivotal to these strategies are the District of Workforce Shortage (DWS) classification system and the Australian Standard Geographic Classification – Remoteness Areas (ASGC-RA) classification system.

This chapter will examine the alignment of current programs with this workforce priority; including an analysis of whether program objectives are being met and opportunities to better align the various measures. Potential options for reform of the ASGC-RA classification systems will be presented, including discussion of issues surrounding its current usage as a distribution mechanism. Options for reform of the DWS classification system is discussed in more detail in Chapter 6.

### 4.1 *Health education strategies for rural distribution*

The use of education and training programs to influence health workforce distribution has been a major focus of the Health portfolio over more than a decade. This has seen substantial investment in rural training initiatives and increasing engagement with universities and postgraduate training providers delivering targeted government programs designed to achieve health workforce outcomes.

Students play an important role in the supply of health professionals in rural areas. Increases to allocations of Commonwealth supported medical places over the last ten years have been accompanied by measures to address workforce shortages in rural areas.

By the time current medical graduate numbers are forecast to plateau from 2014 onwards (at around 3,800 a year), Australia will have more than doubled graduates over a decade, and almost tripled graduate numbers since 2001.<sup>65</sup> Similarly, nursing graduates will have increased from just over 5,000 annually to almost 10,000 in the same period (including international students),<sup>66</sup> with similar expansions occurring in the dentistry and allied health disciplines.

Ensuring that this growth in graduates flows through to improvements in workforce distribution is a key challenge which has attracted considerable effort and government investment. Over \$820 million has been allocated towards health education initiatives (excluding scholarships) over the forward estimates, representing the largest ongoing component of the Health Workforce Fund.

The main strategies used to influence health professionals in such a way as to achieve supply and distribution outcomes centre on the professional entry education

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<sup>65</sup> Medical Training Review Panel Fifteenth Report, Commonwealth of Australia, 2012

<sup>66</sup> Department of Health and Ageing, analysis of data from Department of Education, Employment and Workplace Relations 2011, February 2012

stage. Policy and programs targeted at this period are based on evidence which suggests that students who: (1) come from a rural background and/or (2) spend time training in a rural setting will be more likely to pursue a rural career upon qualification.

Targeted investments in rural medical education initiatives aim to increase the proportion of rural students entering university to study medicine and to provide opportunities for large numbers of medical students to undertake extended rural training placements.

A number of stakeholders are now seeking to build on these initiatives by establishing medical school courses either fully located in rural and regional areas, or providing a substantial component of training outside major metropolitan areas.

There have also been substantial investments in prevocational and vocational training for doctors, which have been designed to increase training capacity and expand medical education into new areas such as primary care, rural hospitals and private health care settings. In particular, vocational training for GPs is structured to a large extent to help achieve supply and distribution outcomes, with incentives (many linked to Medicare access) available to encourage rural practice.

Measures for nursing and allied health education designed to affect workforce supply and distribution are not as well developed. In part, this is because the Commonwealth historically has had a far less direct role in the employment and funding of these categories of the workforce. Allied health, dentistry and nursing stakeholders are calling for substantial new investment in training in their disciplines, both on equity grounds and to address predicted shortfalls in the rural workforce.

Government influence on supply and distribution begins with student selection. The most important supply control is the cap placed on Commonwealth supported medical places in Australian universities. This cap is intended to maintain control of the medical training pipeline in order to manage the number of medical graduates seeking internships, generally in the public health system. This cap is controlled by the Minister for Tertiary Education and the Department of Industry, Innovation, Climate Change, Science, Research and Tertiary Education (DIICCS RTE), which regularly seeks advice from the Department of Health and Ageing (DoHA) on medical student numbers.

Most Australian medical schools receive Government funds under the Rural Clinical Training and Support (RCTS) program. The RCTS program provides recurrent funding (supported by capital funding, now provided from other Commonwealth sources) to establish clinical training schools in rural areas. The program provides targeted funding to participating Australian medical schools in a number of key areas including: rural student selection; the enhancement of support systems for students and rural medical educators; and the provision of structured rural placements for all Australian medical students.

Since 2009-10 the RCTS program has been a component initiative within the larger Rural Health Multidisciplinary Training (RHMT) program, which is part of the Health Workforce Fund.



**Box 4.1: Rural Health Multidisciplinary Training (RHMT) program**

The component initiatives of the RHMT program are currently:

- The Rural Clinical Training and Support (RCTS) program;\*
- The University Departments of Rural Health (UDRH) program;
- The Dental Training Expanding Rural Placements (DTERP) program; and
- The John Flynn Placements Program (JFPP).

\*The RCTS program, which commenced on 1 July 2011, is the result of a merger between the previous Rural Clinical School (RCS) and Rural Undergraduate Support and Coordination (RUSC) programs.

The RCTS program targets include the following requirements: 25% of Australian medical students are to undertake a minimum of one year of their clinical training in a rural area (defined as ASGC-RA 2–5) by the time they graduate; 25% of Commonwealth supported medical students are to be recruited from a rural background; and all Commonwealth supported medical students must undertake at least four weeks of structured residential rural placement in an ASGC-RA 2–5 region. There are currently 17 universities participating in the RCTS program.

There is debate about the effectiveness of the 25% rural origin target in influencing workforce distribution, with some studies suggesting students from a rural background are up to three times more likely than urban students to become rural doctors, while others have suggested this factor has only limited impact on career choice.<sup>67</sup> The demographic profile of the student cohort examined in these studies appears to have had some impact on the results, with older cohorts of graduate entry medical schools less likely to show rural origin as a factor in ultimate choice of practice location. Regardless, evidence continues to show the importance of rural origin as a predictor of career choice in many cases, and it is suggested that this 25% target should remain in place and be closely monitored.

The recent Senate Community Affairs Reference Committee inquiry into the *Factors affecting the supply of health services and medical professionals in rural areas* recommended that the definition used for the RCTS program should be tightened on one hand, while adding a classification to measure ‘rural mindedness’ on the other, the latter to enable urban students to access preferential rural entry schemes at medical schools.<sup>68</sup> While the intent of such a recommendation is laudable, measuring how “rurally inclined” a particular student may be seems to be a highly problematic concept which would potentially be open to gaming by students who are participating in a highly competitive process. While there could be merit in tightening the data definitions currently used for this target, there are also risks and potential costs in terms of upgrading existing data collection systems used by medical schools.

At this stage it is suggested that the key focus should be on ensuring all medical schools have strategies in place to achieve the current target, noting that in 2011 six of the 17 medical schools participating in the RCTS program appear to have failed to

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<sup>67</sup> Department of Health and Ageing, *What evidence is there that increasing rural origin admissions and undergraduate rural exposure produces more rural doctors?* Literature Review, 2008

<sup>68</sup> Senate Community Affairs Reference Committee, *The factors affecting the supply of health services and medical professionals in rural areas*, Commonwealth of Australia, August 2012

achieve their 25% quota.<sup>69</sup> Overall however, the yearly national intake across Australia is around 25%, with 23.6% of domestic medical students reported as having a rural background in 2011.<sup>70</sup> RCTS preliminary program data indicates that almost all participating universities have met this requirement in 2012 and that the national average is above the 25% quota.

Evidence captured by monitoring student exam results and evaluation surveys suggests that rural placements have the potential to provide a better learning experience than that of the urban campus, due to the close contact between student and supervisor in the rural setting.<sup>71</sup> Such placements are in high demand among students and it is important to note that recent studies by the University of New South Wales, Sydney University, Flinders University and the University of Western Australia appear to show strong linkages between students completing long-term rural placements and the choice of a rural postgraduate training pathway. The University of Queensland has also undertaken a ten year longitudinal study into its rural training program, which has demonstrated that around 40% of graduates were currently working in non-urban locations.<sup>72</sup>

Despite these useful studies, the RCTS program would benefit from an enhanced evidence base and a more consistent and systematic approach to monitoring rural career choices of participating students. There are many cases of experiences in rural clinical schools leading to a career in rural medicine, as well as some regionally based outcome evaluations conducted by individual universities, but long-term data is not yet available for large numbers of graduates at the national level.

The nature of the RCTS program has led to some positive outcomes in terms of increased rural health service delivery. It has also encouraged innovative models of education which are tailored to the unique communities in which they are delivered.

### Box 4.2: Case study of an innovative rural teaching model

The University of Melbourne – Shepparton Medical Centre opened in 2011. This is the first primary care based purpose built teaching facility in Australia and is an extension of the University's Rural Clinical School (RCS) and University Department of Rural Health (UDRH) facilities in Shepparton. It is designed to optimise active student learning and interactions between general practitioners, allied health professionals and specialists working in the centre. Facilities include individual consulting rooms for medical students and registrars, a well-equipped teaching room ('student hub'), and procedure rooms. GPs, medical students and registrars are scheduled to enable access to Grand Rounds<sup>73</sup> and are encouraged to participate in the academic and professional development activities which regularly take place on site. The medical centre appears to be an innovative rural health teaching model which increases clinical rural health service delivery, as well as student training.

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<sup>69</sup> MTRP Fifteenth Report, Table 2.12

<sup>70</sup> *ibid.*

<sup>71</sup> RCTS program consolidated reporting data, Department of Health and Ageing

<sup>72</sup> Eley et al, "A decade of Australian Rural Clinical School graduates – where are they and why?", *International Electronic Journal of Rural and Remote Health Research*, 2012

<sup>73</sup> **Grand Rounds** are an important teaching tool and ritual of medical education and inpatient care, consisting of presenting the medical problems and treatment of a particular patient to an audience consisting of doctors, residents and medical students.

A consistent theme in recent studies of the RCTS program has been the suggestion that longer placements generate better outcomes than those conducted over a shorter period. A recently published study by Playford and Cheong, through the University of Western Australia, suggested that the “longer students are supervised in rural settings, the better.”<sup>74</sup>

The primary barrier to achieving longer placements appears to be the mandatory nature of the current RCTS program target, requiring all domestic medical students to complete at least four weeks of rural placement. Feedback from stakeholders, backed by the various academic studies, suggests that requiring all students to undertake a rural placement when some will have no interest whatsoever in rural health is counterproductive and only serves to place unnecessary strain on rural clinical training capacity.

Short term rural placements may have value as an introduction to further rural training, provided the students are willing. Later-year elective placements in remote areas and Aboriginal and Torres Strait islander communities also appear to be effective, provided students are well prepared in terms of cultural competency and have well supported access to clinical training. Considerable efficiencies could be introduced to the RCTS initiative by removing the mandatory nature of multitudes of short-term placements and, instead, focusing resources on quality longer placements for students with a demonstrated interest in rural health, as well as focusing on better coordination with other sectors of the training pipeline.

Notwithstanding the above, voluntary schemes such as the John Flynn Placement Program (JFPP) have demonstrated that non-compulsory short-term options for rural training are popular with students. At present 1,200 students participate in the JFPP each year, with placements conducted primarily during the university vacation periods. Selected medical students are placed into a rural community for two weeks per year for four years to encourage engagement with the local community and to allow the student to experience life as a rural doctor. The program is defined less around the clinical aspects of being a practitioner in a rural area and more about the lifestyle and community opportunities which being a doctor in such a community can offer.

The JFPP placements in this sense are quite different to other university placements funded under the RHMT program in their focus on community experiences. Program outcomes data suggests that this initiative is having a positive impact and is a valuable, complementary strategy to the rurally based clinical training under the RCTS program. There may be the potential for administrative efficiencies, through aligning the management of the RCTS program and JFPP and it is suggested that the universities (through existing UDRH and RCTS networks) should have the opportunity to collectively tender for the management of the JFPP which is currently under the auspices of ACRRM.<sup>75</sup> However, it is recommended that the program should be maintained as a separate funding stream within the larger RHMT initiative.

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<sup>74</sup> D Playford, D and E Cheong, “Rural Undergraduate Support and Coordination, Rural Clinical School, and Rural Australian Medical Undergraduate Scholarship: rural undergraduate initiatives and subsequent rural medical workforce”, *Australian Health Review*, 2012

<sup>75</sup> The Royal Australian College of General Practitioners (RACGP), which has a large rural doctor membership, has also expressed interest in being able to submit a new tender for the administration of the program.

University management of all components of the RHMT program could address the lack of consistency across programs and training pathways at the undergraduate level. Such inconsistency can currently result in discrepancies in the degree of access students have to sufficient, high-quality training experience in rural areas – compromising the intent of the RHMT program. That is, payments to supervisors under the JFPP may be undermining goodwill that UDRH placements rely upon in delivering placements without direct financial incentives. Both ACRRM and the universities are competing to secure placements for their students in a limited pool of rural supervision resources. Removal of the four-week clinical placement requirement from the RCTS program may also reduce the pressure on supervisor capacity in this domain.

The University Departments of Rural Health (UDRH) Program establishes a university presence in rural areas and offers clinical training opportunities for medical, nursing and allied health students and offers research and educational opportunities for students and health professionals in rural areas. There are 11 UDRHs nationally, funded as part of the larger RHMT program.

UDRHs are managed under funding agreements with a single host university, but often support student placements from multiple universities. The Combined Universities Centre for Rural Health in Geraldton, for example, has partnership arrangements with six different tertiary education providers in Western Australia. These partnerships are effective ways of meeting the needs of a broad range of students, but can be complex to manage and bring associated costs.

Feedback from stakeholders, as well as the analysis of program performance to date, suggests that the network of multidisciplinary UDRHs has significant potential to provide enhanced education services including in areas such as re-entry courses for rural and remote nurses seeking to re-start their professional careers and in other postgraduate training fields. This is detailed further in Chapter 7 on nursing workforce development.

However, UDRHs have argued for many years that funding restrictions inhibit their ability to provide a greater range of training and educational support services. The geographic scope of the UDRH network is limited, with only one UDRH covering all of WA and areas of other states including southern NSW, southern QLD and the Riverland region in SA not benefiting from a UDRH presence. While some UDRHs have accessed HWA funding, this has not been consistent across the network.

Once again, many examples exist of students choosing a rural career on the strength of an experience at a UDRH but long-term data do not yet exist. As outlined below, the majority of UDRH placements are fairly short-term in nature and it is likely that some universities are using their UDRHs as coordinating institutions to meet the mandatory rural placements targets for medical students. This may not be the best use of precious UDRH resources.

A related benefit of both the RCTS program and the UDRH program is the infrastructure support they provide to rural centres and their ability to reduce professional isolation. The work of the Mount Isa Centre for Rural and Remote Health is an excellent example of this, providing a focus for local recruitment and training, particularly of Aboriginal and Torres Strait Islander staff, and providing noneconomic incentives for health professionals, including medical staff, to live and work in the district. These are important centres and provide many benefits to the

towns in which they are established. The programs have been supported by significant Government capital works investments in rural areas, which provide teaching and office space, clinical rooms, student and staff accommodation, libraries and laboratories.

Nevertheless there is a continuing need for multidisciplinary student accommodation to support rural placements which are a key strategy to overcome rural workforce shortages long term. Current accommodation limits for students undertaking placements remain as a barrier to achieving program targets and while a total of 530 beds for students and staff are provided through the UDRH network, this is not sufficient to cover the needs of the large numbers of participating students.<sup>76</sup> For example, there are particular issues in sourcing adequate accommodation in Mt Isa due to the impact of the mining boom on the local property market.

RCTS placements also impact on the availability of reasonably priced hospital accommodation as many universities have contracts with hospitals for their accommodation, which gives preference to RCTS students. However, students from one discipline should not need to be prioritised over others due to space restrictions. Insufficient reasonably priced options can currently result in accommodation budgets being exceeded where demand outstrips supply, such as during the JFPP/RCTS placement cross-over periods. Further, there is a risk that the current lack of a designated funding source for investments in new capital projects is limiting the capacity of universities to support clinical training placements.

The RCS and UDRH programs were evaluated in 2008 by Urbis Pty Ltd, with generally positive findings in terms of their ability to meet key program targets and their potential to provide a positive impact on rural workforce distribution, both in terms of attraction of new professionals and the retention of existing staff.<sup>77</sup> This evaluation did raise a number of challenges for these programs in achieving their ultimate workforce aims, some of which are discussed below.

There are many similarities between the RCTS and UDRH programs and it has often been suggested that the two programs should be merged to create a more integrated and multidisciplinary rural training platform. Some universities, such as Melbourne, Newcastle and Monash, have effectively already integrated their RCSs and UDRHs, primarily because of the physical co-location of the two programs. However some medical schools (University of Queensland, University of New South Wales, and the University of Notre Dame) do not have a UDRH and may struggle to meet combined program targets without substantial additional funding.

There is also a view amongst some UDRH stakeholders that the multidisciplinary nature of their program could be lost to a focus on medical training if the program was integrated with the RCTS. Nevertheless, there could be administrative savings from further consolidation. This should be considered on a case-by-case basis and supported where stakeholders agree on the potential benefits.

In particular, research activity between the RCTS and UDRH programs appears to be an area in which there are significant opportunities to benefit from economies of scale and the expertise of a wider group of research-minded rural professionals.

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<sup>76</sup> UDRH Program Consolidated Reporting data, Department of Health and Ageing, 2012

<sup>77</sup> Urbis Pty Ltd, *Evaluation of the University Departments of Rural Health Program and the Rural Clinical Schools Program*, report prepared for the Department of Health and Ageing, 2008



Rural health research is included in the parameters/objectives of both programs, yet there is no national strategy to coordinate these efforts and the selection of new projects for research investment appears to be quite ad hoc. More core funding appears to be spent on research by the UDRHs, and some units have significant and internationally recognised expertise in this area. Notwithstanding this, some research funded under both programs has been described as boutique in nature, with limited value in terms of developing evidence-based national workforce development programs.

The Australian Rural Health Education Network (ARHEN) has developed an informal 'Research Leaders Network' within the UDRH program, which has the potential to provide a greater focus for collaborative work across different sites. Objectives of the network include promotion of UDRH research activity and uptake of findings by government across the rural health sector, facilitation of collaborative research interests (potentially via publication on the ARHEN website), developing future research capacity within the UDRH network and building research leadership in rural health scholarship. The network may take a leading role in identifying potential research projects, gaps and issues in the health and education field.

It is recommended that the ARHEN network, in consultation with individual UDRHs, is the ideal platform to reach agreement on an appropriate maximum proportion of the UDRH's core operational grant to be committed to research. Further, support from this network, in the form of rural health research stewardship, should also serve to produce a more coherent, better directed body of work in this area. Without leadership of this kind, there is the potential risk that investment in research is reducing the focus on multidisciplinary training. It is important that a consensus is reached with stakeholders on the right balance between training and research activities in the context of limited UDRH budgets.

### Rural education strategies for allied health

At present, the UDRHs are very active in coordinating rural clinical placements for allied health students, with pharmacy, physiotherapy, dentistry, occupational therapy, dietetics and oral hygiene students among those regularly placed. A number of UDRHs, such as the Broken Hill UDRH, have recently pioneered a new service learning model aimed at strengthening clinical training.

The model is based on the principles of improving community access to health care while providing enhanced student learning, and involves students providing services to patients under supervision in carefully controlled clinical environments. The model therefore has the potential to increase the capacity of a region to support more students on clinical placements while delivering necessary services to underserved population groups.

The following case study provided by ARHEN describes the service learning model.

Key features of this model include:

- redesigning the short-term UDRH student placements to accept groups of students from different disciplines for extended placements (e.g. six to eight students from a feeder university for periods between 6 to 12 weeks and longer);
- consulting with local communities and regionally based service providers about their key health issues and creating placement opportunities in both health and



other sectors, including school education, aged care and disability services, and welfare agencies; and

- negotiating with parent universities to align their educational objectives with the service learning and placement opportunities identified locally.

### Box 4.3: Case study – Broken Hill Allied Health in Primary Schools Program

The progressive development of service learning models has occurred in Broken Hill and region primary schools since 2008, in response to community concern about lack of access to allied health services.

The objectives of the service learning program are to:

- Provide students a high quality clinical educational experience and improve child development and family well-being for Broken Hill and region residents;
- Increase the clinical training opportunities for health students in the Broken Hill region;
- Provide accessible, high quality community-orientated health services in a socio-economically disadvantaged and underserved community through student service learning models; and
- Consolidate existing partnerships across school education, health, tertiary education, local council, and community.

Lessons learned through the pilot phase of the program with speech pathology and its expansion to include disciplines of occupational therapy, physiotherapy, dietetics and orthotics now provides a strong platform for further progression of this model. The program evaluation, which includes both formal and informal feedback from health students, is extremely positive.

Community benefits include comprehensive multi-professional health screening, assessment, intervention and referral in the areas of speech and language, fine and gross motor skills, growth, diet, overweight and obesity, vision and optic nerve and muscle development, for all children entering primary school. The acquisition of new skills and knowledge for teaching staff in the role and activities of allied health professionals has also further enhanced the development of sustainable interventions and builds social capital.

Summary table: Student numbers – Broken Hill Allied Health in Primary Schools Program

	2009	2010	2011	2012*
<i>Discipline</i>	No. (wks)	No. (wks)	No. (wks)	No. (wks)
Speech pathology	3 (18)	12 (72)	18 (108)	24 (144)
Occupational therapy	5 (35)	4 (28)	16 (112)	24 (168)
Physiotherapy	3 (15)	4 (20)	8 (40)	15 (75)
Orthoptics	--	--	6 (24)	6 (24)
Dietetics	--	--	4 (24)	12 (48)
Exercise physiology	--	--	--	12 (48)
Total	11 (68)	20 (120)	52 (308)	93 (507)

\* Planned numbers for 2012

Appropriate supervision and a supporting environment is a crucial part of this model to offset any impact this may have on local clinicians and service organisations.

The need to enhance supervision support has cost implications for UDRHs pursuing this more comprehensive placements model. Nevertheless, further adoption of this training model has the potential to enhance outcomes for nursing, dentistry and allied health training delivery in rural and remote areas and warrants further investigation.

It has also been suggested that universities participating in the RCTS program could play a greater role in supporting multidisciplinary training. This would substantially expand the rural training network and cover a greater geographic area than currently supported by the network of 11 UDRHs. While there would be major cost implications if the RCTS model were to be genuinely applied across allied health and nursing, at the very least the rural infrastructure supporting the 17 universities participating in the RCTS program (both in terms of physical, intellectual and social capital) should be leveraged to support training for other disciplines beyond medicine.

The RCTS program parameters currently provide that universities should:

*“...provide support for the development of multidisciplinary training placements and the provision of interdisciplinary learning opportunities for students (most likely through the provision of access to physical training facilities, placement coordination services and access to established rural community support networks).”<sup>78</sup>*

Access to placement support and facilities could be particularly beneficial for allied health students undertaking regional placements. Program reporting information suggests that some universities have begun to adopt a more multidisciplinary focus, but that achievements have been variable and hard data on the level of support provided is not consistently available. This issue warrants further exploration in discussion with universities. This is one area where greater integration between the RCTS and UDRH initiatives could be particularly beneficial.

The following table outlines UDRH placement support activity across the health disciplines in 2011.

*Table 4.1: UDRH support activity*

	Placements of 2 weeks duration or more	Total weeks of student training	Average placement period (weeks)
Undergrad – medicine	1,016	4,014	4
Undergrad – nursing	1,874	6,481	3.5
Undergrad – allied	1,389	9,291	6.7
Undergrad – total	4,279	19,786	4.6
Postgrad – total	320	2,728	8.5

Source: UDRH Program, Consolidated Reporting data, Department of Health and Ageing, 2011.

<sup>78</sup> Department of Health and Ageing, *Rural Clinical Training and Support (RCTS) – 2011–2014 Operational Framework*, DoHA, 2012, p. 14

While this placement support function represents a significant level of activity, to date most UDRHs have primarily focused on short-term placements, involving linking nursing and allied health students with local clinicians and health services in a coordinating role. While these placements provide students with valuable exposure to the realities of rural health service provision, as outlined above, recent research has suggested that placements of a longer duration (eight weeks or more) are more likely to generate sustained interest in rural careers.<sup>79</sup> It is likely that these findings will apply equally to placements in nursing and allied health.

While investments targeted at university level are essential, it would be remiss to ignore the fact that higher education pathways do not begin only when students commence tertiary education. In fact, choice of future career path often starts with information and options available to students in the later years of their secondary education. It has been argued that, in general there is not a strong level of encouragement and resourcing for school leavers to take up an allied health career. However the choices for rural students are arguably better in this area given that more universities offer allied health courses in rural regions and, once accepted, there is some support for rural allied health students while at rural universities.

It has also been suggested that current university rural origin entry targets for medicine should be extended to the allied health disciplines. The 25% target was originally introduced in medicine as it sought to align with the estimated rural population level at the time. The concept has some merit, given the evidence linking rural career choice to rural origin. However, because of the high numbers of allied health courses and the large number of allied health and nursing students in the tertiary education sector, the costs of pursuing, monitoring and administering such a target could be significant. It is also more difficult to monitor targets in terms of student numbers due to the demand-driven funding model for non-medical Commonwealth supported places (CSPs).

If this option were to be pursued the likely costs would need to be quantified and discussed in detail with relevant universities to determine what implementation arrangements would be needed in order to make targets achievable. Consultation with the Education Portfolio would also be necessary. Further, it should be noted that a 25% target across such a diverse study body may not be appropriate in all cases and this will need to be considered in the context of administration costs and the capacity of universities to recruit rural students in these proportions.

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<sup>79</sup> D Playford and E Cheong, "Rural Undergraduate Support and Coordination, Rural Clinical School, and Rural Australian Medical Undergraduate Scholarship: rural undergraduate initiatives and subsequent rural medical workforce", *Australian Health Review*, 2012. See also A Smedts and M Lowe, "Efficiency of clinical training at the Northern Territory Clinical School: placement length and rate of return for internship", *Medical Journal of Australia*, 189(3), 2008, pp. 166-168.

### Current proposals for new and expanded medical schools

One recommendation from the recent Senate Community Affairs Committee inquiry was that: "...the Commonwealth government explore options to provide incentives to encourage medical students to study at regional universities offering an undergraduate medical course".<sup>80</sup>

While incentives to encourage medical students to attend rural universities are certainly consistent with the view that time spent training in rural areas encourages the uptake of a rural career, there are few universities teaching whole medical courses in what could be considered rural areas, generally extending from a major regional centre out to surrounding areas:

- James Cook University (Townsville);
- the University of Newcastle and the University of New England (Tamworth and Armidale);
- Deakin University (Geelong); and
- the University of Wollongong (Wollongong).

Medical places at those universities are already in high demand and appear likely to be filled irrespective of whether an incentive exists for students to attend, so this recommendation has very limited application.

Existing rurally based medical schools are well established and have been operating over-subscribed training programs for a number of years. However, there have been proposals in recent years seeking support for the establishment of new rural medical schools.

#### Box 4.4: Case study – proposal for a new rural medical school

Charles Sturt University has proposed the establishment of a new rural medical school with 80 commencing CSPs in a six year undergraduate medical program. The first intake would be scheduled for two years after initial construction commences. Under the Charles Sturt University proposal, up to 60% of entering medical students would be from a rural background. The proposal suggests that under this model more graduating medical students will be attracted to careers as rural doctors because they will receive all their undergraduate training in rural areas and will be able to maintain connections to rural communities.

To date, proposals for new medical schools have not been supported by the Government, primarily on the basis that sufficient clinical training capacity does not exist to accommodate new CSPs in medicine. This position recognises feedback from medical education stakeholders that training capacity at the undergraduate and prevocational training levels is currently under severe pressure due to the rapid expansion of medical school places over the last decade. The potential benefits to rural and regional areas of having a medical school based in those locations has not necessarily been contested, but the timing of proposals during a period where all medical school places have expanded rapidly appears to be a major issue.

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<sup>80</sup> Senate Community Affairs Reference Committee, *The factors affecting the supply of health services and medical professionals in rural areas*, Commonwealth of Australia, August 2012, Recommendation 11, p. xvi

The growth in medical student numbers during the past ten years has placed significant stress on the clinical training systems which caters to both university students (who typically spend the final two years of their degree in clinical environments) and interns. Beyond the internship years, the medical training pipeline remains constricted because access to specialist training is also limited.

The medical training pipeline begins to narrow when medical students begin their clinical training years and remains narrow through to the completion of specialty training. Until the future of the medical training pipeline becomes clearer, for example through the planning work being undertaken by HWA,<sup>81</sup> it is likely that the Commonwealth will find it difficult to support any increases in medical CSPs. It has been argued that new CSP approvals will not create a demand on clinical training for some years and are required now because the growth in medical graduates declines after 2015. Critics of the proposal respond that:

- clinical training capacity may remain tight for many years and may become even tighter in some jurisdictions due to financial constraints; and
- the expansion of clinical training capacity in many jurisdictions may not keep pace with the expected growth in graduates to 2015, meaning that some jurisdictions may take several years to be able to provide training opportunities for the current number of expected graduates.

While there is a growing body of evidence to suggest that extending rural training experiences for as long as possible could enhance workforce outcomes, it is unlikely that existing programs would be able to continue to operate sustainably if any new medical schools are established in the short to medium term. This would have flow on implications for the ability of these current medical schools to support clinical training needs for existing CSPs.

Yet, evidence does indicate that current rural programs are having the desired impact despite containing metropolitan training components. The University of Sydney, in its submission to this review process, has pointed to promising signs with approximately 20% of graduates from their rural program taking up rural postgraduate training positions, where they are available.<sup>82</sup> Further time and evaluation is needed to determine the true strength of arguments from both sides.

Rather than the cost and other pressures of entirely new medical schools, some stakeholders have made requests for support of other innovative education and training models based on enhancing existing training programs to provide longer rural training experiences. Each of these models would require significant upfront and recurrent funding. However, there is some merit in these proposals and they are worthy of further consideration and possible testing in the mix of different education and training models. The following two case studies outline the proposed approaches to expanding existing medical school programs.

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<sup>81</sup> Including the clinical training plans it is envisaged will be produced by the National Medical Training Advisory Network (NMTAN) which is currently being established by HWA.

<sup>82</sup> University of Sydney, Submission to the Review of Australian Government Health Workforce Programs, 2012

### Box 4.5: Case study – University of Sydney

The University of Sydney proposed expansion of the School of Rural Health:

- would be located in Dubbo and Orange (where the current Rural Clinical School is located) with the University Department of Rural Health sites at Lismore and Broken Hill also becoming part of a new consolidated Rural Health School network;
- would be a 4-year graduate-entry program enrolling 35 students of the university's yearly allocation of 228 CSPs;
- would be designed to provide multidisciplinary education, with nursing and allied health students using the facilities as well (although it will predominantly cater for medical students);
- would require significant, but currently unquantified, capital investment: the university intends a major building adjacent to the Rural Clinical School in Dubbo and a multi-purpose facility in Broken Hill as well as accommodation in Dubbo and Orange; and
- would enrol full-fee paying overseas students, although the final number is not known.

### Box 4.6: Case study – Flinders University

The Department currently funds the Flinders University Northern Territory Medical Program which enables medical students to complete an entire medical degree without having to leave the Northern Territory. The NT Medical Program is designed specifically for the NT, recruiting students from within the NT and establishing mechanisms to prepare students to work as doctors in small remote Australian communities and to encourage the recruitment of Indigenous and non-Indigenous students from Central Australia. The program therefore, has the potential to provide a viable workforce for the NT, addressing local health workforce shortages and doctor retention.

The Centre for Remote Health, a joint centre of Flinders University and Charles Darwin University, is seeking to extend the NT Medical Program to Central Australia through a cohort of eight students for each of the four years of the Graduate Entry Medical Program. The eight students would be drawn from Alice Springs and the Central Australia region, using industry-sponsored places rather than new CSPs, as per the current NT Medical Program model. The expansion would train students in a generalist model of care integrating primary health care and multidisciplinary practice.

Such proposals have merit in terms of the potential outcomes that could be generated by offering students a comprehensive rural medical education experience. Recurrent funds from the existing RCTS program grant could be used to contribute some funding support for these sorts of proposals. Existing infrastructure and training networks could be leveraged to support student training. This type of model has the potential to be significantly more cost-effective than establishing a new rurally based medical school. Detailed scrutiny of the costing model for this type of proposal is required to ensure value for money. It is not suggested though that any support should involve new CSPs, in keeping with current policy settings and the acknowledged pressure on health system clinical training capacity.

### Rural training pathway – post university

Training doctors in rural areas is a key part of the strategy to ensure that there is a measurable increase in the supply of health services to communities in the long term. However, the appropriate structures do not yet exist to fully integrate and complement all of the education and workforce initiatives developed for this purpose.



All medical graduates need to complete an internship to gain general medical registration. Under current models, the intern year tends to be spent in larger population centres where traditional teaching hospitals are located – rotations in medicine, surgery and emergency medicine are compulsory but not available everywhere. Therefore the ability to influence the distribution of interns is limited by this requirement.

In addition, the employment of interns and junior doctors has previously been the sole responsibility of states and territories (described in more detail in Chapter 3). It has only been fairly recently, with a large increase in medical student numbers, that state and territory governments have been willing to consider expansion of intern training in the private sector, due to the valuable public hospital workforce provided by interns and junior doctors.

The lack of rural internships was one of the major risks identified in the 2008 evaluation of the RCS and UDRH programs to achieving the outcomes of the Government's investment in rural training.<sup>83</sup> This issue was also a predominant discussion point during the Rural Health Education roundtable conducted as part of this review. Exact figures on available intern placements in rural and regional Australia are not known but it is clear that despite the approximately 800 medical students graduating from an RCTS annually, only a small proportion are able to access a rural internship, despite a preference to do so.

Stakeholders have also cited the lack of a clear pathway from undergraduate rural training into employment as a rural doctor (post-fellowship) as a key reason why students who are interested in rural health are regularly lost to the metropolitan health system during this crucial decision point in their career, as they enter paid employment as doctors and commence their vocational training. However, addressing this issue and increasing capacity of the system overall is not dependent only on creating new rural internships in traditional settings.

There could be merit in exploring more structured investments in networked intern places, involving a combination of acute care and primary care training within a range of settings in a particular region (e.g. private, community or Aboriginal Medical Service). This type of approach has the potential to build stronger links between trainees and communities and could be a more cost-effective way of enhancing intern training capacity while continuing to support a focus on training in primary care (for instance, internships funded by the Commonwealth Government could require a rotation in primary or community health care, in addition to the mandatory rotations required by the Medical Board). Recent announcements of Commonwealth funding for private sector intern training positions in a number of jurisdictions have set a precedent for this type of approach.

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<sup>83</sup> Urbis Pty Ltd, *Evaluation of the University Departments of Rural Health Program and the Rural Clinical Schools Program*, 2008

### Box 4.7: Case study – Murray to the Mountains project

A good working model of developing a more integrated approach to training has been established through the Murray to the Mountains project in Victoria. This project provides integrated rural internships supported by a partnership between Northeast Health Wangaratta, Albury Wodonga Health, Bogong Regional Training Network and the University of Melbourne's Rural Health Academic Centre in Shepparton. The program has been developed as part of a long-term strategy to address medical workforce shortage within small rural towns. The model involves an innovative training program based on interns spending the whole year in rural areas, and being based in a general practice for 20 weeks and "rotating in" to the regional hospitals, rather than vice versa. The strength of the system is that it involves both academic support and access to a broad range of health care settings for trainees. The development of this approach demonstrates the effectiveness of regional collaboration and innovative uses of available funding.

At the national level, this new approach could be based on adoption of the successful Specialist Training Program (STP) model, through which health care settings (often through consortia arrangements) apply to support networked training posts involving multiple settings providing different parts of an accredited position. This often involves linkages between the public and private sectors and in many cases is a better reflection of how graduates will work once they finish their training.

Under this type of arrangement the host setting is responsible for negotiating accreditation arrangements, building and maintaining partnerships with other health settings within their training network and then recruiting a suitable registrar to fill the training position. This model is well developed and is currently supporting 750 registrar training positions (growing to 900 by 2014). STP funding is directed to successful applicants through larger agreements between the Department and each specialist college, providing a direct linkage between health care providers and educational institutions.

If each of the current medical training initiatives were functioning to deliver their ideal intended outcomes, the following pathway into careers in rural medicine would exist:



This model recognises that students of urban origin may be equally likely to choose a rural career, if the right training conditions exist to encourage that choice. Equally, it is acknowledged that periods of metropolitan training may be desirable at different points in the continuum to ensure educational quality. Specialist training would include general practice.

Figure 4.1 below demonstrates the integration of networked intern training along the new rural pathway to vocational registration from the student perspective. These arrangements may be of particular interest and benefit to students who are bonded under the current Bonded Medical Places (BMP) and Medical Rural Bonded Scholarship (MRBS) schemes. While it is not possible to quarantine individual training places for named individuals, the availability of such a pathway would simplify the process for those practitioners wishing to study and remain in rural areas. It should be noted that the current state-based systems of intern allocation would require adjustment in response to this approach. Or it may be considered

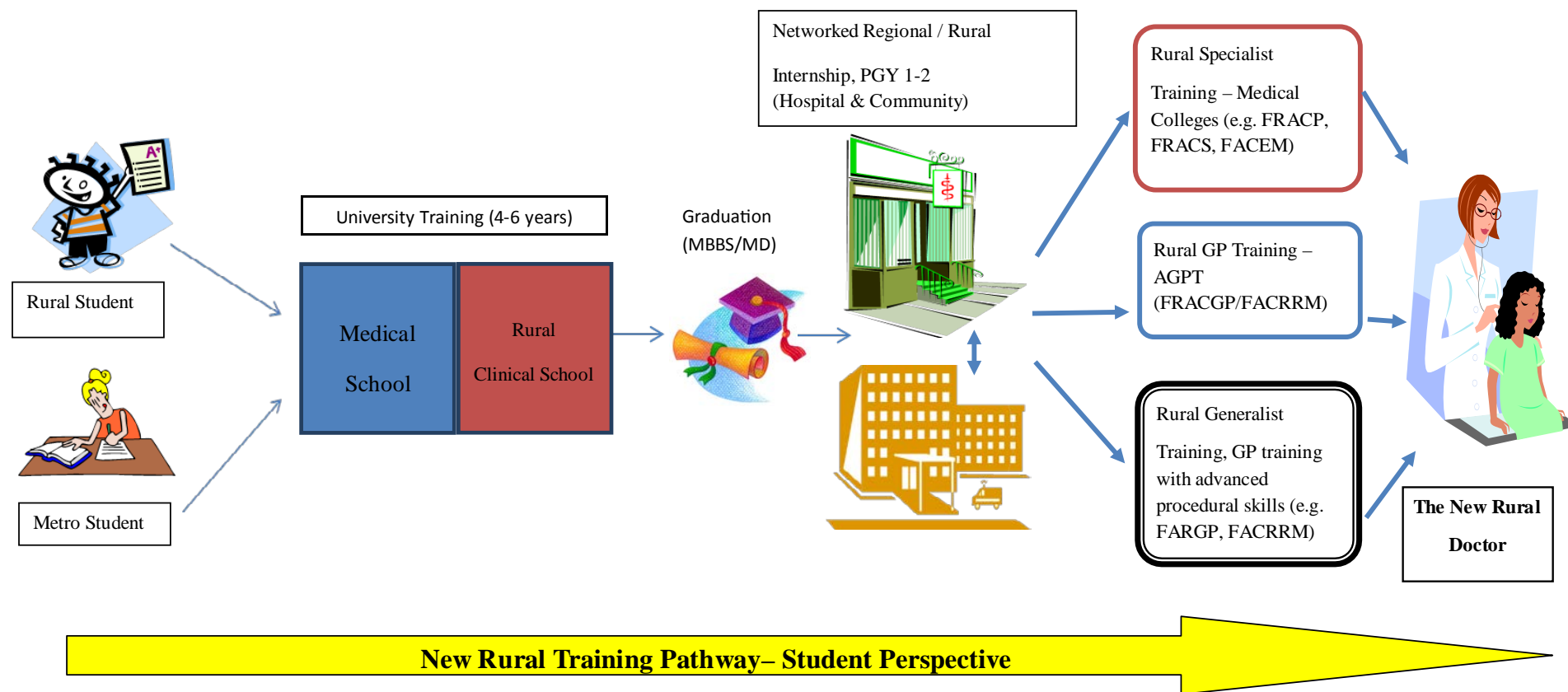
necessary to develop a complementary but discrete application and allocation system for students commencing as interns on the rural pathway if changes to the current systems are not viable.

A rural training pathway already exists for general practice under the AGPT, administered via General Practice Education and Training Limited (GPET). However, as identified above, the missing link is the availability of rurally-based internship positions through which rurally trained medical students can transition directly to vocational GP training.

In the other specialties, this lack of rurally-based intern positions is further hampered by limited rural training opportunities for specialist trainees in pursuit of fellowship of one of the specialist medical colleges. Innovative strategies for supporting rural specialist training have already been trialled via the STP, through which up to 50% of new places are targeted towards rural and regional areas.

Extending this approach to allow settings (such as local health networks or private hospitals) to apply for a combined intern and registrar training position should be possible, although it would require an enhanced level of coordination in the accreditation process between the specialist colleges and the jurisdictional postgraduate medical councils.

Figure 4.1: New rural training pathway from the student perspective



A similar system to the networked intern training described above could be explored for supporting a competitive rural intern application process, with possible extension into the metropolitan private sector (as currently occurs within the STP). Funding arrangements would need to be developed in more detail, with consideration given to whether the existing STP model of providing funding through colleges will be appropriate to support intern training.

In some cases more direct arrangements with health care settings may need to be developed with appropriate administrators and fund holders identified by the Commonwealth. Available evidence indicates that it would not be suitable for the Commonwealth to contract directly with settings. Advice is that such a direct funding approach was attempted in the early stages of the STP implementation but was abandoned in favour of college management due to limited capacity within the Department to administer a large number of contracts of this type. This kind of administrative congestion is also seen currently with the management of contracts for the Medical Rural Bonded Scholarship and Bonded Medical Places schemes within the Department, which are not resourced to ensure effective tracking and are unsustainable in the long term.

Under this new model, rather than facilities applying directly for funding as per the STP, regional training providers, in collaboration with their Local Area Health Network, private hospital and/or Medicare Local would bid for Commonwealth funded training positions. These positions may represent an internship year or they may encompass an ongoing funding commitment across the intern and vocational training years to ensure access to a rural specialist training pathway. Nominated rural hubs would take on the role of primary allocations centres, with rotations *between* rural sites, not out from metropolitan settings.

The importance of contractual security over the long term is vital to the success of this model. Facilities which are recruiting interns and specialist trainees are understandably reluctant to commit to supporting positions in the face of short-term funding only. Anecdotally it is also more difficult to attract individual practitioners to permanently relocate often not only themselves but spouses and children without guarantee of ongoing employment. Subject to performance, a trainee under this proposal could be offered a contract for up to six years, equal to the length of their vocational training. This also provides sustainability for intern positions within the same network which require time intensive supervision, usually provided by registrars tiered under a consultant in a pyramidal supervisory structure.

There is the potential for rural clinical schools to play an academic support and coordination role to assist in this process, providing a link between students, health service providers and medical education providers in rural areas. The likelihood of rural training pathways being successfully developed and maintained depends heavily on collaboration between these multiple organisations with involvement at various stages of training. Regional training providers and associates must also undertake early engagement (ideally facilitated by the local RCTS training coordinator) with the relevant postgraduate medical education council in order to obtain the necessary accreditation.

HWA's Integrated Regional Clinical Training Networks (IRCTNs) could also play an important role in developing these arrangements. With a total of 27 regional networks established, and three broader coordinating IRCTNs in place, the establishment of this new coordination structure presents a significant opportunity.

In 2010, the PricewaterhouseCoopers/Phillips KPA Mapping Clinical Placements report for HWA was hesitant to recommend Medicare Locals as suitable hosts for IRCTNs due to their (at the time) fledgling status.<sup>84</sup> Arguably, their status as independent legal entities, clearly distinguished from the governance of Local Health Networks, makes them suitable for this role. UDRHs and regional training providers of the GPET network share this independent governance model. It may be timely to review the capacity of Medicare Locals and other regional entities to participate in this new rural training pathway model.

Alternatively, the specialist medical colleges and regional training providers already receive administrative funding to manage training places under the STP and AGPT respectively. Given their experience in handling similar arrangements it may be appropriate that they are nominated as fund holders for the model proposed above, with associated economies of scale, given their current funding. In short, funds would flow from the Commonwealth via the specialist colleges and GPET (and/or the two GP colleges) to regional training providers or equivalent who had successfully bid for places with the appropriate accreditation in place. Decisions about the allocation of funds would be solely the prerogative of the Commonwealth.

It must be noted that there are at present no new funds available within the HWF for the new rural training model and all investments will require redirection from other sources. Both the source of funds and the funding requirements at the different stages could be accommodated as per Figure 4.2 below, which provides an example of the way current funding systems could be used to support the development of the proposed rural pathway model.

In cases such as the STP, removal of funds would not be detrimental to the core program but rather would build on existing program components. Under the 2013 STP priority framework, preference was given to applications which could demonstrate the capacity for an individual trainee to complete the majority (>50%) of training requirements for fellowship in an on-going position in a rural/regional/remote or outer metropolitan setting i.e. where there is potential to advance from 1<sup>st</sup> year/basic training to fully qualified. Of 150 selected posts in 2013, at least 50 met this requirement. Incorporating these posts into a larger pool of funding, with the requirement for collaboration between local networks, addresses the limitations of ad hoc funding to individual facilities and promotes sustainable, well supported positions in the long term. While there is some potential to redirect existing funding streams to create a new rural training pathway program, establishing these pathways for large numbers of graduates would be likely to require new investment. Notwithstanding the funding limitations, the potential exists to at least trial the proposed model.

Careful consideration should be given to whether initiatives such as the RCTS and UDRH continue to focus on the original mandate of delivering university medical curriculum only, or expand their scope and capacity, through a link to universities as Centres of Excellence to provide an oversight of students through to vocational training. There is merit, should funds be available, to pilot the funding of a position within the RCS/UDRHs to work with appropriate specialist colleges and jurisdictions to support this training, advocate for internships and vocational training positions and

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<sup>84</sup> Mapping Clinical Placements. Identification of potential Integrated Regional Clinical Training Networks and host organisations. PWC/Phillips KPA December 2010



mentor those students and graduates who are interested in a rural career. These new positions could become a critical linking point in developing regional solutions to the development of better training pathways.

Continued metropolitan training rotations would often be necessary to ensure educational needs are met, but this type of model would enable graduates to remain based in, and retain strong links to, regional areas while completing their full training program. There would be a range of benefits from this type of approach, as follows:

- Much greater certainty for medical graduates interested in pursuing a rural career pathway;
- A more genuine and measurable expansion of intern training capacity that meets the need to distribute the medical workforce more equitably;
- The development of more effective partnerships between primary care and acute care settings in supporting postgraduate training by developing networked training arrangements; and
- Increased access to services for communities, as graduates will treat patients while they train.

Figure 4.3 below outlines how this type of approach could work in practice, detailing the different steps that could be taken in the process of identifying potential training positions, securing accreditation and funding and finally producing a new rural doctor at the end of the process.

This scenario also helps to create an environment where the burden of teaching is reduced for general practitioners and supports them in their role as educators. This needs to be considered in the current environment of increased numbers of student placements and an overstretched existing rural health workforce. Many of our university RCS leaders have advocated that vertical integration, that is, having registrars and medical students together, will promote teaching as an integral part of a clinician's life – the teaching load is shared and the students benefit from the clinical knowledge of the more recent graduates.

Clearly this model would require significant development and consultation across the medical education sector before it could be successfully implemented. However similar reforms have been successful in undergraduate medical education (the RCTS program) and specialist vocational training (the AGPT and STP programs) so there is no reason to suggest that a more structured pathway could not be established to link these different stages of training in rural settings.

Figure 4.2: Proposed funding flow – new rural training pathway program

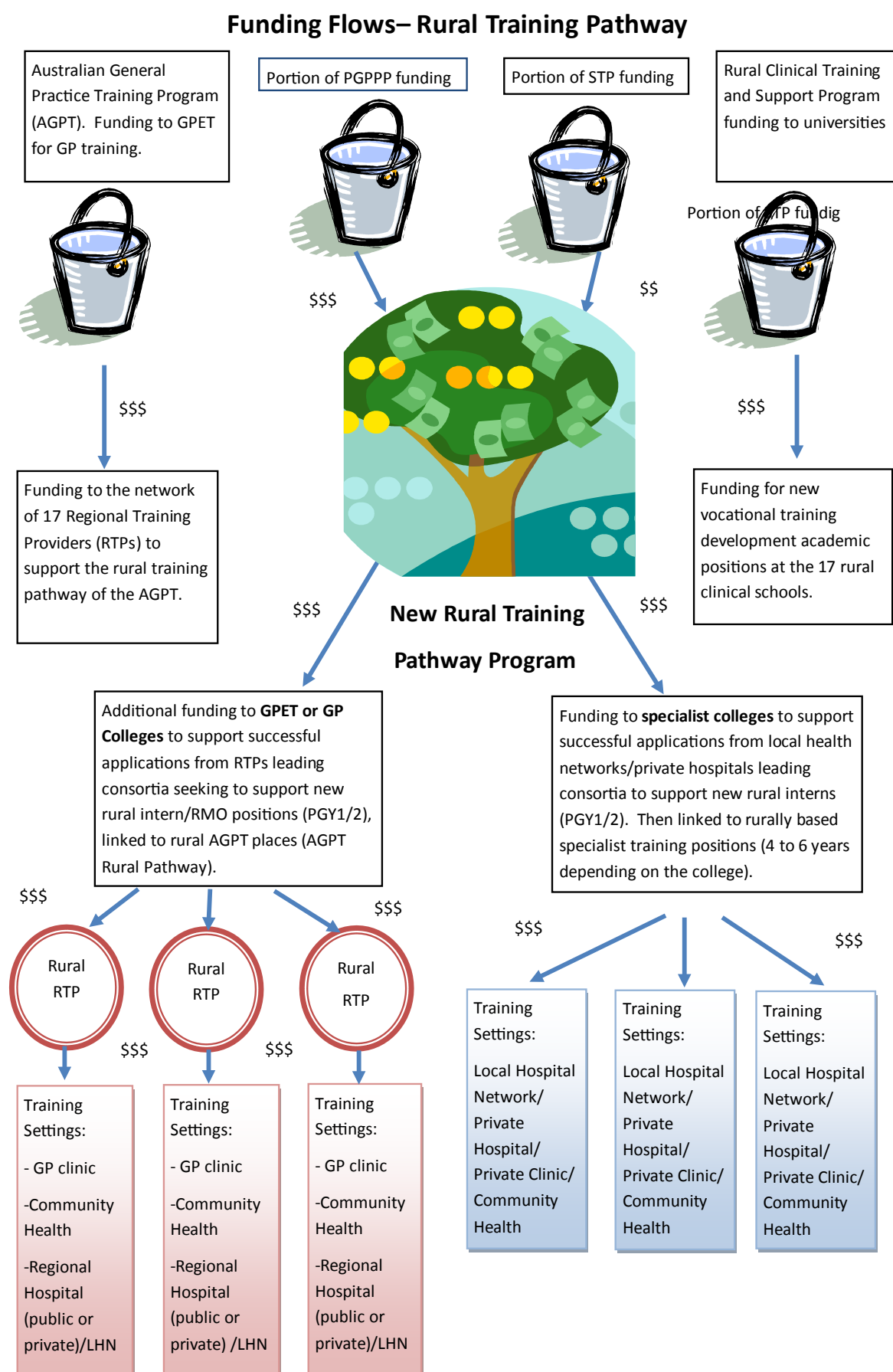
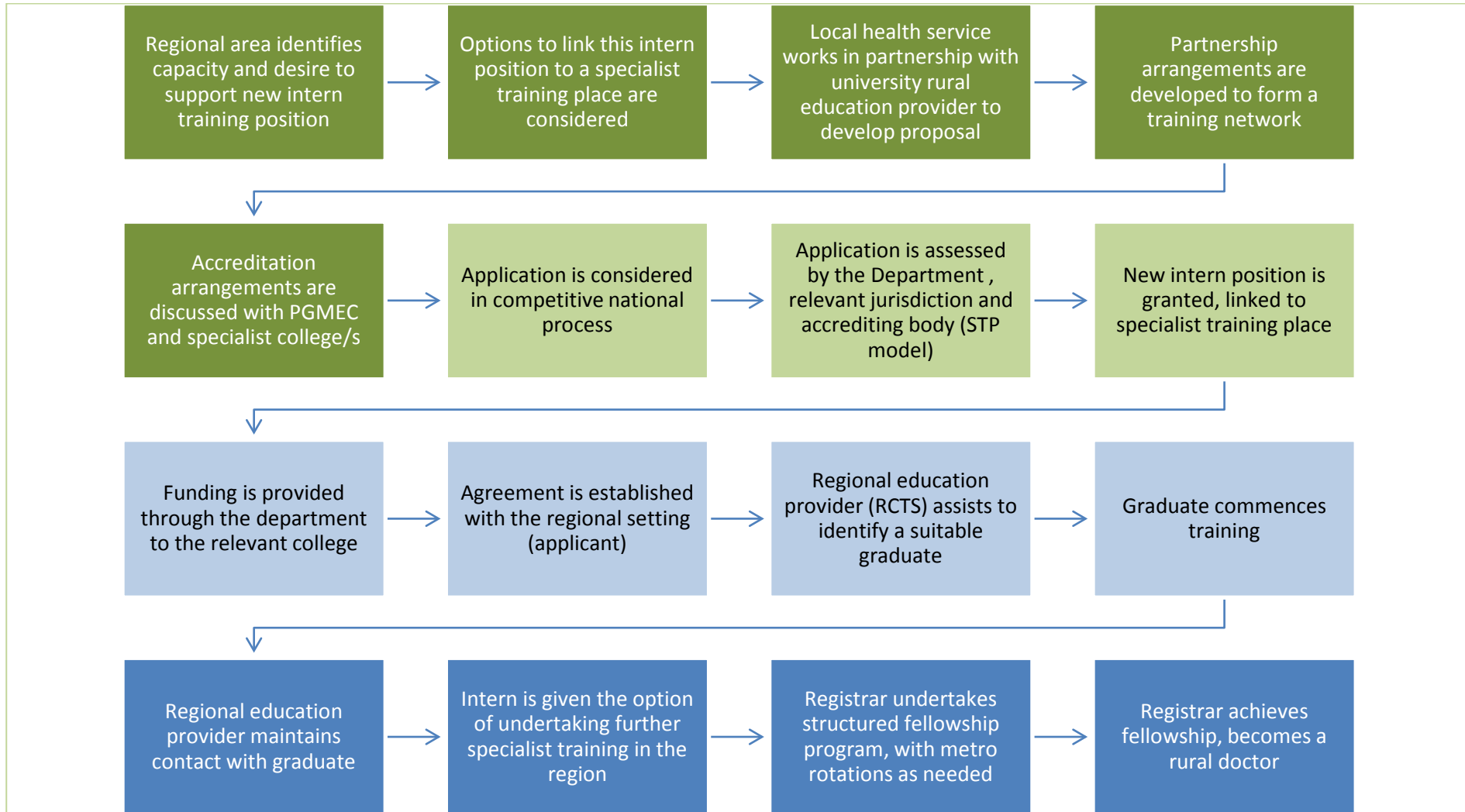


Figure 4.3: Process for establishing a regional training pathway



Under this model, the onus would be on the host settings to negotiate these arrangements at the regional level in order to ensure training quality and sustainability. The model would be particularly applicable to generalist specialist training programs (general practice, general medicine, emergency medicine, psychiatry, general surgery etc). As noted by the Rural Doctors Association of Australia (RDAA) in their 2013-14 Budget submission, a national advanced rural training program (with a strong generalist component) represents one of the most promising ways to ensure patients in rural and remote communities have access to appropriate, high quality care.<sup>85</sup>

Enhancing activity in this area would also address one of the key issues identified in HWA's HW2025 report, that a greater focus on generalist specialty training needs to be encouraged. One initial approach could be a position that works with the Royal Australian College of Physicians, as they are in the process of implementing a number of regionally based pilot projects to explore the concept of a model of dual-trained physicians who will have 'core training in general medicine and further training in an additional specialty'.

This specialty would need to be accommodated within the rural community. However, it makes sense to trial this approach for a university who is receptive, especially when evidence suggests that facilitating the growth of accessible medical specialist services in small communities could lead to reduced hospital admissions, improved quality of life for patients through reduced interactions with the health care system and the development of system-wide savings over time. HWA has recently announced that it is funding a pilot of ten demonstration projects of the dual training model.

Due to the unique nature of rural general practice, the RDAA and other rural health groups have been advocating for a national pathway for rural generalists since 2009. The rural generalist pathway supports junior doctors wishing to pursue a vocationally recognised career as a rural generalist. The pathway provides doctors with the training, skills and qualifications necessary in providing comprehensive health care in rural and remote Australia.

The pathway would focus on the advanced skills required in rural and remote locations, including emergency medicine, obstetrics, surgery, anaesthetics, indigenous health, mental health etc. The proposed rural generalist pathway addresses similar issues to those described above in the discussion around introducing mechanisms to link rural intern training with specialist positions. The key point of difference is that the current rural generalist pathway proposal is exclusively targeted at upskilling GP trainees, as opposed to building a broader specialist generalist approach.

The Government funded a review of the Queensland Health Rural Generalist Pathway in 2010, through Nova Pty Ltd. The review found that the Queensland Health Rural Generalist Pathway has many positive features, and it has been successful in Queensland to date. The report noted it would be challenging to expand the Queensland rural generalist model nationally due to the different structural, policy and industrial conditions in the jurisdictions across the nation.

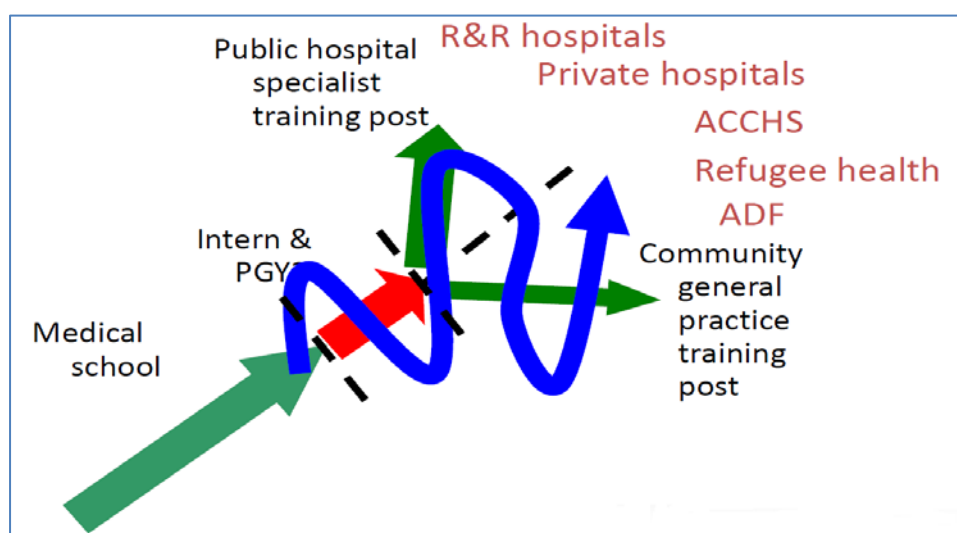
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<sup>85</sup> Rural Doctors Association of Australia. *Federal Budget Submission 2013-14*

In its submission to this review the Australian College of Rural and Remote Medicine (ACRRM) outlined some of the complexities and myriad choices that graduates interested in careers as rural generalist practitioners can currently face in pursuing this career pathway, particularly in those jurisdictions that have not made significant progress in establishing a generalist model.<sup>86</sup>

ACRRM provided the following diagram in its submission to illustrate this situation, described as the:

#### **Rural generalist scenic route**



Nova's 2010 review has been provided to Health Workforce Australia (HWA) for further consideration as part of its broader examination of workforce planning. Once HWA finishes its analysis further work will be required at the Commonwealth level to determine the extent to which national reform and funding support is required to support any proposed new model to build on existing advanced rural skills training options. However, the model described above may provide a platform for a new focus on training both rural generalist specialists and GPs. As shown in Figure 4.2, existing funding programs could be leveraged to provide graduates with more options as they move through the training pathway. This approach could be effective provided current barriers, such as the availability of internships, are addressed.

It is important that the development of rural generalist training pathways and employment arrangements do not focus exclusively on the public sector, but recognise private practice options for rural generalists.

#### **Nursing and allied health rural pathway/funding model**

While it is not possible to compare the education and training requirements for nursing and allied health disciplines to medicine there remains a strong argument to support Commonwealth funding to ensure highly qualified professionals are working in rural areas where they are needed. There are some parallels in that access to Medicare by doctors, nurse practitioners and certain allied health professionals remains contingent upon achieving mandated levels of education and registration.

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<sup>86</sup> Australian College of Rural and Remote Medicine, *Submission to the Review of Australian Government Health Workforce Programs*, 2012

It may be appropriate to adapt the medical rural training pathway model to enhance *postgraduate* training opportunities and to ensure that the right mix of service delivery is being provided through enhanced skill sets amongst this workforce. Providing training in a rural area for nurses wishing to advance their skills and qualify as a nurse practitioner seems like a logical method to attract and retain such nurses into the future local workforce. Something like a 'rural nurse practitioner' pathway could be trialled with Medicare Locals or UDRHs acting as fund holders and administrators.

### Developing an outcomes reporting strategy

Measuring the impact of rural education programs and rural incentives schemes is embedded in current performance indicators for some programs at both the participant level (contractual reporting requirements with quantifiable targets) and at Government level (e.g. monitoring Medicare billing data to assess improvements in community access to services).

However, there is potential to improve the evidence base for such investments via the development of more sophisticated key performance indicators (KPIs) under a reporting strategy designed to better measure the impact of programs on the sustainable delivery of services. It has been suggested during this review's consultations that service outcomes could encompass such indicators as:

- Retention of clinical staff;
- Reduction in the need for rural health services to employ locums;
- Reduction in the need for Fly-In Fly-Out (FIFO) practitioners;
- Reduced need for patients to travel to metropolitan areas for particular services (recognising that some specialist services, particularly diagnostics like MRI will continue to require a hub and spoke approach); and
- Reduced expenditure under (usually state-based) travel and accommodation assistance schemes for isolated patients.

Different KPIs would need to be aligned with the various program objectives as not all service outcomes can be realistically achieved under a single program.

This is illustrated in the case of the RHMT program. If service learning models (see the Broken Hill Allied Health case study above) continue to be supported across the disciplines, this may result in reduced patient travel for some primary and allied health care services. Attempting to measure this may illustrate whether the service learning approach is having an effective impact at the community level.

On the other hand, rural placements for undergraduate health, nursing and medical students are unlikely to impact on the immediate needs for FIFO and/or locum specialists, at least not until after their training is complete, and they hopefully return to the rural areas in which they trained to provide services. Using a KPI on reducing FIFO practitioners might not be appropriate in this case.

Further, some of the suggested service-oriented KPIs listed above are easier to quantify than others. Reduced expenditure and retention of clinical staff would benefit from (presumably) available retrospective data whereas measuring reduction in patient travel and/or need for FIFO practitioners necessitates some broader assumptions around the clinical case load in a specific region across time.

Any introduction of a new outcomes reporting strategy would not negate the importance of continued data gathering and analysis under existing program



outcome measures, such as the emerging, encouraging data on increasing the number of new rural doctors as rurally trained students return to rural areas as qualified practitioners.

Although discussed further in the rural recruitment and retention strategies section below, it should be noted that financial incentives are not the only factor in retention of the health workforce in rural areas. As such, KPIs which consider links to professional development, research potential and ongoing training may be equally important. These factors may also have weight under the new proposed regional incentives model, which would encourage distribution of funds with consideration of local needs. This model is discussed in the next section of this chapter.

Chapter 9 of this review discusses the need to develop better outcomes evaluation strategies across all health workforce programs. The potentially enhanced KPIs for rural programs outlined above should be considered in this context.

### *Recommendations*

Recommendation	Affected programs	Timeframe
<p><b>Recommendation 4.1:</b> The Commonwealth should take leadership in developing a new, more integrated rural training pathway, linking its investment in rural undergraduate medical training with new support for rural intern places and continued growth in specialist training positions.</p> <p>The model will need to build on existing programs and maintain access to primary care and private sector training though the development of a more networked approach to delivering quality education.</p> <p>This may need to involve some re-profiling of existing investments.</p> <p>It will need to be delivered through a highly collaborative approach involving consortia of key training/accreditation bodies and health service providers. All available policy levers, including contracting and reporting mechanisms, should be directed at incentivising collaboration by local and regional agencies and supporting a local network approach.</p>	AGPT, STP, RCTS PGPPP, HWA clinical training funding.	Medium term – timeframes will be subject to reform of funding arrangements and engagement with stakeholders around new educational models.
<p><b>Recommendation 4.2:</b> The Commonwealth should consider opportunities for extending the approach to building rural training pathways in the allied health, dentistry and nursing</p>	New funding activity	Medium term – subject to available funds.

Recommendation	Affected programs	Timeframe
disciplines. This will need to retain the core principles of providing a more seamless transition from undergraduate training into rural practice or further professional rural training for students in these disciplines. However, it will be important to note the different structure of postgraduate training in medicine compared to other disciplines.		
<b>Recommendation 4.3:</b> The Commonwealth should seek that the Standing Council on Health engage with the national health professional boards and their accrediting agencies to encourage development of intra- and inter-profession courses that enable health practitioners to provide a broader range of services in rural areas.	Nil	Medium term
<b>Recommendation 4.4:</b> Commonwealth support to extend rural training at medical schools to cover full degree programs could generate positive outcomes. Current workforce projection data, including the findings of <i>Health Workforce 2025</i> , suggests that the distribution of new graduates needs to be the priority rather than increasing overall graduate numbers. Current proposals in this area should continue to be explored with careful analysis of the costs and benefits of the different models.	RCTS, NT Medical Program.	Longer term – any extension of existing rural medical programs will be subject to funding availability and the development of comprehensive costing models.
<b>Recommendation 4.5:</b> The Rural Clinical Training and Support (RCTS) program should expand its focus on supporting multidisciplinary training placements. This activity is already included within the program parameters but needs to be pursued more vigorously, where funding is available. Consideration should be given to RCTS infrastructure needs to support a multidisciplinary approach.	RCTS	Medium term – RCTS activities could begin to expand in this area from 2014.
<b>Recommendation 4.6:</b> The mandatory four week rural placements required for all medical students under the RCTS program should be abolished, in favour of increased support for longer-term high quality elective placements which are	RCTS	Medium term – current placement arrangements could be reformed from the

Recommendation	Affected programs	Timeframe
currently generating good outcomes. Funds released from supporting short-term placements should be redirected towards other priorities within the RCTS initiative. This should include enabling training sites to play an enhanced role in developing integrated vocational training pathways. This would be achieved through supporting new academic positions to play a key role in developing networked training partnerships.		start of 2014, in consultation with medical schools.
<b>Recommendation 4.7:</b> The advantages of extending the current RCTS program rural medical student enrolment target approach to other health disciplines should be examined. The target level and the likely implementation cost across the health disciplines would need to be determined, including the resources required by universities to achieve agreed goals.	RCTS	Longer term – funding implications and the ability of other health disciplines to achieve this type of target are more complex issues.
<b>Recommendation 4.8:</b> There is strong potential for the network of 11 University Departments of Rural Health (UDRHs) to play a greater role in supporting longer term, more structured, rural training placements for allied health, dental and nursing students. This should be supported by the Commonwealth where funding is available. The service learning model put in place by the Broken Hill UDRH should be explored further, including the cost implications of this model across the UDRH network.	UDRH	Medium term – expansion of UDRH training is subject to funding availability. New activities would need to be progressed during the next funding period.
<b>Recommendation 4.9:</b> Any extension of a comprehensive rural training program to cover nursing, allied health and dentistry should be supported by the collection of longitudinal outcomes reporting. The value of adopting a similar approach to the Medical Schools Outcomes Database project, and linking this to national registration data, should be considered.	UDRH and allied health clinical training support programs (SARRAH/ NAHSSS)	Longer term – reflecting long lead times for the development of data systems.
<b>Recommendation 4.10:</b> Research activities funded under the core operational grants of the RCTS and	RCTS, UDRH	Medium term – a new research strategy will

Recommendation	Affected programs	Timeframe
<p>UDRH programs need to be examined in consultation with key program stakeholders to ensure they are effective and well-targeted.</p> <p>The Commonwealth should encourage greater rural research collaboration and seek to reach agreement across the UDRH network on an appropriate maximum research proportion of the program's core operational grant. This process could build on the work of the Research Leaders Network that has been established through Australian Rural Health Education Network (ARHEN).</p>		require extensive development work and consultation.
<p><b>Recommendation 4.11:</b> There could be benefit for the Commonwealth and for universities in pursuing further consolidation of the RCTS and UDRH programs. This should be pursued on a case-by-case basis, taking into account the willingness of individual universities to pursue integration and administrative efficiencies. This approach will have benefits for some organisations but may not be appropriate in all cases.</p>	RCTS, UDRH	Medium term – case-by-case consolidation could begin to occur as existing funding agreements expire.
<p><b>Recommendation 4.12:</b> Rural health clubs should extend their focus to maintaining the involvement of graduates as they progress into further training beyond university. Expanded activities in this area may require additional funding support.</p>	RHMT	Medium term – subject to available funding.

## 4.2 Rural recruitment and retention strategies

Distribution problems can stem from difficulties in attracting the medical workforce to rural and remote areas and then in retaining those who have relocated, at least for a reasonable period. Research indicates that it is the total personal and professional experience including non-remunerative benefits and not salary alone that impacts on recruitment and retention.<sup>87</sup>

<sup>87</sup> J Humphreys et al. "Improving Workforce Retention: Developing an integrated logic model to maximise sustainability of small rural and remote health care services", *Australian Primary Health Care Research Institute ANU College of Medicine, Biology & Environment*, 2009.

The Commonwealth provides a range of financial and non-financial incentives with the aim of attracting and retaining the rural and remote health workforce. These incentives may provide some support but are unlikely to be the sole or even main factor in choosing a career in rural health. Multiple lifestyle and financial factors are likely to influence a health practitioner's decision to practise in rural or remote Australia.

### Background

In response to the 2008 Audit of the Health Workforce and the subsequent review of rural health programs, the \$134.4 million Rural Health Workforce Strategy (RHWS) was announced as part of the 2009-10 Federal Budget. The RHWS included several existing workforce programs and introduced a number of new initiatives.

The RHWS is underpinned by two key reforms:

- Transition of program eligibility to a new geographic remoteness classification system; and
- Scaling or gearing of incentives and return of service obligations (RSO) to provide greatest benefits to the most remote communities.

Since the introduction of the new incentives in 2010, concerns have been raised by stakeholder groups that the Australian Standard Geographical Classification – Remoteness Area (ASGC-RA) system, which categorises communities into remoteness areas, is disadvantaging some rural communities across Australia. These concerns are addressed in detail towards the end of this chapter.

Medicare billing data indicates that as at 30 June 2012, the number of full-time workload equivalent (FWE) general practitioners in regional, rural and remote Australia had increased by 9.7% since the introduction of the RHWS on 1 July 2010. Because of the many factors influencing location of practice, it is not possible to determine how much of this increase is attributable to the RHWS alone. Programs under the strategy are listed below:

- The General Practice Rural Incentives Program (GPRIP), which provides incentives to encourage medical practitioners to move to and remain in a regional, rural or remote area.
- The Rural GP Locum Program, which helps to provide access to locum services for rural GPs.
- The HECS Reimbursement Scheme, which introduced scaling to fast track the repayment of medical school fees for doctors practising in outer regional, remote or very remote areas.
- The Scaling Incentive for overseas trained doctors (OTDs), which enables a reduction of the ten year Medicare moratorium for participants practising in a regional, rural or remote location.
- Scaling of Medical Rural Bonded Scholarship and Bonded Medical Places return of service obligations to encourage bonded scholars to complete their obligations in more remote areas.
- The Department also conducted a range of communication activities under the RHWS to address some of the preconceived notions regarding rural practice and promote the benefits of regional, rural and remote opportunities.

Financial incentives for rural doctors are a key element of the Government's rural workforce strategy and were a major focus of consultations with stakeholders as part

of this review process. A significant ongoing investment has been made in the distribution of retention and relocation payments to rural doctors through GPRIP, which has an allocation of \$116.4 million in 2012-13.

GPRIP was implemented in 2010 as part of the RHWS. The purpose of the program was to address the maldistribution of the medical workforce by providing targeted financial incentives to encourage doctors to relocate to and remain in rural and remote areas. The introduction of GPRIP streamlined and consolidated two existing rural incentive programs for general practitioners and registrars that were run separately, the Rural Retention Program and the Registrars Rural Incentives Payments Scheme. This streamlining sought to address inequities in payment amounts between registrars and GPs.

Originally GPRIP was intended for general practitioners providing primary care services. However, because of the way in which the eligibility criteria are set with regard to the Medicare Benefits Schedule some specialist medical practitioners (i.e. anaesthetists, cardiologists, and obstetricians and gynaecologists) were subsequently given access to incentive payments.

As outlined above, there has been a significant increase in the number of doctors providing services in regional, rural and remote areas since the RHWS was introduced. Incentive payments for rural doctors may have played a part in contributing to this growth. It is therefore recommended that incentives should be a feature in ongoing efforts to support rural workforce sustainability.

However it is difficult to determine if the GPRIP on its own has generated rural workforce increases as the overall rural package contains a range of initiatives including rural education programs, support for rural and remote general practitioners and various locum support schemes. There has also been an increasing number of medical graduates entering the workforce as a result of the increases in medical student numbers over the past ten years.

Whilst the GPRIP has only been in operation for a little over two years, take-up and participation rates for the two retention components have been much higher than originally forecast (noting that forecasts were not prepared on the basis that non-GP specialists would be eligible for the payments). In 2010-11 and 2011-12 more than 11,000 participants were assessed as eligible to receive annual incentives. This includes specialists (billing the Medicare Benefits Scheme), GPs and GP registrars. Existing participants (as of 1 July 2010), including GP registrars, are grand-parented under their previous scheme for a three year period to ensure that they are not disadvantaged by the transition to GPRIP.

Given the fundamental purpose of the scheme, it is important to note that the major growth in GPRIP retention payments has been in ASGC-RA 2 areas (inner regional) and not the more remote ASGC-RA 3–5. When the Government adopted the ASGC-RA system for incentive payments (in July 2010) a large new geographic area in RA2 and some areas of RA3 became eligible for support. In 2010-11 almost 8,000 doctors became newly eligible for retention payments.

Program data indicates that the majority of the medical practitioners currently accessing retention payments are those practitioners who have in fact been providing services in the area for a significant amount of time, and may indeed have chosen to remain in the location regardless of whether the new retention allowance had become available. While payments are clearly appreciated by doctors (based



on feedback received during the consultation process) it is far from clear that retention payments in inner regional settings have been a major or deciding influence on career choices.

While the *retention* component of GPRIP has clearly been embraced by rural doctors, the results for the *relocation* element have been disappointing. Program data shows that only 33 doctors qualified for relocation payments in 2011-12, against a target of 70. Stakeholders such as Rural Health Workforce Australia (RHWA) have suggested that the strict eligibility requirements for this component of the scheme may be partially to blame for the limited uptake. This includes the need to apply for the relocation incentive prior to commencing work at a rural location rather than seeking these funds retrospectively. Stakeholders gave strong evidence to this review that the process was frustrating and overly bureaucratic.

In 2011-12, at least half the number of participants that received initial approval for relocation incentives had withdrawn from the program. This was primarily due to participants not meeting the minimum level of service requirements in order to receive their first and second grant payments and therefore being deemed ineligible for the program. This issue should be addressed to reduce the rate of withdrawal. Increasing the number of doctors who relocate to rural areas and remain rather than simply retaining the current workforce is a key policy imperative.

While program eligibility rules are likely to be a factor in the slow uptake of the relocation grants, it also appears that the level of the grants themselves may not be sufficient to motivate doctors to take up rural careers. Research undertaken by the Monash University School of Rural Health indicates that of the very small subset of practitioners prepared to consider relocation in any circumstances, practitioners would only consider relocating to a rural location of 5,000 people or less for an additional 64% of their current salary. For towns with a population size between 5,000 and 20,000, an additional 30% incentive would be required.<sup>88</sup> This level of payment far exceeds the current GPRIP relocation incentive amounts.

It is important to note that of the survey participants in the Monash research, 86% of doctors would not move at all, regardless of the level of incentive.<sup>89</sup> This evidence suggests that monetary incentives are not the critical factor in increasing the health workforce in rural and remote settings. It also provides further evidence to support the need for a vertically integrated model of rural training described above.

### Proposed regional incentive model

One of the major themes arising from the stakeholder consultation process conducted as part of this review has been the need for programs to be more flexible and better targeted at the regional level. A range of stakeholder groups have suggested that one-size-fits-all models for delivering government programs are often administratively complex, don't allow innovation to match regional needs and can result in perverse unintended consequences.

The current system of administering GPRIP appears to be an example of this sort of approach, where a significant investment in Government funding support is in fact

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<sup>88</sup> Professor John Humphreys, Presentation to the Review of Australian Government Health Workforce programs, 2012

<sup>89</sup> *ibid.*

generating considerable frustration for stakeholders. Groups such as the RDAA have suggested that the current GPRIP system is in fact providing an incentive for doctors to move from under-serviced smaller locations into the larger regional centres and is fundamentally unfair in the way it allocates financial support.

The primary issue with GPRIP in its current form is that it is almost entirely driven by the ASGC-RA rural classification system (to determine payment levels) as well as the use of Medicare billing data (in terms of eligibility). The program is administered by the Department of Human Services (DHS), with policy oversight from DoHA. Central administration costs are high, with DHS receiving an ongoing allocation of over \$1.7 million to maintain its GPRIP payment system. Any system changes within DHS also attract additional costs. There are also costs within DoHA, with approximately three ongoing staff devoted to GPRIP management.

An alternative approach to managing GPRIP could provide a range of benefits. This would involve moving the program to a system of regional management under a set of broad outcomes-based funding parameters supported by simplified eligibility requirements determined by the Government. The allocation of funding to individual participants would occur at the regional level and would be based on an assessment of local workforce needs rather than the current entitlement approach.

A number of management models could be adopted to implement this approach. One model that has been suggested involves harnessing the regional knowledge, expertise and local networks of agencies such as the Rural Workforce Agencies (RWAs), of which there are seven, and/or rurally based Medicare Locals (of which there are approximately 41).

RWAs are well established, mature organisations with a demonstrated track history in successfully delivering rural workforce support initiatives.<sup>90</sup> Medicare Locals are at least potentially a vital mechanism for delivering support to health practitioners, including for after-hours services. Combined, the two organisations offer great strengths that could be utilised to deliver more effective incentives.

Under this system DoHA would provide funding under a formula for allocating incentives to each area. This could be based on determinants such as rural population, the level of remoteness of rural population centres, the number of smaller population centres servicing communities, the chronic disease profile and the rural Aboriginal and Torres Strait Islander population. Clearly, such an approach places an emphasis from the outset on outcomes for patients and population health, which is highly desirable, rather than an approach which focusses on the appropriate remuneration of practitioners, important though that may be. This funding formula would then provide an allocation of funds to be managed within that area by the relevant RWA or Medicare Local, through an agreement with DoHA.

RWAs would then be charged with managing a process to allocate funds to each of the Medicare Locals in their state or territory, either through a competitive tender process or through reaching a consensus through discussions. They would be responsible for broad oversight of this funding allocation but would leave the determination of local needs to each Medicare Local.

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<sup>90</sup> RWAs are discussed further on p. 144.

Regional organisations like Medicare Locals, RWAs, or a partnership between these (and potentially other) organisations, would then be responsible for disbursing funds to individual practitioners or categories of practitioner, based on an assessment of where the greatest workforce needs lie. In some cases continued retention payments to local doctors may be the priority. In others, regional needs analysis may determine that enhanced relocation incentives would provide a greater boost to the local workforce, which would provide benefits to all service providers by reducing their workload. There would also be the opportunity to design regionally based incentive arrangements to reward procedural doctors involved in teaching or providing critical after-hours services, or to provide incentive packages to other health practitioners needed in that local area.

Administrative costs of delivering this type of model would be offset by savings made in releasing DHS from its role in administering payments to thousands of individual practitioners. It would nevertheless be important to contain administrative costs, recognising the core funding that both RWAs and Medicare Locals already receive.

RHWA, the peak national body for the RWAs, could play a valuable role in supporting the RWAs. RHWA could promote a collaborative approach between the RWAs and would also assist in maintaining effective links between each RWA and DoHA. The Australian Medicare Local Alliance (AMLA) could play a similar role in assisting to maintain positive relationships within the Medicare Locals network. RHWA could potentially also play a fund-holding role involving management of one large agreement with DoHA and the disbursement of funds to each RWA.

This type of regionally based approach also provides an important opportunity to broaden the allocation of incentive payments beyond doctors. Subject to local requirements, there may be instances where incentives would best be directed towards supporting nurses, dentists and allied health providers working in the private sector. Retention and relocation incentives could make a substantial difference in making rural private practice in the allied health and nursing disciplines more attractive and sustainable.

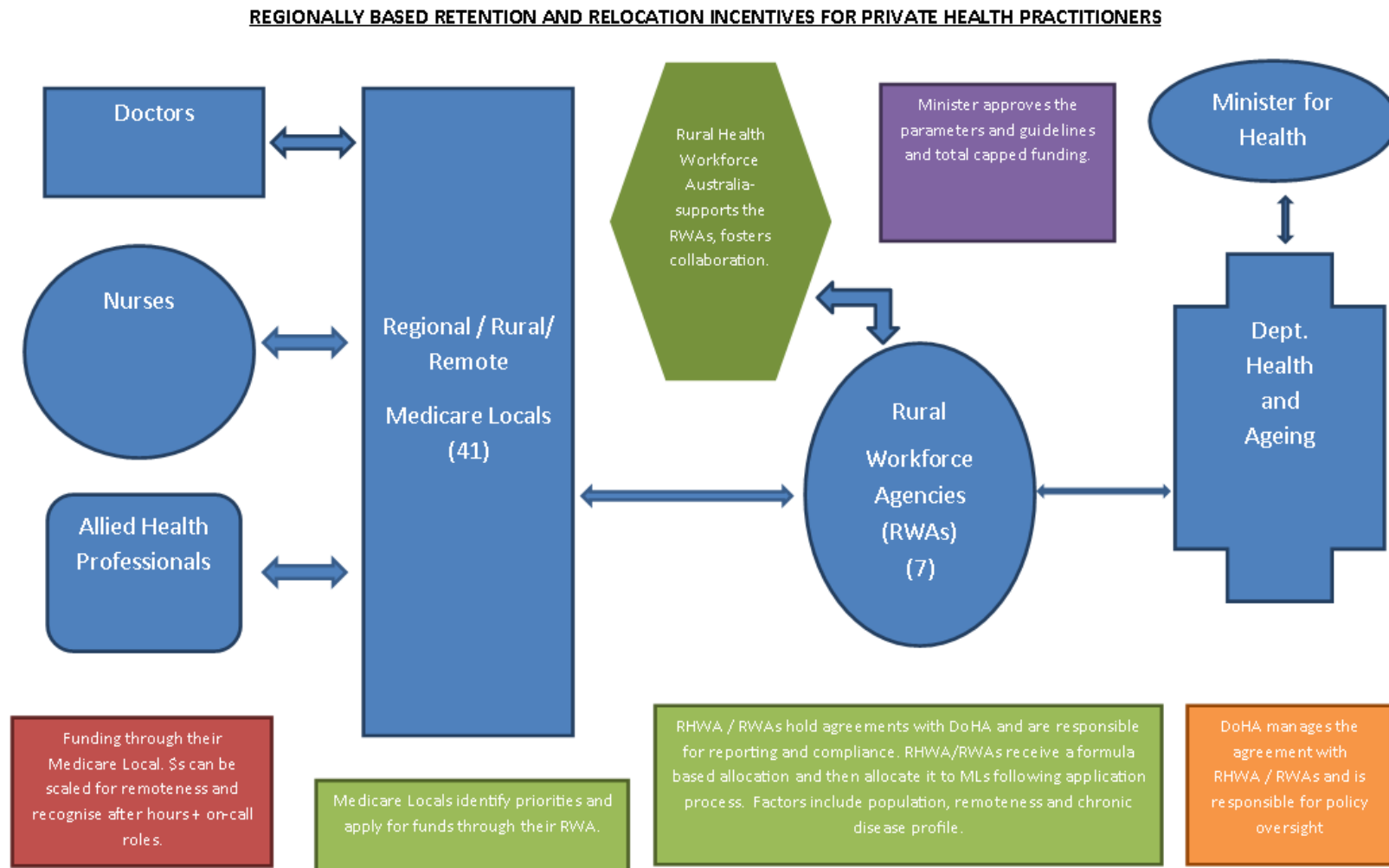
This proposed broadening of incentive arrangements would encourage a more multidisciplinary approach to delivering health care where the emphasis would be on enabling investment to meet local needs rather than encouraging an entitlement approach. Incentives should be provided to generate good evidence-based outcomes, rather than being based on competition between professional groups.

While Figure 4.4 below presents one approach to reform, there are of course other options for the administration of regionally based incentives. DoHA funds Medicare Locals directly to undertake a range of functions, including after-hours services, and a similar approach could be adopted for incentive payments. However, the involvement of the workforce agencies would enhance their existing recruitment and support role and would be a simpler management model at the departmental level, involving seven agreements instead of 41 or more, with consequent saving of administrative costs.

An appropriate transition period would be important to test the practicalities of implementing such a model and ensure it could be implemented without undue disruption. It will also be important to align any changes with proposed reforms to the rural classification system, as discussed below.

On this basis existing GPRIP arrangements would need to stay in place during at least 2013-14; although this of course means that the scheme is likely to continue its current trajectory of over-expenditure with a trade-off in reduced funding for other DoHA programs given a budget neutral environment. During this transitional period the Government would need to carefully consider the future quantum of its investment in rural incentives to determine the level of capped funding to be allocated to the proposed new scheme.

Figure 4.4: Regionally based retention and relocation incentives for private health practitioners



### *The alternative approach*

A second option is to retain GPRIP in its current form with revised eligibility criteria linked to a better defined rural classification system. Improvements to the classification system will allow better differentiation between locations which are currently considered equivalent for incentive purposes but which have very different service level challenges. This approach would allow funding to be reprioritised towards smaller locations and more remote areas. This could assist to address some of the concerns raised by the RDAA and other rural groups during their participation in this review. Potential improvements to the current ASGC-RA system are described later in this chapter.

### **The HECS Reimbursement Scheme**

The HECS Reimbursement Scheme was established following the 2000-01 Budget and aims to promote careers in rural medicine and increase the number of doctors in rural and regional areas. Up until 2010, participants in the scheme had one fifth of their Higher Education Contribution Scheme (HECS) fees for the study of medicine reimbursed for each year of training undertaken or service provided in rural and remote areas of Australia.

With the introduction of the RHWS, the scheme was modified to allow doctors to reduce the period for reimbursement of the cost of their medical studies from five years to two years, depending on the classification of their training or practice location, with more remote locations attracting higher payments.

DoHA has policy responsibility for the scheme, including managing it as an uncapped demand-driven initiative. DHS administers payments to individual recipients.

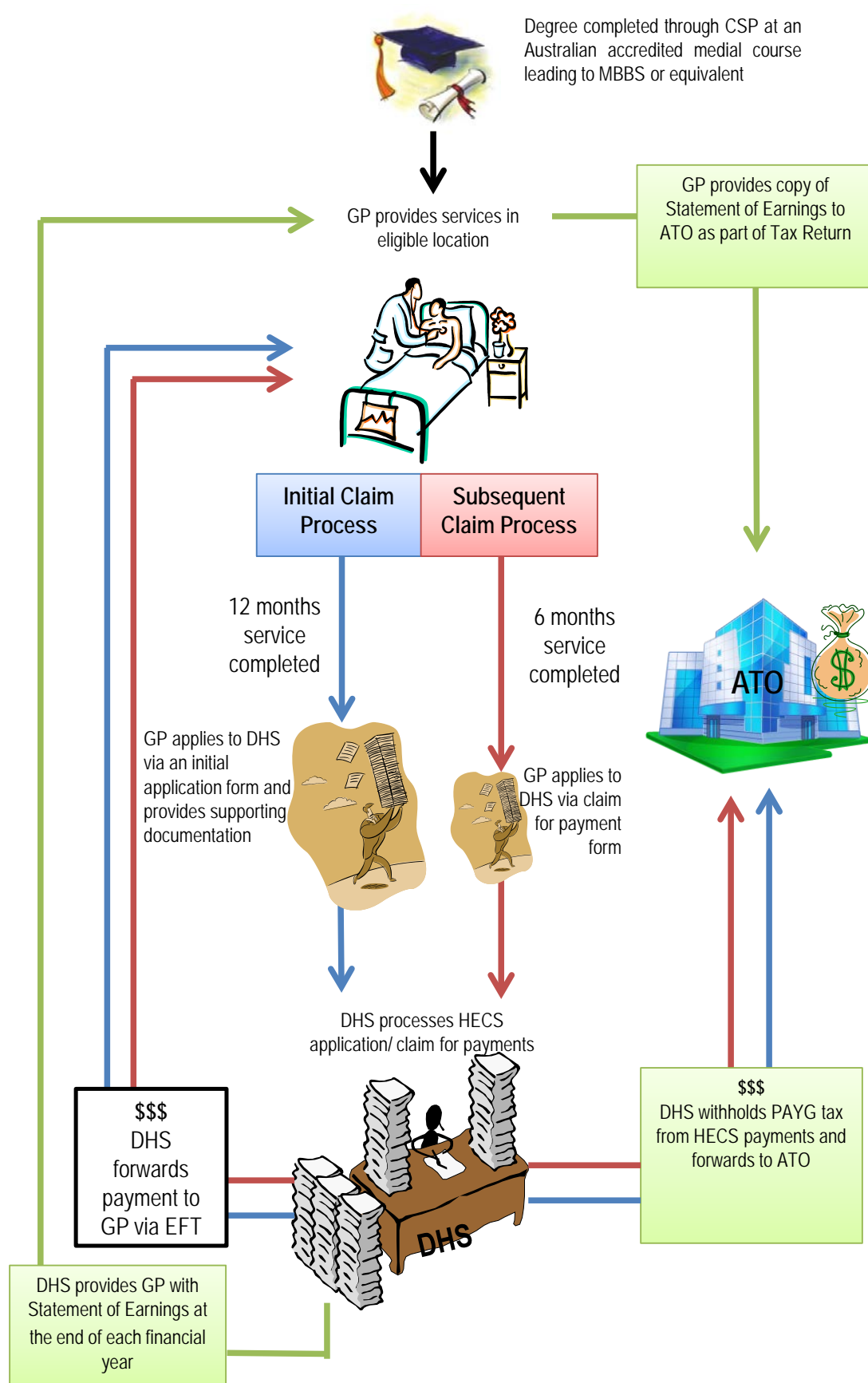
Despite its title, the program does not operate within the straightforward administrative pathway of a revenue foregone scheme and payments are subject to taxation requirements. Recipients have no requirement to use the funds to pay off their HECS debt. Figure 4.5 below indicates the complicated and administratively expensive process applicants must undergo to participate in the scheme.

The analysis of the scheme during this review process has revealed that uptake of the HECS incentives has mostly been by trainee doctors undertaking their intern year, rather than fully registered doctors. Given that interns have limited options for where they undertake their training, this suggests that the incentive effect of the scheme is limited. As discussed elsewhere in this review report, rural internships are limited and in high demand so financial incentives at this stage of vocational training may be an unnecessary and inefficient use of resources.

The scheme has not been meaningfully evaluated since 2003 at which time there were only 40 participants. As such, there is no currently meaningful data as to its effectiveness (or, indeed evidence to the contrary). Anecdotally, the scheme is viewed by rural stakeholder groups as a simple and clear potential policy lever available to government. Representations are frequently made to expand eligibility to include other health disciplines.



Figure 4.5: Claims process under HECS Reimbursement Scheme



The Senate Community Affairs Reference Committee also recommended that the expansion of the scheme should be explored and it is arguable that HECS reimbursement for other health professionals may be more effective than it has been for doctors. The relative gap in salaries and the potentially larger effect that receiving a financial incentive may have on other professionals could mean that providing funds to cover HECS debts could be more effective for these groups. Certainly, this argument was made powerfully by some Aboriginal and Torres Strait Islander stakeholder groups.

An alternative HECS forgiveness scheme, administered by DIICCSRTE and the Australian Taxation Office (ATO), exists for nursing and education graduates who take up employment in their professions. Unlike the DoHA HECS Reimbursement Scheme, which effectively provides incentive payments, the DIICCSRTE scheme provides a reduction in the participant's HECS-HELP (Higher Education Loan Program) debt owed through the taxation system. It would seem that awareness of this other program is fairly limited.

The DIICCSRTE scheme also has rural and remote eligibility criteria for certain professions (early childhood education) and appears to offer a simpler administrative model than the HECS Reimbursement Scheme. From a workforce development point of view, it makes more sense to have a consolidated, simpler scheme which would enable the targeted use of HECs forgiveness in response to evidence of changing workforce need. Consideration should therefore be given to transferring the HECS Reimbursement Scheme to DIICCSRTE to operate on the same basis as the nursing and education scheme.

### Drivers for rural retention and relocation

Many of the current rural incentives for medical practitioners are focused on financial provisions as the main 'carrot' to entice rural practice. However, increasing amounts of literature in this space have found that there is a wide range of motivators for medical practitioners to take up rural practice and remain in these areas for extended periods of time. There is certainly an argument that policies which focus on financial incentives, and ignore issues such as community engagement and professional satisfaction are fundamentally counterproductive. It can also be argued that a model which focusses on financial compensation for 'hardship' instead of the advantages and attractions of rural practice is ultimately stigmatising and destructive.

During its investigation into the factors affecting the supply of medical practitioners in rural areas, the Senate Community Affairs Committee found the following causal factors to be of importance:<sup>91</sup>

- The need to provide training and professional development opportunities;
- The need to provide options for career development;
- Strategies to assist with high workload and on call hours;
- The need to provide opportunities for spouse and children;
- The need to provide peer and professional support;
- A reliable locum service;
- Appropriate remuneration and recognition;

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<sup>91</sup> Senate Community Affairs Reference Committee, *The factors affecting the supply of health services and medical professionals in rural areas*, August 2012, pp. 19–23

- Provision for adequate housing/childcare; and
- Potentially higher incomes available in private practice in metropolitan areas as a disincentive to rural practice.

The provision of purely financial incentives would not be enough to address all of these issues, and approaches which deal specifically with the issues of infrastructure, training and professional development need to be considered more carefully. Many of these matters cross portfolios and different levels of government and will require a more challenging combined response to addressing community needs.

Additional incentives to affect distribution come at the point of medical school entry with the MRBS Scheme, which as outlined in Chapter 3, provides a relatively generous scholarship in exchange for a return of service obligation in a rural or remote area and the BMP Scheme, which provides a medical place in return for a commitment to work in a district of workforce shortage (see the discussion in Chapter 6 on return of service obligations). Other scholarships which support health education for the future rural workforce include the Rural Australia Medical Undergraduate Scholarship (RAMUS) scheme and the Nursing and Allied Health Scholarship and Support Scheme (NAHSSS). These latter initiatives have already been discussed in the relevant sections in Chapter 3.

### Alternative service models

For some locations considered to be either too small and/or too remote to support a permanent live-in doctor, it may be necessary to introduce alternative models of primary care. Options could include the implementation of an 'easy-entry, gracious exit' model which would require an external administrator to manage the practice; expanded services through a 'fly in, fly out' and/or 'hub and spoke' model; and the provision of funds to enterprises for the purpose of establishing medical clinics in underserved areas.

It is recognised that the Government's Medical Specialist Outreach Assistance Program (MSOAP) is meeting some of the service delivery needs of rural and remote communities experiencing market failure in the delivery of health services. This has ongoing substantial support from the Royal Flying Doctors Service. While valuable, these types of models of rotating services don't provide the same level of continuity of care or community engagement that are highly valued by rural communities.

It has been suggested during this review process that there could be merit in examining enhanced linkages between rural and urban health care settings, with practitioners serving in both settings on a rotational basis.

#### Box 4.8: Case study – alternative service models

The RDAA has cited a working model of this approach in operation at a remote medical practice in Queensland. The merit of this particular model is that it also involves close integration with the work of the James Cook University Rural Clinical School and other providers in training and supporting local staff, including Aboriginal and Torres Strait Islander nursing staff and Aboriginal health workers, producing a sense of community engagement for local practitioners which is highly validating. The role of government in supporting this approach may be worth exploring during the implementation of the *Rural Primary Healthcare Strategy*.

There have also been some suggestions during the review process about the way Government programs could support overworked remote GPs by enhancing access to other health professionals to assist in delivering team-based care. Greater use of nurse practitioners and practice nurses is beginning to occur but could be expanded further, as discussed in Chapter 7 of this report.

One suggestion that may have some merit is to extend the current Practice Nurse Incentive Program (PNIP) to cover physician assistants in certain remote areas. While this new workforce may not be an appropriate solution in all areas (and is opposed by some nursing professional groups) it appears that, particularly in regional areas of northern QLD, these new professionals are playing a valuable role that could be enhanced with some targeted financial support.

All options would require careful consideration of their benefits and potential cost to the Commonwealth. However, the adoption of these new primary care alternatives could be used as an alternative to the current direct financial incentives that are paid to practitioners.

### Continuing rural professional development

There are no DoHA programs which directly provide rural continuing professional development education, but some exist which support it either through the Rural Health Continuing Education (RHCE) grants or through the educational broadcasts delivered by the Rural Health Education Foundation through its satellite broadcast network and regular webcasts.

Maintenance of support for the Foundation, building on its new digital television channel, will provide a useful platform for delivering professional development services in more remote areas. This is critical to support rural health professionals to meet mandatory continuing professional development (CPD) requirements for registration.

Targeted at qualified practitioners the RHCE program was announced in the 2009-10 Budget and consolidates funding from the Rural Advanced Specialists Training Scheme, the Support Scheme for Rural Specialists, the Rural Health Support Education and Training Program and the Rural Health Education Foundation.

The RHCE provides access to professional training and support in rural and remote areas for medical specialists (stream 1), and for allied health professionals, nurses, general practitioners and Aboriginal and Torres Strait Islander Health Workers (stream 2).

Stream 1 of the RHCE is administered by the Committee of Presidents of Medical Colleges and provides project grants of up to \$40,000 and \$60,000 grants for accredited/registered training providers to develop and/or deliver relevant training programs for rural and remote medical specialists. While this program has been consistently oversubscribed, there have been challenges including participants experiencing difficulties commuting to training and arranging for their position to be backfilled.

Stream 2 of the RHCE is administered by the National Rural Health Alliance (NRHA) and is targeted at allied health professionals, GPs, nurses and midwives and Aboriginal and Torres Strait Islander health workers. It provides project grants of up to \$60,000 to accredited/registered training providers for the development and delivery of CPD, continuing professional education (CPE), inter-professional learning

(IPL), or orientation programs and support of up to \$6,000 (per grant) for individuals or organisations to access CPD, CPE, IPL or orientation activities.

The allocation of funding between streams 1 and 2, particularly given the relative size and make-up of the workforces they apply to, requires further examination especially as both streams are currently oversubscribed.

An evaluation of stream 1 was completed in 2012. Analysis indicated that the direct workforce benefits of the RHCE program are difficult to measure, with little evidence available to demonstrate enhanced quality of care or staff retention. The evaluation noted better indicators were required to measure the longer term outcomes.

Further analysis of demand for specialist CPD training under the RHCE program would be beneficial to ensure this program is appropriately targeted and effective in delivering professional development support where it is needed most. Successful applications should not only be based on the rural classification model but also take into account areas of need and the benefit the training will provide to the community.

To increase the number of participants in RA 4–5 locations, an emphasis on training health professionals in these areas should be promoted by the administrator. Increasing the training opportunities for health professionals in the areas in which they live and work would obviously decrease travel costs and backfilling issues identified by stakeholders. However, the number of specialists by profession practising and living in each RA classification needs to be quantified. Also, in the case of specialists and nurses it should be considered whether they are currently provided with individual CPD funding from their employer (state Government).

As with the funding for specialists under stream 1 of RHCE, stream 2 is heavily oversubscribed. There is clearly strong demand for professional development support amongst rural allied health professionals with the 244 eligible grant applications received under the scheme far exceeding the 75 projects that have been supported within the available funds.<sup>92</sup>

In a similar way to the suggestions made in this review about other rural training programs, consideration should be given to how providers of professional development training funded through RHCE can be linked with similar organisations, like the UDRHs, to benefit from shared approaches and economies of scale.

### Locum support

Funding for locum back-filling is one of the other areas in which the Commonwealth provides valuable, less direct support for rural and remote practitioners. Funding for locums enables GPs and other professionals to take time for personal leave as well as to undertake professional development activities. Locum schemes are an important retention measure and generally provide good value for money provided they are not used as a replacement for permanent staff in rural areas. A number of Australian Government programs are in place.

The Nursing and Allied Health Rural Locum Scheme (NAHRLS) is a component of the Australian Government's health reform agenda. Two national Health Reform initiatives funded in the 2010-11 Budget: the Rural Locum Scheme for Allied Health

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<sup>92</sup> Rural Health Continuing Education program summary data, Department of Health and Ageing, 2012



Professionals and the Rural Locum Scheme for Nurses were combined to create the NAHRLS, which is externally administered by Aspen Medical Pty Ltd.

NAHRLS provides locum placements for up to 14 days to enable nurses, midwives and allied health professionals to take leave for personal and professional reasons. It also enables interested nurses, midwives and eligible allied health professionals to experience rural practice through a locum placement.

The program has not been operating long enough to assess its effectiveness. However, there has been a low uptake of placements. The administrators attribute this to low use by state public health systems who potentially have existing locum service arrangements and lack of funding for the locum's wage. This is one example of differing levels of support between NAHRLS and other locum schemes which do provide subsidies for locum salaries. Pharmacy stakeholders have requested inclusion on the scheme. However, it should be noted that a separate pharmacist locum scheme is funded under the 5th Community Pharmacy Agreement.

The National Rural Locum Program (NRLP) was a consolidation of three previous initiatives: the Specialist Obstetrician Locum Scheme (SOLS) which commenced as a pilot program (funded by DoHA) in 2006; the General Practitioner Anaesthetists Locum Scheme (GPALS) which was an expansion of SOLS introduced in the 2008-09 Budget, and the Rural General Practitioner Locum Program (RGPLP), which was a component of the RHWS.

The NRLP aims to maintain and improve access to quality care for rural communities by increasing the locum support available to the rural medical workforce. Support to allow existing rural doctors to have time to rest and undertake ongoing education and training is a crucial retention mechanism. Eligibility is limited to doctors in ASGC-RA 2–5 areas.

From 31 January 2013, the funding for RGPLP has been devolved to Medicare Locals. A funding agreement was executed with the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) on 4 October 2012 to administer the remaining elements (SOLS and GPALS), with the combined schemes now being called Rural Obstetrician and Anaesthetist Locum Scheme (ROALS). The funding agreement with RANZCOG operates until 30 June 2014.

The ROALS operates by providing eligible host doctors (specialist and GP obstetricians, and GP anaesthetists) with subsidised support to offset the cost of obtaining a locum. Subsidies are available for locum costs, travel time and travel costs. Hosts can claim up to 14 days of locum support per financial year.

The NRLP has been reviewed (completed in April 2011). The following key areas were identified for improvement:

- Streamlining of the current administrative structure of the program
- Development of a national approach to improving locum supply
- Review of the model to provide enhanced access to the subsidies
- Improved and refined definition of the target GP population group for the program
- Improved focus on meeting the needs of proceduralists with multiple specialties
- Reduced administrative requirements for locums.



The review also found that:

- SOLS and RGPLP have met targets and program objectives. GPALS has had limited reach with only small numbers of GP anaesthetists participating in the program.
- SOLS has been accessed by approximately 25% of the rural and remote specialist obstetric workforce.
- RGPLP exceeded its targets, but due to the capped funding of the program, the reach was less than 4% of eligible GPs.

The Rural Procedural Grants Program (RPGP), incorporating the Rural Locum Education Assistance Program (Rural LEAP) commenced in July 2004. In February 2012, Rural LEAP was included within the RPGP to allow urban GPs to undertake emergency medicine training. Rural LEAP originally commenced in early 2010. RPGP enables procedural GPs in rural and remote areas to access a grant to attend relevant training, upskilling and skills maintenance activities. The Program has two components offering a grant to cover up to:

- ten days training, to a maximum of \$20,000 per GP per financial year for procedural GPs practising in surgery, anaesthetics and/or obstetrics in rural and remote areas (ASGC-RA 2–5); and
- three days training, to a maximum of \$6,000 per GP per financial year for GPs practising emergency medicine in rural and remote areas (ASGC-RA 2–5) to attend approved skills maintenance and upskilling activities.

Rural LEAP provides financial assistance to urban GPs who undertake emergency medicine training and commit to a four week (20 working days) general practice locum placement in a rural locality within a two year period. This is a one off incentive with participants able to obtain financial assistance of up to \$6,000 for three days of emergency medicine training.

The program currently substantially meets its targets. An external review was conducted in April 2008. The 2008 review found that the program was effective in helping GPs to access training to improve/maintain their procedural and emergency medicine skills. Anecdotal evidence suggests that Rural LEAP participants are committing to additional rural locum work over and above the required four weeks.

Locum programs are an important component of the Government's rural workforce strategy and it is important that funds can be directed efficiently towards the areas of greatest need. While recognising this, the review has identified some inconsistencies between the different locum programs in terms of the support they provide to different professional groups and the administrative costs of delivering this funding.

There may be potential for administrative efficiencies by consolidating or streamlining these activities within the one administrative framework, while still enabling funds to be directed towards the different professional groups. A competitive tender process could be conducted to appoint one administrator. There would be benefits to this approach by co-locating all locum support activities with the one agency, making locum services easier to access to rural professionals.

If this option is not pursued, SOLS and GPALS could be integrated with delivery of the Specialist Training Program, with funding managed by RANZCOG under two targeted activity streams.

### Rural workforce agencies

RHWA and the RWAs play a pivotal role in supporting and delivering rural health programs for and with the Commonwealth.

RWAs, located in each state and the Northern Territory, are funded by the Commonwealth to improve the recruitment and retention of GPs to regional, rural and remote areas (ASGC-RA 2–5) which includes helping communities to recruit GPs, finding appropriate placements for doctors who want to relocate to rural Australia, assisting with the costs of relocation, supporting families with fitting into a new community and helping doctors access the necessary infrastructure, support and training.

RWAs also promote rural and remote general practice to Australian and international markets and provide support to international and Australian medical graduates moving to rural areas, with a focus on job orientation, training and education support.

Funding is provided to RWAs through RHWA, the national peak body. RHWA also provides national advocacy and representation, coordination and administration, and management of national data relating to rural workforce activities.

### Communication activities

In order to target some of the preconceived notions regarding rural practice, DoHA has conducted a range of communication activities under the RHWS. These activities are aimed at demystifying rural practice and promoting the benefits of regional, rural and remote opportunities. This includes the Rural Health Champions Project, a select group of medical professionals who speak, write and blog about their experiences in rural practice. The penetration of this initiative, in terms of its impact on influencing metropolitan health professionals, is difficult to assess. In addition to this, in 2011 DoHA commenced the ‘Go Rural’ project, where the RWAs in each state and the Northern Territory conduct a variety of events to promote rural practice.

The Rural and Remote General Practice Program (RRGPP) was established by the Australian Government in 1998-99 as a result of the “Report of the General Practice Strategy Review Group” (1998). Under this program RWAs are required to collect and report on a set of KPIs in relation to the recruitment and retention of GPs in regional, rural and remote Australia. Each state or territory has different benchmarks under the various KPIs. Some vary by up to 40% such as retention for a six month period after recruitment. The inconsistent basis of funding for RWAs, along with different performance benchmarks, suggests there may be scope for efficiencies in administration arrangements. Nevertheless, the program appears to have been successful in recruiting and retaining doctors in rural areas.

The implementation of more rigorous data reporting arrangements in response to the findings of the 2005 review of RRGPP has provided a basis for future workforce planning and the capacity to identify and respond to long-term workforce policy issues. The administrative arrangements for the program should be considered in light of the ongoing role of Medicare Locals, and the potential for efficiencies to be gained through contracting RWAs through RHWA.

RHWA’s submission to the review recommended that investment into specific workforce programs under the existing funding agreement be continued at current levels to support the RHW agency network’s core business; key performance

indicators associated with funded workforce programs administered by the network be reviewed and revised to better reflect the full scope of activities and services provided; improved structured collaborative arrangements are introduced to maximise the outcomes to rural and remote communities and provide a better return on Commonwealth investment by eliminating service gaps, unnecessary duplication and lack of system-wide clarity.

Specific recommendations from RHWA regarding the RRGPP include ensuring that from July 2013 funding should be sufficient to reflect the breadth of core services provided, the expected increase in Australian trained graduates and the demonstrated need to continue international health professional recruitment and increase in workforce targets and geographical coverage resulting from the change from the Rural, Remote and Metropolitan Areas (RRMA) classification system to ASGC-RA in 2010.

RHWA also recommended that the National Rural Health Students Network (NRHSN) program continue to be funded and that the NRHSN extends the continuity of their involvement with the future health workforce through a graduate (Alumni) program. This could be a valuable contribution to supporting students as they commence their rural and remote health careers and may provide an avenue for postgraduate data collection and feedback gathering.

Administratively it may be possible to consider converting to a header agreement with RHWA, provided this is consistent with other activities to be delivered by RWAs. The efficiencies generated by this approach would need to exceed the overall risks. The difference in benchmarks for KPIs across jurisdictions should be considered as part of any future negotiations and a more consistent national funding methodology for the RWAs should be developed in consultation with stakeholders.

### *Recommendations*

<b>Recommendation</b>	<b>Affected programs</b>	<b>Timeframe</b>
<b>Recommendation 4.13:</b> Continued support for rural doctors, including targeted financial incentives, should remain a key component of the Government's health workforce strategy to address the serious ongoing maldistribution of health professionals.  However, there is currently insufficient emphasis on support for other health professionals. A broader approach to rural health workforce development, focussing on social and professional issues as well as financing, needs to be taken consistently to complement the Government's current investments.	GPRIP, HECS Reimbursement	Ongoing, with longer term development of new approaches, as outlined below.
<b>Recommendation 4.14:</b> Expenditure on the General Practice Rural Incentives Program (GPRIP) needs to be better	GPRIP	Medium term – new models of financial support

Recommendation	Affected programs	Timeframe
<p>targeted for equitable workforce outcomes by:</p> <ul style="list-style-type: none"> <li>• Adopting a modified rural classification system and better targeting financial incentives towards smaller regional settings in Australian Standard Geographic Classification – Remoteness Areas (ASGC-RA) RA2 and 3, while maintaining expenditure in RA4 and 5; and</li> <li>• Designing and implementing a new capped, decentralised incentive approach delivered through regionally based workforce development agencies such as Medicare Locals and Rural Workforce Agencies.</li> </ul> <p>Movement to a regionally based approach in the medium to longer term is strongly preferable as it offers both fiscal certainty and the opportunity to enhance outcomes.</p> <p>Determining need at the local and regional level is likely to be more effective than the current centralised entitlement system. This approach also provides flexibility to direct resources to the recruitment and retention of other professional groups, subject to local workforce requirements and identified health needs.</p>		<p>will require extensive consultations with stakeholders and the development of revised administrative systems.</p>
<p><b>Recommendation 4.15:</b> Any change to a new incentive system should feature an appropriate transition period, of at least one financial year, and further consultation with stakeholders about the detailed requirements and funding allocation systems. Arrangements for supporting rurally based GP registrars should be considered as part of this process.</p>	GPRIP	Medium term
<p><b>Recommendation 4.16:</b> The HECS Reimbursement Scheme should be integrated with the similar HECS-HELP forgiveness initiative already managed by Department of Industry, Innovation, Climate Change, Science, Research and Tertiary Education (DIICCS RTE) and the</p>	HECS Reimbursement	Medium term

Recommendation	Affected programs	Timeframe
<p>Australian Taxation Office (ATO).</p> <p>While the latter scheme already covers nurses, the benefits and costs of participation by rural allied health professionals should also be examined.</p> <p>Integration should achieve administrative savings and an ability to target HECS forgiveness in a responsive manner to projected workforce shortages.</p>		
<p><b>Recommendation 4.17:</b> The Rural Health Continuing Education (RHCE) program (Stream 2) provides a good basis for supporting postgraduate training in allied health and nursing, but is significantly oversubscribed. The Commonwealth should consider expanding this program and linking it to other training initiatives, subject to the availability of further funding.</p>	RHCE	Longer term – expansion will be subject to funding availability.
<p><b>Recommendation 4.18:</b> The Commonwealth should progress the consolidation of the administration of the various discipline-based locum programs into an integrated rural multidisciplinary locum provision service.</p>	SOLS, GPALS, Rural LEAP, NAHRLS	Medium term – consolidation should be pursued as existing funding agreements expire.
<p><b>Recommendation 4.19:</b> Government involvement in alternative rural health service models should continue to be explored. Investments in developing new practice models in areas of market failure may assist to ensure more remote communities can access reasonable levels of service.</p>	Primary and Ambulatory Care Division programs, new workforce initiatives.	Longer term – new models require significant development for national implementation, subject to available funding.

### 4.3 Reform of the ASGC-RA rural classification system

Prior to the commencement of this Review, submissions were tendered to the Senate Community Affairs Committee Inquiry into the *Factors Affecting the Supply of Health Services and Medical Professionals in Rural Areas* which described specific issues relating to use of the Australian Standard Geographic Classification - Remoteness Areas (ASGC-RA) classification system.

The Senate committee concluded that while the ASGC-RA is a useful tool to determine remoteness, better outcomes may be achieved if it were overlaid with other measures rather than as the sole determinant of incentive payments. The

committee recommended that the current classification systems used for workforce incentive purposes be replaced with a scheme that takes account of regularly updated geographical, population, workforce, professional and social data to classify areas where recruitment and retention incentives are required.<sup>93</sup>

Of particular concern amongst stakeholders is the creation of unintended perverse incentives within workforce programs which rely on the ASGC-RA for eligibility, and perceived disadvantages for rural communities which must compete with larger centres within the same classification band to attract and retain health practitioners.

The Department provided advice to the Senate Inquiry that the effectiveness of the ASGC-RA as a basis for workforce incentives would be considered during this Review and there would be opportunities to gather more information about stakeholder concerns at that time. During the consultation phase of the Review, the participation of stakeholders enabled a better understanding of the issues at play, and reform of the current rural classification system has been identified as a major priority.

### Background

The ASGC-RA is a geographic classification system that was developed in 2001 by the Australian Bureau of Statistics (ABS), as a statistical geography structure which allows quantitative comparisons between 'city' and 'country' Australia. The purpose of the structure was to classify data from census Collection Districts (CDs) into broad geographical categories, called Remoteness Areas (RAs). The RA categories are defined in terms of 'remoteness' - the physical distance of a location from the nearest Urban Centre (access to goods and services) based on population size.<sup>94</sup>

The Department adopted the ASGC-RA system to support the introduction of scaled incentive programs for GPs under the Rural Health Workforce Strategy.

The use of ASGC-RA replaced the earlier Rural, Remote and Metropolitan Areas (RRMA) and Accessibility/Remoteness Index of Australia (ARIA) classification systems. The use of the ASGC-RA is not unique to DoHA. It is used extensively by Centrelink, the Department of Families, Housing, Community Services and Indigenous Affairs, (FaHCSIA) and the Department of Education, Employment and Workplace Relations.

The Government, with advice from DoHA, considered a number of alternatives before concluding that ASGC-RA was the most efficient mechanism, based on the reasoning that:

- ASGC-RA was independently updated by the ABS after each population census
- ASGC-RA could be easily used to monitor the performance of programs
- Other agencies (such as DHS) are able to build payment systems and update as necessary
- ASGC-RA presented fewer anomalies than other models

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<sup>93</sup> Senate Community Affairs Reference Committee, *The factors affecting the supply of health services and medical professionals in rural areas*, August 2012, Recommendation 8, p. xv

<sup>94</sup> [Doctor Connect](http://www.doctorconnect.gov.au/internet/otd/Publishing.nsf/Content/ra-intro) website, Department of Health and Ageing, 2012, <http://www.doctorconnect.gov.au/internet/otd/Publishing.nsf/Content/ra-intro>



Since the introduction of the rural workforce incentive programs in 2010, concerns have been raised by key stakeholder groups that the classification system, which categorises communities into remoteness areas, is disadvantaging some small rural communities across Australia, in particular those that are within inner and outer regional Australia (RA2–3).

Twenty three communities were identified by DoHA from stakeholder feedback as experiencing particular issues under the ASGC-RA classification system. These communities are either in close proximity to each other or in the same RA classification band but with different population sizes or communities. These communities include locations such as Mt Isa, Cowra, Ballarat, Roxby Downs and Kalgoorlie.

In late 2010, DoHA engaged GISCA, the National Key Centre for Social Applications of Geographic Information Systems at the University of Adelaide, to investigate and provide advice in reference to a number of communities that were classified within the same category as larger, better serviced, rural communities. GISCA staff are recognised as experts in this field.

The review by GISCA allowed DoHA to clarify and test the concerns raised by some stakeholders regarding the effectiveness of ASGC-RA as the basis of funding for rural health programs.

GISCA completed the review in early 2011. The review found that overall the ASGC-RA classification system was functioning reasonably well.

However, the review did identify inconsistencies and anomalies in the ASGC-RA system, particularly where some smaller communities had been unfairly classified in the same category as neighbouring larger communities. Such identified boundary issues are not uncommon to other geographical classification systems.

A number of alternative classification systems are currently in use.

### Box 4.9: Alternative classification systems in use

RRMA is based on 1991 Statistical Local Area (SLA) boundaries and 1991 population census data. Therefore, it is no longer an accurate model for determining need due to significant population changes and urban expansion. Following the announcement of the RHWS in the 2009-10 Budget and the corresponding use of ASGC-RA in 2009, 32 targeted rural health programs moved to the ASGC-RA.

In February 2010, a further 28 general departmental programs were identified as still using old remoteness classifications (e.g. RRMA). Since then:

- five programs have ceased;
- one program has moved to the ASGC-RA;
- a decision on six aged care programs was deferred until after the Productivity Commission aged care review that reported in August 2011. The government response in April 2012 noted that ARIA would continue to be the system of choice, at this time, noting that further investigation into other classification systems would be undertaken;
- a decision has been made that a remoteness classification is not needed for six pharmacy programs;
- eight programs have not changed – e.g. because budget funding has not been forthcoming; and
- information has not yet been obtained on the status of two programs.

However, RRMA continues to be used for determining eligibility for a small number of programs, particularly under the Practice Incentives Program. Variants of ARIA are also used by some program areas. The use of multiple classification systems across the portfolio has been raised as a significant concern by stakeholders and needs to be addressed.

An update of RRMA was considered in 2004, but did not proceed apparently due to the large number of areas that would be consequently reclassified as ineligible. Further, while a key concern about RRMA is that it uses 1991 Census data, simply updating RRMA with more recent census data would not remedy methodological flaws that have led to distorted incentives. Major issues included:

RRMA measures distances using a straight-line, compared to ASGC-RA's use of road distance.

RRMA classifies all capital cities as RRMA 1 (ineligible for incentives), including Darwin.

It should also be noted that RRMA faced technological obsolescence as the ABS has now moved to the Australian Statistical Geography Standard (ASGS). The ASGC boundaries and codes were published for the final time on 14 July 2011. For one year from July 2011 the ASGC and the ASGS operated in tandem. From July 2012, the ASGS is the sole ABS statistical geography. Remoteness Areas, Section of State and Urban Centres and Localities are now part of the ASGS, but are built from Statistical Areas Level 1 (SA1s) rather than Census Collection Districts. The ASGS has ceased using Statistical Local Areas (SLAs) which are essential to the RRMA classification.

As noted above, the ABS will progressively replace the current ASGC with the new Australian Statistical Geography Standard (ASGS) as its geographical framework. The framework will entail a new range of statistical areas.

The smallest geographic unit of the ASGS will be the 'mesh block', which comprises around 30-60 households. This is smaller than the current ASGC's Census Collection District and may therefore reduce the number of anomalies generated by a remoteness classification. It is expected that the new ASGS-RA geography will be available in mid-2013.

The new ABS ASGS geography structure will be more stable over time and better represent the service areas of general practitioners. The improved precision of the ASGS provides an opportunity to develop a reliable, flexible and credible classification system capable of measuring where population need for medical services have not been met.

The ASGS is based on 2011 census data and will therefore ensure the use of remoteness area classifications are based on the latest population statistics.

The transition to the ASGS may therefore remove some of the perceived inconsistencies of the remoteness area classifications produced under the ASGC-RA. It will not however, alter the core methodology of the current ASGC-RA system or resolve the major concerns of stakeholders.

It should also be noted that even if the proposal for a pooled regional incentives scheme were adopted (discussed under Rural Recruitment and Retention strategies) there would still be a need to refine the rural classification system. The need to determine rurality in a consistent way is not limited under the Health Workforce Fund to incentive based programs. Measures such as the AGPT and STP with distribution and educational objectives also depend on a reliable classification scheme to meet these objectives.

### Rural Classification System Working Group

The findings of the Review have been informed by a key workshop of major stakeholder groups that was conducted in Canberra on 6 November 2012. This working group aimed to develop common understandings of the issues related to the use of rural classifications and work through possible options for system enhancement. The following organisations participated:

- Rural Doctors Association of Australia (RDAA)
- Australian Medical Association (AMA)
- Royal Australian College of General Practitioners (RACGP)
- Rural Health Workforce Australia (RHWA)
- General Practice Registrars Australia (GPRA)
- National Rural Health Alliance (NRHA)
- Australian Medicare Local Alliance (AML Alliance)
- Rural Health Research – Monash University School of Rural Health

There was general consensus across the working group that the current ASGC-RA classification system fails to categorise towns effectively in relation to health workforce requirements. The working group proposed that a classification system should be a structured system with some flexibility to enable it to be adapted for individual program guidelines. The system needs to be one that all stakeholders can understand. There was also strong support for the idea that there should be flexibility at the local level in any new system. The key tenet was a mechanism which permits greater consideration of the workforce situation on the ground, rather than the current approach derived from uniform statistical analysis.

It was broadly agreed by all parties that it is important that a classification system use reliable and up-to-date data, as population growth changes quite rapidly in some areas which affects community health needs. It was noted that the ASGC-RA system can be updated every five years with ABS population census data.

While the ASGC-RA system provides a useful platform as a rural classification measure to determine eligibility for health workforce initiatives, the system needs to become more defined to avoid unintended negative consequences and to allow more targeted program investment.

The working group identified that, should a decision be made to reform the classification system, it would be important that an announcement and transition dates be communicated to stakeholders as soon as possible. The transition period should allow stakeholders adequate time to adjust particularly in respect of reporting requirements.

### Reform options

#### *Key principles*

As part of the review process, consideration has been given to how the rural classification system can be used effectively by a range of programs, addressing stakeholder concerns about the current system, while being cost-effective and efficient to implement.

There is no ‘natural’ classification which differentiates ‘rural’ and ‘remote’ communities from urban centres. Any ‘rural-urban’ classification used to guide

resource allocation must be fit-for-purpose and the best use of a system may vary between initiatives.

The key concept is to have a system that is sufficiently well defined to be used with a degree of flexibility between different programs, which may vary in the purposes for which rurality is measured. Adoption of a more defined system, which better enables recognition of the differences between locations in the same RA band, will enable program eligibility requirements to be designed to be fit for purpose and better understood by participants.

Following the completion of stakeholder consultations a number of commonly agreed key principles have been defined that should be a feature of any new rural classification system for health workforce programs:

- Objective and evidence-based – meets the needs of programs and recipients
- Easy to interpret
- Regularly updated (preferably by an independent source such as the Australian Bureau of Statistics)
- Is not subject to arbitrary amendments
- Remains stable over time (i.e. will not alter in accordance with short-term fluctuations in service)
- Allows for discrimination between large and small towns in less remote areas
- Maintains the current mechanism of scaling for remoteness to provide greater incentives to communities of highest need
- Measures both remoteness and rurality, to allow differentiation between locations of a similar size which may vary greatly in accessibility.

While these key principles will be an important aid in the reform process it is further recognised that there is no perfect system to measure rurality and that anomalies will occur regardless of the model that is implemented. These issues will vary based on how any revised classification system is applied to different programs. In particular, boundary issues will be inherent to any system. The appropriate management of these is to minimise ‘within-group’ variance and to maximise ‘between-group’ variance.

In some cases risks can be mitigated by designing revised programs with flexibility at the regional and local levels, nevertheless, the potential challenges and uncertainties of using a rurality defining system need to be recognised before final decisions are reached on implementation of any new model. Consideration must be given to the impact of applying any new system to a wide range of diverse programs which do not necessarily reflect the purpose for which the classification was developed.<sup>95</sup>

While the ideal reform of the rural classification system would lead to adoption of a single measure of rurality across all programs within DoHA, the logistics, cost and lack of stakeholder support present risks which at present, outweigh the benefits of pursuing this end. From a technical perspective, DHS requires at least 12 months (and a significant financial investment) to incorporate changes of this nature in to their system. Given the number of programs in the portfolio which do not presently use ASGC-RA, transition arrangements including stakeholder education and support would entail additional funding requirements and increased workload for program

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<sup>95</sup> Humphreys and McGrail – correspondence with DoHA, December 2012.

areas. However, this does not preclude the recommendation that all new programs commencing from 2013 onwards have ASGC-RA as the preferred classification system for measuring rurality.

Discussion at the rural classification system working group meeting centred on the use of the Humphreys'/Monash model.

### Box 4.10: Humphreys'/Monash model

The "Monash model" is based on research by Professor John Humphreys and Dr Matthew McGrail of the Monash University School of Rural Health. The model is an attempt to design a new multi-layered series of classification zones to be used for rural incentive initiatives using an evidence-based approach. ASGC-RA remains the basis for the Monash model.

The model comprises geographical data, population data and data from the *Medicine in Australia: Balancing Employment and Life Study (MABEL)* to form a 13 category system.<sup>96</sup> However, it has been refined to six categories for ease of application by the Commonwealth and stakeholders. The categories are:

- RA1 (usually ineligible for most programs)
- RA 2–5 and populations greater than 50,000 people
- RA 2–5 and populations between 15,000 and 49,999 people
- RA 2–5 and populations between 5,000-14,999 people
- RA 2–3 and populations between 0-5,000 people
- RA 4–5 and populations between 0-5,000 people

These categories are based on the principle that it is vital to maximise "between group" differences and minimise "within group" differences in order to fairly measure access to health services and the need for differing incentive levels as part of program design. Analysis has shown that the adoption of a new six-level rurality classification measures is statistically equivalent to the full 13-level classification.<sup>97</sup>

Australian and international literature indicates that 24 hour on-call/after-hours care is one of the biggest barriers within the primary health care setting. Other professional factors that affect workforce distribution include hours worked, type of procedures, on-call arrangements and ability to have time off. Non-professional factors include spouse support and schooling arrangements. These are known as the six sentinel indicators, which were mapped under *MABEL*. However, the initial study demonstrated that while geographical remoteness was statistically associated with all six indicators, population size provided a more sensitive measure in directing where recruitment and retention incentives should be provided.<sup>98</sup>

The "Monash model" has appeal on a number of levels and was generally well supported in discussions at the Rural Classification System Working Group and during other review consultation forums. The use of "sentinel indicators" (listed above) was considered to be the major strength of this model, as opposed to modelling based in Medicare data which does not take into account these factors.<sup>99</sup>

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<sup>96</sup> Presentation to the review of Australian Government Health Workforce Programs, Humphreys et al. 2012

<sup>97</sup> Humphreys et. al, "Who should receive recruitment and retention incentives? Improving targeting of rural doctors using medical workforce data", *Australian Journal of Rural Health* 20, 2012, pp. 3-10.

<sup>98</sup> *ibid.*

<sup>99</sup> *ibid.*



While MABEL data has driven the development of the “Monash” model it does not need to be used on an ongoing basis. The analysis of the MABEL data led the Monash research team to the position that town size is an excellent proxy for effectively measuring the six “sentinel indicators”.

The Review has identified a number of advantages and disadvantages to the use of this system, as follows:

### *Advantages:*

- Incorporates statistical measurements linked to health service data as opposed to being merely a blunt geographic tool. Represents a more evidence-based approach to determining the best classification system.
- Addresses the disadvantage small towns and localities experience under the current RA classification.
- Provides the ability to link higher incentives to smaller locations with demonstrably greater health needs.

### *Disadvantages:*

- Doctors could be perversely incentivised to locate just outside town boundaries where they will receive a higher incentive than if they were based inside the town.
- Towns that are accessible to and are serviced by larger towns will be treated the same as similar sized towns in more remote locations that experience workforce shortages e.g. Alice Springs, Mt Isa and Port Hedland.
- Similar size towns will receive the same incentive irrespective of remoteness or access to services. For example, Coffs Harbour, NSW is in the same category as Mt Isa, QLD and Margaret River, WA is in the same category as Newman, WA.

The lack of a defined measurement of remoteness was raised as a significant drawback with this model during the ASGC-RA Workforce Group discussions.

In general, stakeholders were of the view that remote areas need to continue to have a separate classification in any new system, recognising the particular challenges these areas face due to the tyranny of distance. This is the case even for larger towns in remote areas such as Mt Isa and Alice Springs. Although these areas may have a reasonable core base of health service providers, the overall view was that they still face more difficult challenges in recruitment and retention than less remote towns with similar population levels.

### *The modified Monash model (proposed system)*

As discussed above, there is significant appeal to the Monash model, particularly in its use of evidence to provide a more accurate measure of service needs in different communities. The major concern is the way in which this model appears to discount the impact of remoteness upon communities, with subsequent consequences for health workforce recruitment and retention.

A “modified Monash model” has therefore been developed and is put forward for consideration by Government.



**Box 4.11: The modified Monash model**

This new model continues to use town size as the key classification determinant, as per the original Monash proposal, but recognises the different health service issues caused by remoteness, leaving the classifications for RAs 4 and 5 unchanged.

The seven categories under the proposal are:

1. RA1;
2. RA2 and RA3 with population > 50,000;
3. RA2 and RA3 with population 15,000 to 50,000;
4. RA2 and RA3 with population 5,000 to 15,000;
5. RA2 and RA3 with population < 5,000;
6. RA4;
7. RA5.

The model currently applies the proposed incentive structure to towns based on the ABS 2006 Urban Centre/Locality (UCL) classification and the 2006 ASGC remoteness area (RA) classification. The list of towns that fall into each category is based on the 2011 UCL classification and the 2006 RA classification. The 2011 ASGS-RA classification has been released in December 2012 and this should be incorporated into the final model.

There are a number of strengths of the proposed classification, based on a revision of the "Monash" model, including;

The proposed classification addresses the disadvantage small towns in RA2 and RA3 experience relative to larger towns.

By retaining separate categories for RA4 and RA5, the proposed system recognises disadvantages experienced by medium-large towns in remote areas (e.g. Mt Isa, QLD).

The proposed classification addresses anomalies under the current ASGC-RA system (e.g. Cherbourg, QLD).

The proposed classification addresses boundary issues along the RA2–3 boundary. Towns of similar size and location that sit on either side of the boundary no longer receive different incentives (e.g. Orange & Forbes, NSW).

The proposed classification introduces more categories in RA2 and RA3, recognising the diversity of towns in RA2–3.

To incorporate town size into the classification system, defined town boundaries will need to be settled on. The ABS UCL classification is the most logical definition to achieve this but there are some challenges with this approach, as discussed below.

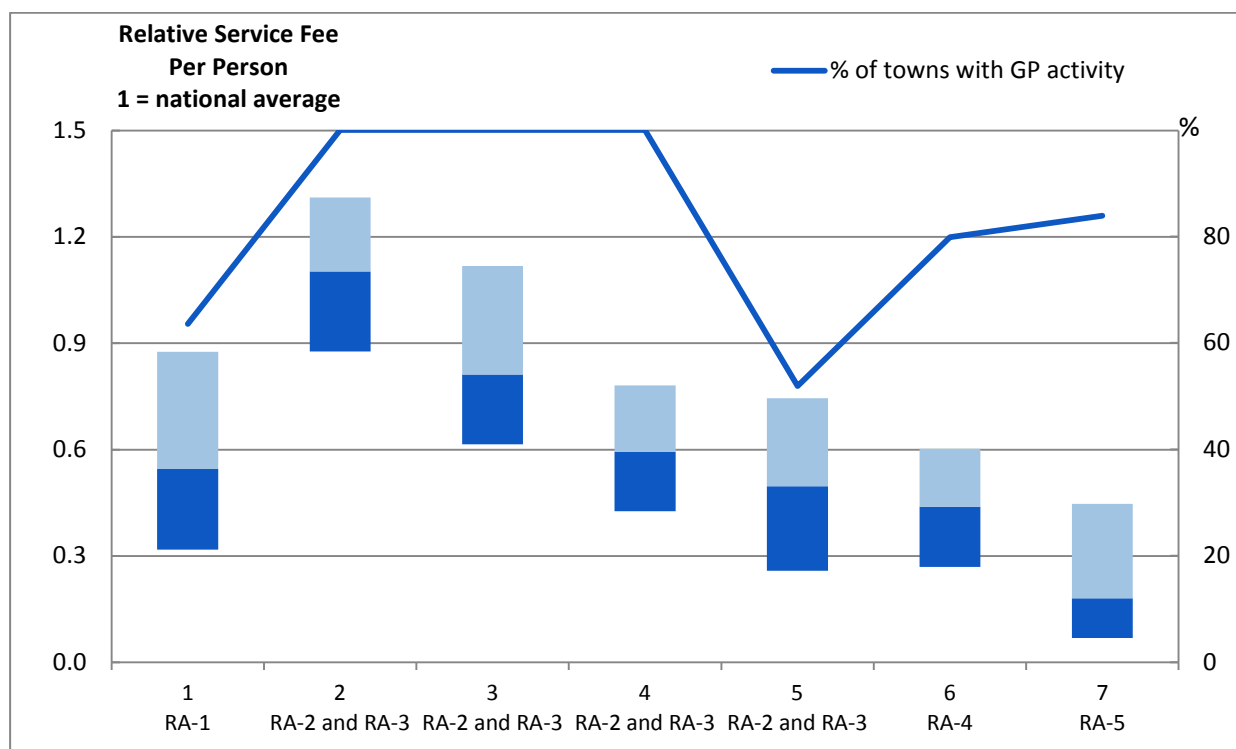
***Analysis of the proposed model***

A key consideration in determining the appropriateness of this proposed classification is how well it targets communities most in need of primary care services.

To illustrate this issue the Review has examined how the proposed revision to the RA system might impact on incentive payments administered under GPRIP, which is the main financial incentive initiative current using the ASGC-RA system. It is recognised that the RA system is used for a range of other government programs, which may not experience some of the issues related to how the RA system impacts on incentive payments.

In the absence of complete data on the availability and usage of health services within communities, 2010-11 Medicare data on GPRIP eligible services were compared with town populations weighted by age specific GP access rates. This was used to produce a relative GP Medicare service level for every town. The following chart illustrates the distribution of relative GP Medicare service levels in each town under the proposed classification.

Figure 4.6: Relative MBS service levels by town, 2010-11<sup>100</sup>



Source: Data analysis, Portfolio Strategies Division, Department of Health and Ageing, 2012

Figure 4.6 shows that median GP service levels in 2010-11 were progressively lower as the incentive class increased from 2 to 7. This suggests that the proposed incentive classification appropriately provides a basis through which program eligibility and payment levels can be adjusted to enable higher incentives (or other forms of support) to be directed towards towns with relatively higher need.

There are also weaknesses in this model, as exist in any classification system. The model is inherently more complex than continued use of the current ASGC-RA system and would essentially involve the Health portfolio designing and maintaining its own overlay classification methodology. This has impacts in terms of keeping data up to date (with ABS census updates) as well as consistency with other Commonwealth portfolios.

The key weaknesses in the model that have been identified are as follows:

<sup>100</sup> The proportion of towns with GP billing activity appears to be misleadingly low in RA 1 because there are a number of towns in RA 1 (e.g. Otford, NSW) with very little GP activity within the town itself, but whose population can readily access the nearest major city for GP services. Median service level is represented in the chart by the line where the light blue and dark blue boxes meet.

- Similar sized towns in RA2–3 are treated the same irrespective of their proximity to larger towns. For example, small towns within a short distance of Ballarat, VIC are treated the same as Charters Towers, QLD on the edge of RA3.
- Exacerbates existing disparities along the borders between RA1–2 and RA3–4. Small towns on the edge of RA1 (e.g. Kurri Kurri, NSW) and medium-large towns on the edge of RA3 (e.g. Kalgoorlie, WA) would receive considerably less in incentives than nearby towns in RA2 and RA4 respectively.
- The Government must maintain and update the classification, define towns/catchment areas and establish business rules to implement in the DHS system, which diverts resources otherwise available for programs to benefit health workers.

Different programs may need to use the modified ASGC-RA system in more flexible ways. Rural training programs (where program eligibility rules determine where students can undertake placements) may require a slightly different application of the system in comparison with incentive programs. Depending on how the proposed new system is used, further work and consultation with stakeholders may be required in order to minimise potential anomalies in the system and ensure it is as fair as possible.

For example, if the GPRIP Program is maintained in its existing form issues will arise from the new classification such as:

- Population cut points, where particular townships are either just under or just over the level required to generate different incentive amounts;
- Boundary issues that arise because towns and localities along category boundaries receive different incentives to nearby towns;
- Using town size as a determinant means greater use of the ABS Urban Centre/Locality (UCL) boundaries. UCLs are not designed to capture health service flows or catchment areas and cover only a small portion of the overall landmass of Australia. Rules would have to be established for the treatment of doctors practising outside UCL boundaries.

Creating buffer zones (such as a set radius e.g. 20km around UCL boundaries) or catchment areas (based on the distances people travel to work) may be a logical solution to address issues with UCL boundaries. While there are a number of possible options for designing buffer zones, each of these has limitations and further analysis is required before this type of approach could be applied to program rules.

While it is acknowledged that additional work is required to fine tune the proposed rural classification model, it does appear to offer significant advantages in comparison to continued use of the ASGC-RA classification without refinement. If the Government agrees to implement this model, it should do so in consultation with key stakeholders, to ensure important users understand the new systems and work with Government to resolve the boundary and other issues before the new system is implemented. An implementation working group could be established for this.

This model builds on the evidence base provided by the Monash University research team but maintains the measures of remoteness considered desirable by stakeholders. This proposal would provide a system that can be used with a degree of flexibility within individual programs, allowing greater targeting of different types of government investment. Changes to program delivery models, as discussed elsewhere in this review, may help to mitigate some of the risks. How the system is

used by each program becomes the key consideration, rather than the geographic system itself.

This principle of flexibility may go some way to addressing local inequities which prevent successful recruitment and retention of medical practitioners, however, broader lifestyle concerns including expectations of on-call roster participation, educational opportunities for offspring and employment for spouses cannot be overcome merely by increasing the difference in incentives across the RA bands.

Incentives are only a powerful tool insofar as they form part of the total experience of a medical professional within the community.

As highlighted by the RDAA in recent media articles,<sup>101</sup> doctors are currently departing Mt Isa (RA4), potentially for other more 'desirable' practice locations such as Cairns or Townsville (RA3). While the "modified Monash model" if implemented, would not change the classification of these locations, there are fundamental differences in the locations themselves which would continue to exist regardless of the size of any incentive. Government investments would be best directed in ways which will generate meaningful incentives at the regional level, rather than attempting a catch-all fix for every comparable location across Australia.

#### *Other options for systems to measure rurality*

In considering this issue a number of other proposals have been examined which would combine continued use of the ASGC-RA system with other measures designed to allow greater definition of rural areas, as a means of determining need.

#### **Box 4.12: Other options for systems to measure rurality**

##### **SEIFA**

A proposal has been considered to combine ASGC-RA with a measure of socioeconomic status. The best available measure is the ABS Socioeconomic Indexes for Areas (SEIFA). This proposal would involve a sub-classification with the RA boundary in accordance with relative socioeconomic disadvantage.

Under the proposal, towns would be classified by ASGC-RA and sub-classified by relative levels of socioeconomic disadvantage, e.g.

- RA1
- RA1 and relatively high levels of socioeconomic disadvantage
- RA2
- RA2 and relatively high levels of socioeconomic disadvantage
- RA3
- RA3 and relatively high levels of socioeconomic disadvantage
- RA4
- RA4 and relatively high levels of socioeconomic disadvantage
- RA5
- RA5 and relatively high levels of socioeconomic disadvantage

The SEIFA classification would target towns most in need and addresses many problem areas. However, the model also presents some problems, including:

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<sup>101</sup> Cronin, S. "A right, rural mess: sort out classification", *Medical Observer*, National. 22 March 2013

- Large towns generally contain highly disadvantaged and highly advantaged populations making a single SEIFA score meaningless.
- Current SEIFA scores are based on out-dated 2006 census data. 2011 census-SEIFA data will not be released until late March 2013.
- DoHA would have to determine what it considers to be a high level of disadvantage. This determination will disadvantage towns that fall below the cut-off point.
- SEIFA has not previously been used for this purpose. There may be unknown drawbacks to its use.

On balance, the complexity associated with use of the SEIFA system combined with ASGS-RA, and the challenges of implementing it across various programs lead to the recommendation that this approach is not suitable for health workforce programs.

### **Survey-based data systems**

Other proposals recommend combining ASGS-RA and/or town size with a measure of doctor service levels in a town or measures of difficulty recruiting doctors to a town.

These types of models revolve around ongoing surveys and data systems designed to more definitively measure health service needs.

Such a classification has the potential to direct incentives to where they are needed most but presents challenges in implementation and system maintenance.

This type of classification would:

- be highly volatile as service levels and recruitment activity fluctuates (particularly in small towns);
- create the potential for perverse incentives for doctors to underservice or for practices to leave vacancies unfilled;
- be vulnerable to manipulation to the extent medical practices control service levels and recruitment activity; and
- potentially disadvantage towns with high demand for services relative to towns with less demand.

While this type of approach may be beneficial at the local level, it would be challenging to implement nationally and is not recommended.

### **Implementation**

Immediately following the Review, further development of the “modified Monash model” classification and data systems will be required. In the medium term, the transition of Health Workforce Programs and potentially other Commonwealth initiatives should be overseen by an Implementation Working Group, the composition of which will be determined in consultation with the initial stakeholder working group convened in Canberra in November 2012.

### ***Use of the reformed classification system***

The following are a list of circumstances in which the new rural classification system could be used:

- 1) To inform funding allocations to regions under a novel regional incentive model, allowing remoteness and town population related issues to be accommodated within the funding formulas.
- 2) To support an alternative to a new incentive model, where GPRIP is retained but incentives are better targeted on the basis of need.
- 3) To inform funding allocations and define eligibility requirements under rural training programs such as the RCTS and the STP.

- 4) To define eligibility requirements and funding for locum schemes.
- 5) As a potential mechanism to allow more targeted investments in scholarships such as RAMUS, with preference given to recipients from smaller, more remote locations or who complete their education or training in such locations.

### *Recommendations*

Recommendation	Affected programs	Timeframe
<p><b>Recommendation 4.20:</b> The ASGC-RA system should be substantially adapted to the needs of health workforce programs to more appropriately recognise differing access to health services within broad geographic regions and within communities.</p> <p>A modification to the “Monash model” is recommended as the approach most likely to provide positive enhancements to current systems. This ‘modified Monash model’ would retain the ability to provide greater definition between locations in the same ASGC-RA bands (RA2 and 3) while recognising the need to allow for remoteness as a key factor (retaining RA4 and 5).</p> <p>The geographic classification components of the revised system should be based on the Australian Statistical Geography Standard (ASGS), as the ABS will soon replace the use of ASGC with this enhanced system.</p> <p>Further work on the implementation of this model will be required before it can be used within individual programs. The model is not appropriate for application inflexibly across programs. Each initiative may need to adjust its guidelines to use the revised system in the most effective way.</p> <p>The Department should commence discussions with stakeholders on a revised model based on the core principles outlined in the Report. This should include discussions across the portfolio around the implications for other program areas and the potential for broader application of the model outside</p>	GPRIP and other incentive programs, rural training programs	<p>Short term – further development of the classification model and data systems will be required immediately following this review.</p> <p>Medium term – health workforce programs, and potentially other Commonwealth initiatives, will need to transition to the enhanced system.</p>



Recommendation	Affected programs	Timeframe
workforce initiatives. An implementation working group should be established.		



## Chapter 5: Supporting the Aboriginal and Torres Strait Islander health workforce

This chapter provides an overview of the current status of the Aboriginal and Torres Strait Islander health workforce and Commonwealth health workforce programs that are intended to strengthen Aboriginal and Torres Strait Islander health workforce capacity and improve the ability of the broader health workforce to address the needs of Aboriginal and Torres Strait Islander people.

The recommendations within this chapter have been informed by consultations with key stakeholders during this review.

The chapter focuses predominantly on the allocation of funding from the Health Workforce Fund (HWF) to support the Aboriginal and Torres Strait Islander health workforce.

Within the Health portfolio, the Office for Aboriginal and Torres Strait Islander Health (OATSIH) is responsible for overall health policy regarding Aboriginal and Torres Strait Islander people. OATSIH is currently developing the National Aboriginal and Torres Strait Islander Health Plan (the Health Plan), which includes consideration of developing the health workforce as a key issue.

The Health Workforce Division (HWD) is tasked with contributing to increasing the number of Aboriginal and Torres Strait Islander people in the health workforce, increasing the retention of Aboriginal and Torres Strait Islander people in the health workforce, supporting Aboriginal and Torres Strait Islander health professional organisations to play an active leadership role in health workforce development, and ensuring health education and training equips health professionals with the knowledge, skills and understanding to provide culturally appropriate care.

### 5.1 Context

#### Overview of Aboriginal and Torres Strait Islander health

In the 2011 Census, approximately 550,000 people identified as being of Aboriginal and/or Torres Strait Islander descent, equating to around 2.5% of the Australian population.<sup>102</sup> Up to 75% of Aboriginal and Torres Strait Islander people are located in major cities and regional areas, with the remaining 25% located in remote areas.<sup>103</sup> In understanding the health needs of Aboriginal and Torres Strait Islander Australians it is therefore important to bear in mind the needs of urbanised populations as well as the (often quite different) needs of regional and remote Aboriginal and Torres Strait Islander communities.

In comparison with the broader Australian population, Aboriginal and Torres Strait Islander people on average die younger, have significantly higher rates of ill health and are more likely to have a disability. The majority of health concerns experienced by Aboriginal and Torres Strait Islander people are those of a chronic nature, such

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<sup>102</sup> Australian Bureau of Statistics, *2015.0 – Census of Population and Housing – Counts of Aboriginal and Torres Strait Islander Australians*, ABS, 2011

<sup>103</sup> Community Services and Health Industry Skills Council, *Environmental Scan*, CS&HIC, 2012, p. 8

as cardiovascular disease, cancer, respiratory disease, diabetes, mental illness and oral health. The health issues experienced by Aboriginal and Torres Strait Islander people are affected by high levels of socioeconomic disadvantage.<sup>104</sup>

In 2008, 26% of Aboriginal and Torres Strait Islander people aged 15 years and over reported problems with accessing health services. Access issues were higher in remote areas (36%) than non-remote areas (23%). Of the people reporting problems accessing services, close to 20% reported problems accessing dentists, followed by doctors (10%), hospitals (7%) and Aboriginal and Torres Strait Islander health workers (6%). Key barriers identified to accessing health services included:

- waiting time too long/not available at time requested (52%);
- not enough services in area (42%);
- no services in area (40%);
- transport/distance (34%);
- cost of service (32%);
- don't trust services (10%); and
- services not culturally appropriate (7%).<sup>105</sup>

Chronic disease is identified in the *Aboriginal and Torres Strait Islander Health Performance Framework 2012 Report* (Performance Framework) as a key area of concern. DoHA was advised that during the development of the National Aboriginal and Torres Strait Islander Health Plan, many health experts and Aboriginal and Torres Strait Islander community members suggested that barriers to early detection of chronic disease include lack of awareness of the role of primary health care services, how welcoming the services are to Aboriginal and Torres Strait Islander people, the relationship with the health care providers as well as trust in the providers, and communication issues.<sup>106</sup>

### Overview of the Aboriginal and Torres Strait Islander health workforce

2011 ABS Census data indicates an increase in the total number of Aboriginal and Torres Strait Islander people in the health workforce since the last census in 1996. Table 5.1 below shows an increase in the workforce from 1996 to 2011 in selected health-related occupations. The table highlights that the number of Aboriginal and Torres Strait Islanders working in the majority of health professions increased between 2006 and 2011.

There has also been a significant increase in the number of Aboriginal and Torres Strait Islander people studying health-related disciplines since 2006. While there have been efforts from both Commonwealth and state/territory governments to increase the size of the Aboriginal and Torres Strait Islander health workforce in recent years, there has also been an increase in the number of people identifying as Aboriginal and Torres Strait Islanders in the 2011 Census.

Despite the increase in numbers in the workforce, Aboriginal and Torres Strait Islander people remain under-represented in the health workforce (as a proportion of

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<sup>104</sup> *ibid.*

<sup>105</sup> Australian Health Ministers' Advisory Council (AHMAC), *Aboriginal and Torres Strait Islander Health Performance Framework 2012 Report*, AHMAC, Canberra, 2012

<sup>106</sup> Department of Health and Ageing, *Development of a National Aboriginal and Torres Strait Islander Health Plan – Discussion Paper*, Commonwealth of Australia, 2012.

the population) when compared with the non–Aboriginal and Torres Strait Islander health workforce. ABS data shows that approximately 1.8% of Australia's health workforce consists of Aboriginal and Torres Strait Islander people.<sup>107</sup>

The Performance Framework identifies that increasing the proportion of Aboriginal and Torres Strait Islander people currently in the health workforce is essential to closing the gap in Aboriginal and Torres Strait Islander life expectancy. It also supports the aspirational target of Aboriginal and Torres Strait Islander people comprising at least 2.6% of employees in the public health sector by 2015 (this target has recently been increased to 2.7%).<sup>108</sup>

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<sup>107</sup> Australian Bureau of Statistics, 2011 Census: Employment, Income and Unpaid Work – accessed by DoHA through Table Builder, January 2013.

<sup>108</sup> Australian Health Ministers' Advisory Council (AHMAC), *Aboriginal and Torres Strait Islander Health Performance Framework 2012 Report*, AHMAC, Canberra, 2012

*Table 5.1: Aboriginal and Torres Strait Islander people employed in selected health-related occupations, 1996, 2001, 2006 and 2011*

Occupations	1996	2001	2006	2011	Difference (2011-2006)	Percentage change 2006-2011
<b>Registered Nurses</b>	640	832	1104	1709	605	54.80%
<b>Enrolled and mothercraft nurses</b>	564	202	216	287	71	32.87%
<b>Nursing support worker and personal care workers</b>	579	808	984	1438	454	46.14%
<b>Midwives</b>	27	40	50	70	20	40.00%
<b>Nurse Managers and Nursing Clinical Directors</b>	20	38	54	81	27	50.00%
<b>Nurse Educators and Researchers</b>	7	11	17	21	4	23.53%
<b>Indigenous Health Workers</b>	667	853	965	1255	290	30.05%
<b>Generalist medical practitioners</b>	41	57	80	129	49	61.25%
<b>Pharmacists</b>	6	10	11	28	17	154.55%
<b>Medical Imaging Professionals</b>	7	14	20	20	0	0.00%
<b>Ambulance officers and paramedics</b>	49	83	153	216	63	41.18%
<b>Psychologists</b>	13	19	43	85	42	97.67%
<b>Social Workers</b>	113	166	269	462	193	71.75%
<b>Physiotherapists</b>	16	29	54	78	24	44.44%
<b>Dietitians</b>	n.p.	18	7	25	18	257.14%
<b>Occupational therapists</b>	n.p.	n.p.	13	23	10	76.92%
<b>Dental practitioners</b>	12	13	18	23	5	27.78%
<b>Dental hygienists, technicians and therapists</b>	18	17	15	30	15	100.00%
<b>Dental assistants</b>	117	125	171	266	95	55.56%
<b>Speech professionals and audiologists</b>	7	10	17	18	1	5.88%
<b>Podiatrists</b>	6	8	7	5	-2	-28.57%
<b>Optometrists</b>	n.p.	n.p.	8	5	-3	-37.50%
<b>Totals</b>			<b>4276</b>	<b>6274</b>	<b>1998</b>	<b>46.73%</b>

Source: ABS 2011 Census: Employment, Income and Unpaid Work - accessed by DoHA through Table Builder January 2013



Aboriginal and Torres Strait Islander people are clearly under-represented in nursing, medical practice and allied health professions. Interestingly, though, the most common health-related course for Aboriginal and Torres Strait Islander undergraduate students in 2010 was nursing. Of all the health-related professions, the participation rates in rehabilitation therapies, dental, pharmacy, radiology and optical studies were the lowest.<sup>109</sup> Table 5.2 below shows a comparison of Aboriginal and Torres Strait Islander people working in each health profession compared with non-Aboriginal and Torres Strait Islander people.<sup>110</sup>

DoHA has indicated that while there has been significant improvement in Aboriginal and Torres Strait Islander data collection, data quality limitations are still prevalent and should be recognised when interpreting results. It is important to take this into account when evaluating Aboriginal and Torres Strait Islander health and the health workforce.<sup>111</sup>

*Table 5.2: 2011 ABS Census data – health professions*

Occupations	Indigenous health professionals	Total number of health professionals	Indigenous as a percentage of total health professionals
<b>Health Diagnostic and Promotion Professionals</b>	5	156	3.21%
<b>Dietitians</b>	25	3707	0.67%
<b>Medical Imaging Professionals</b>	20	13244	0.15%
<b>Occupational and Environmental Health Professionals</b>	298	18925	1.57%
<b>Optometrists and Orthoptists</b>	5	4303	0.12%
<b>Pharmacists</b>	28	19935	0.14%
<b>Other Health Diagnostic and Promotion Professionals</b>	569	5595	10.17%
<b>Health Therapy Professionals</b>	0	169	0.00%
<b>Chiropractors and Osteopaths</b>	10	4348	0.23%
<b>Complementary Health Therapists</b>	19	5949	0.32%
<b>Dental Practitioners</b>	23	10988	0.21%
<b>Occupational Therapists</b>	23	9248	0.25%
<b>Physiotherapists</b>	78	15929	0.49%
<b>Podiatrists</b>	5	2801	0.18%
<b>Speech Professionals and Audiologists</b>	18	6799	0.26%
<b>Medical Practitioners</b>	3	1432	0.21%
<b>Generalist Medical Practitioners</b>	129	43430	0.30%
<b>Anaesthetists</b>	3	3764	0.08%
<b>Specialist Physicians</b>	3	5472	0.05%
<b>Psychiatrists</b>	8	2584	0.31%

<sup>109</sup> *ibid.*

<sup>110</sup> *ibid.*

<sup>111</sup> Australian Health Ministers' Advisory Council (AHMAC), *Aboriginal and Torres Strait Islander Health Performance Framework 2012 Report*, AHMAC, Canberra, 2012

Occupations	Indigenous health professionals	Total number of health professionals	Indigenous as a percentage of total health professionals
Surgeons	11	4926	0.22%
Other Medical Practitioners	18	8620	0.21%
Midwifery and Nursing Professionals	3	354	0.85%
Midwives	70	14103	0.50%
Nurse Educators and Researchers	21	5288	0.40%
Nurse Managers	81	12631	0.64%
Registered Nurses	1709	206916	0.83%
Health Professionals	61	2115	2.88%
Health and Welfare Support Workers	68	777	8.75%
Ambulance Officers and Paramedics	216	11939	1.81%
Dental Hygienists, Technicians and Therapists	30	6332	0.47%
Diversional Therapists	43	4257	1.01%
Enrolled and Mothercraft Nurses	287	17893	1.60%
Indigenous Health Workers	1255	1372	91.47%
Massage Therapists	75	10604	0.71%
Psychologists	85	18604	0.46%
Social Workers	462	16917	2.73%
Welfare Support Workers	3575	50206	7.12%
Personal Carers and Assistants	61	1422	4.29%
Aged and Disabled Carers	2669	108215	2.47%
Dental Assistants	266	18824	1.41%
Nursing Support and Personal Care Workers	1438	70503	2.04%
Special Care Workers	246	2794	8.80%
<b>Total</b>	<b>14022</b>	<b>774390</b>	<b>1.81%</b>

Source: ABS 2011 Census: Employment, Income and Unpaid Work - accessed by DoHA through Table Builder January 2013.

### Addressing Aboriginal and Torres Strait Islander health outcomes

A range of issues affect efforts to strengthen the capacity of the health workforce to address Aboriginal and Torres Strait Islander health outcomes. Many of these were identified through the Aboriginal and Torres Strait Islander Health Workforce Roundtable consultation undertaken as part of this review.

#### *Opportunities and key areas for improvement*

Stakeholders made considered and valuable contributions to improving Aboriginal and Torres Strait Islander health outcomes; these are reflected in this chapter. Key recommendations raised in this review's consultation process included:

- the maintenance of mentoring and support programs provided by Aboriginal and Torres Strait Islander peak organisations with the aim of increasing recruitment and retention;

- developing pathways or pipelines from school, to the vocational education and training sector, to undergraduate studies and into the health workforce;
- increasing the health education/training system capacity to deliver culturally safe health care; and
- continuing support for Aboriginal and Torres Strait Islander leadership activities.

### ***Aboriginal and Torres Strait Islander participation in the health workforce***

The under-representation of Aboriginal and Torres Strait Islander people in the health workforce appears to be one of the factors contributing to the lower rates of Aboriginal and Torres Strait Islander people accessing health services compared with non-Aboriginal and Torres Strait Islander people.<sup>112</sup> Increasing the rates of participation and completion of training by Aboriginal and Torres Strait Islander people in the Australian health workforce is fundamental to achieving better health outcomes.

### ***Education***

In relation to tertiary education, there is a need to increase participation of Aboriginal and Torres Strait Islander people in relevant health education and training courses, as well as incorporating Aboriginal and Torres Strait Islander health and cultural understanding into mainstream health workforce education and training. Improved education and training of health practitioners could assist in breaking down current barriers that impact on Aboriginal and Torres Strait Islander people accessing primary health care services.<sup>113</sup>

As the number of Aboriginal and Torres Strait Islander people studying health-related disciplines grows, it is important to provide appropriate support and mentoring within the educational pathway that leads into the workforce. For this to be achieved there needs to be greater collaboration in Aboriginal and Torres Strait Islander health workforce policy and program development, not only within DoHA but across government.

### ***Recruitment and retention***

Recruitment and retention of Aboriginal and Torres Strait Islanders in health-related disciplines is vital to achieve positive health outcomes, as is providing appropriate training and support to non-Aboriginal and Torres Strait Islander health practitioners.

#### **Box 5.1: The Indigenous Chronic Disease Package (ICDP) Sentinel Sites Evaluation (SSE)**

The Sentinel Sites Evaluation (SSE) provides place-based monitoring and formative evaluation of the Indigenous Chronic Disease Package (ICDP). The Menzies School of Health Research has been contracted to undertake the Sentinel Sites Project (2010 to 2013). Twenty-four evaluation sites have been established across Australia covering urban, regional and remote areas. The SSE provides important information in relation to the ICDP at a local level and informs ongoing program refinement.

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<sup>112</sup> Australian Health Ministers' Advisory Council (AHMAC), *Aboriginal and Torres Strait Islander Health Performance Framework 2012 Report*, AHMAC, Canberra, 2012

<sup>113</sup> Department of Health and Ageing, *Development of a National Aboriginal and Torres Strait Islander Health Plan – Discussion Paper*, Commonwealth of Australia, 2012.

The SSE identified a range of “enablers” and “constraints” in the context of developing a workforce with the skills and capacity to improve access to and delivery of high quality services and programs for prevention and management of chronic disease.

The enablers include:

- leadership commitment to workforce development;
- structured and informed management;
- clear articulation of vision and workforce requirements;
- a tiered approach to dissemination of information to enable communications to be tailored to the needs of different organisations and individuals; and
- practical support.

The constraints include:

- highly variable workforce capacity;
- limited availability of skilled workers;
- limited service capacity for mentoring, supervising and developing staff; and
- operational systems that are not well integrated.<sup>114</sup>

A key policy consideration identified by the ICDP SSE was the need to enhance the skills of the existing health workforce (for instance, nurses, who are well distributed in rural and regional areas of Australia), to provide more complex chronic disease management services and care.<sup>115</sup> This highlights the importance of changing the focus towards preventative health care to address chronic disease in Aboriginal and Torres Strait Islander people, rather than continuing an approach based only on uncoordinated episodes of care to treat the symptoms of disease. This has important implications for training of the existing workforce, as well as the education of the future health workforce.

### ***Distribution***

Whilst there is a lot of effort focused on increasing the level of recruitment and retention of the health workforce in rural and remote areas, there are also challenges on building an appropriate health workforce in urban areas.

In addition to addressing geographical distribution of the health workforce, in its 2009 report, *A Healthier Future for All Australians*,<sup>116</sup> the National Health and Hospitals Reform Commission recommended strengthening and expanding the organisational capacity and sustainability of the Aboriginal community-controlled health sector to provide broader comprehensive primary health care services.

### ***New workforce roles***

The Aboriginal and Torres Strait Islander Health Worker Project – *Growing Our Future*, was released by Health Workforce Australia (HWA) in December 2012. Outcome 2.3 of this report proposes a more collaborative and strategic approach to

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<sup>114</sup> Menzies School of Health Research, *Indigenous Chronic Disease Package Sentinel Sites Evaluation Draft Report*, 2013 (unpublished).

<sup>115</sup> *ibid.*

<sup>116</sup> National Health and Hospitals Reform Commission, *A Healthier Future for All Australians: Final Report*, 2009.

planning the Aboriginal and Torres Strait Islander health workforce in response to local needs.<sup>117</sup>

Some key stakeholders consulted as part of this review's consultation process identified that there should be a focus on incorporating additional competencies (training based) into current health workforce professions, including Aboriginal and Torres Strait Islander health workers, rather than creating new, specialised health workforce roles. Stakeholders raised this issue in the context of the creation of new workforce roles under the Indigenous Chronic Disease Package, where they argue that unintended consequences have arisen when existing health workers have left their current roles to take up these new positions.

The introduction of some Council of Australian Governments (COAG) workforce measures, including supporting new positions for Regional Tobacco Coordinators, Tobacco Action Workers, Healthy Lifestyle and Aboriginal and Torres Strait Islander Outreach Workers, has heightened the debate over pay inequity between different types of health workers providing services in these communities. In consultations as part of this review key stakeholders identified that these new workers are reportedly paid more than some existing Aboriginal and Torres Strait Islander Health Workers, without requiring the same level of qualification or having as broad a scope of practice. In consequence, Aboriginal and Torres Strait Islander health workers may be motivated to move out of clinical roles and into the new COAG-funded positions.

However, it should be noted that the ICDP SSE project could not find clear evidence of recruitment of Indigenous Health Outreach Workers or Aboriginal and Torres Strait Islander Outreach Workers in mainstream organisations having a negative impact on the Aboriginal and Torres Strait Islander workforce of other programs or sectors.<sup>118</sup> This highlights the importance of enhancing collaboration in policy and program development to ensure new initiatives do not adversely affect the current health workforce (this is further discussed in Chapter 9 of this report). Linkages between clinical, community support and health promotion roles and their respective competencies also need to be considered in the mapping of workforce roles.

## ***5.2 National initiatives to increase Aboriginal and Torres Strait Islander health workforce capacity***

### **Council of Australian Governments initiatives**

Through the COAG process National Partnership Agreements (NPAs) were developed in 2008-09. The agreements encompass Aboriginal and Torres Strait Islander early childhood, health, education and employment with the health elements being underpinned by a focus on building Aboriginal and Torres Strait Islander health workforce capacity. This has led to greater workforce momentum, reflected in the 2011 census data.

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<sup>117</sup> Health Workforce Australia, [Growing Our Future: Final Report of the Aboriginal and Torres Strait Islander Health Worker Project](http://www.hwa.gov.au/work-programs/workforce-innovation-and-reform/atsihw), December 2011, accessed at <http://www.hwa.gov.au/work-programs/workforce-innovation-and-reform/atsihw>

<sup>118</sup> Menzies School of Health Research, *Indigenous Chronic Disease Package Sentinel Sites Evaluation Draft Report*, 2013 (unpublished).

Although raw numbers in some cases are very small, in percentage terms there have been substantial increases in the numbers of Aboriginal and Torres Strait Islander doctors (61%), registered nurses (54%), enrolled nurses (32%), allied health professionals (ranging from 5% to 257% depending on discipline), and Aboriginal and Torres Strait Islander health workers (30%) between 2006 and 2011. As outlined in Table 5.2 above, despite these recent increases, Aboriginal and Torres Strait Islander people continue to be under-represented in the health workforce (1.8% of health workers nationally in 2011).

The expansion of the Aboriginal and Torres Strait Islander workforce and increased capacity of the health workforce to deliver effective care is a priority area of the Indigenous Chronic Disease Package, under the National Partnership Agreement on Closing the Gap in Aboriginal and Torres Strait Islander Peoples' Health Outcomes (2009–2013). The following summary outlines some of the key planning and consultation processes that have been developed to contribute to achieving the Closing the Gap goals.

### Box 5.2: Examples of various national initiatives

#### *National Aboriginal and Torres Strait Islander Health Plan*

In September 2012 the Minister for Indigenous Health, the Hon. Warren Snowdon MP, launched a Discussion Paper underpinning national consultations for the development of a National Aboriginal and Torres Strait Islander Health Plan. Though there is still work to be completed, from a workforce perspective, the key themes that have already emerged from consultations include:

- the need for clearly articulated flexible pathways from school to vocational education and training (VET) and to either work or undergraduate studies in health; and
- attracting, training and retaining both Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander people in Indigenous health service provision.<sup>119</sup>

#### *Aboriginal and Torres Strait Islander Health Performance Framework*

The Aboriginal and Torres Strait Islander Health Performance Framework 2012 Report was released in November 2012. This report measures the impact of the National Strategic Framework for Aboriginal and Torres Strait Islander Health and identifies some improvements in mortality and avoidable mortality, circulatory disease, education, employment, access to prescription medicines, immunisation and antenatal care.<sup>120</sup> The report, however, notes ongoing data issues and continuing concerns in chronic disease management, cancer, kidney disease, low birth weight and eye health. This work is informing the development of the National Aboriginal and Torres Strait Islander Health Plan and will guide the development of future health workforce initiatives.

#### *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework*

The National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework (2011-15), which was endorsed by the Australian Health Ministers' Advisory Council in 2011, has an aspirational target of 2.6% of the health workforce being Aboriginal and Torres Strait Islander by 2015. The Aboriginal and Torres Strait Islander Health Workforce Working Group (ATSIHWWG) developed the

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<sup>119</sup> Accessed at [www.health.gov.au/natsihp](http://www.health.gov.au/natsihp)

<sup>120</sup> Australian Health Ministers' Advisory Council (AHMAC), *Aboriginal and Torres Strait Islander Health Performance Framework 2012 Report*, AHMAC, Canberra, 2012



Framework. ATSIHWWG is comprised of representatives of Commonwealth, state and territory governments, representatives of the Aboriginal community-controlled health sector and peak Aboriginal and Torres Strait Islander health workforce organisations, who are responsible for monitoring and reporting on progress to achieve targets under the framework.

### *National Registration and Accreditation Scheme*

On 1 July 2012, Aboriginal and Torres Strait Islander health practitioners were included as part of the National Registration and Accreditation Scheme (NRAS), providing Aboriginal and Torres Strait Islander health practitioners and students with opportunities to be nationally registered. The purpose of national registration is to enhance the quality of holistic health care provided to Aboriginal and Torres Strait Islander people. The approved program of study for Aboriginal and Torres Strait Islander health practitioners is currently a *Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care (Practice)*. The majority of Aboriginal and Torres Strait Islander health practitioners currently registered under NRAS are from the Northern Territory.<sup>121</sup>

### *Health Workforce Australia*

Current work is being undertaken by HWA to inform Government policy and program development. In particular, the HWA study of the roles of Aboriginal and Torres Strait Islander health workers and Practitioners may assist with providing a better understanding on how this workforce can contribute to improved health outcomes.

HWA is also working with Indigenous Allied Health Australia and the National Aboriginal and Torres Strait Islander Health Worker Association on a number of projects and studies contributing to building the capacity of these important workforces.

While these significant ongoing consultation, planning and policy development processes are all important steps in addressing Aboriginal and Torres Strait Islander health outcomes they will not, by themselves, translate into measurable change at the community level. As these processes are quite recent and development work is continuing, the achievement of clear outcomes was not completely apparent during the course of this review.

## **5.3 Strengthening education and training**

Increasing opportunities for Aboriginal and Torres Strait Islander people to undertake tertiary education in health disciplines and strengthening the quality of education in relation to Aboriginal and Torres Strait Islander health is vital, although there are many challenges in the way of achieving increased participation by Aboriginal and Torres Strait Islander young people, including family and financial barriers, and the attraction presented by trade-related occupations, particularly in the mining sector.

The 2012 Community Services and Health Industry Skills Council Environmental Scan highlights leadership, mentoring, prevocational training, vocational training and work experience as crucial in providing an appropriate Aboriginal and Torres Strait

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<sup>121</sup> Aboriginal and Torres Strait Islander Health Practice Board of Australia, [Aboriginal and Torres Strait Islander Registration Data: March 2013](http://www.atsihealthpracticeboard.gov.au/About/Statistics.aspx), accessed at <http://www.atsihealthpracticeboard.gov.au/About/Statistics.aspx>

Islander health workforce and developing an appropriate broader health workforce to address Aboriginal and Torres Strait Islander health.<sup>122</sup>

### Commonwealth health-related scholarships

Funding scholarships with a health-related focus is one way the Commonwealth encourages Aboriginal and Torres Strait Islander people to pursue a career in a health-related discipline. DoHA funds a range of scholarship programs targeting specific workforce needs.

Various submissions to the review indicated that there would be value in greater promotion of scholarships to students, raising awareness that Aboriginal and Torres Strait Islander people also have access to additional scholarship programs in the health-related disciplines. The Commonwealth health-related scholarships are more fully described in Chapter 3, but there are three scholarship programs dedicated to Aboriginal and Torres Strait Islander people studying in health, outlined below.

#### *Puggy Hunter Memorial Scholarship Scheme (multidisciplinary)*

The Puggy Hunter Memorial Scholarship Scheme provides scholarships to Aboriginal and Torres Strait Islander people who are undertaking study in a health-related discipline at Certificate IV level, undergraduate level or above. The scheme aims to address the under-representation of Aboriginal and Torres Strait Islander people in the health professions. In 2012, 155 scholarships were awarded as part of this scheme.

#### *Australian Rotary Health Indigenous Health Scholarships Program*

The Australian Rotary Health Indigenous Health Scholarships Program is a relatively small scheme in comparison to other Indigenous scholarship schemes. It provides scholarships to Aboriginal and Torres Strait Islander students in all health-related disciplines. Fifty per cent of the scholarship funding is provided by a local Rotary Club with Governments (Commonwealth or state and territory) contributing the remaining funding. Scholarship recipients also receive mentoring and other support by the different Rotary Clubs around Australia. In 2012, DoHA funding contributed to 40 scholarships.

#### *Aboriginal and Torres Strait Islander Pharmacy Scholarship Scheme*

The Aboriginal and Torres Strait Islander Pharmacy Scholarship Scheme aims to improve access to community pharmacy services by Aboriginal and Torres Strait Islander people by taking account of cultural issues in meeting health needs. The aim is to encourage Aboriginal and Torres Strait Islander students to undertake entry level studies at a university. Scholarships are offered preferentially to students who currently live, or have lived, in a rural or remote community.

### Aboriginal and Torres Strait Islander undergraduate students

The Rural Clinical Training and Support (RCTS) and the University Departments of Rural Health (UDRH) programs have specific objectives in place to encourage and support Aboriginal and Torres Strait Islander people in pursuing a health or medical career (refer to Chapter 4).

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<sup>122</sup> Community Services and Health Industry Skills Council, *Environmental Scan*, CS&HIC, 2012, p. 8

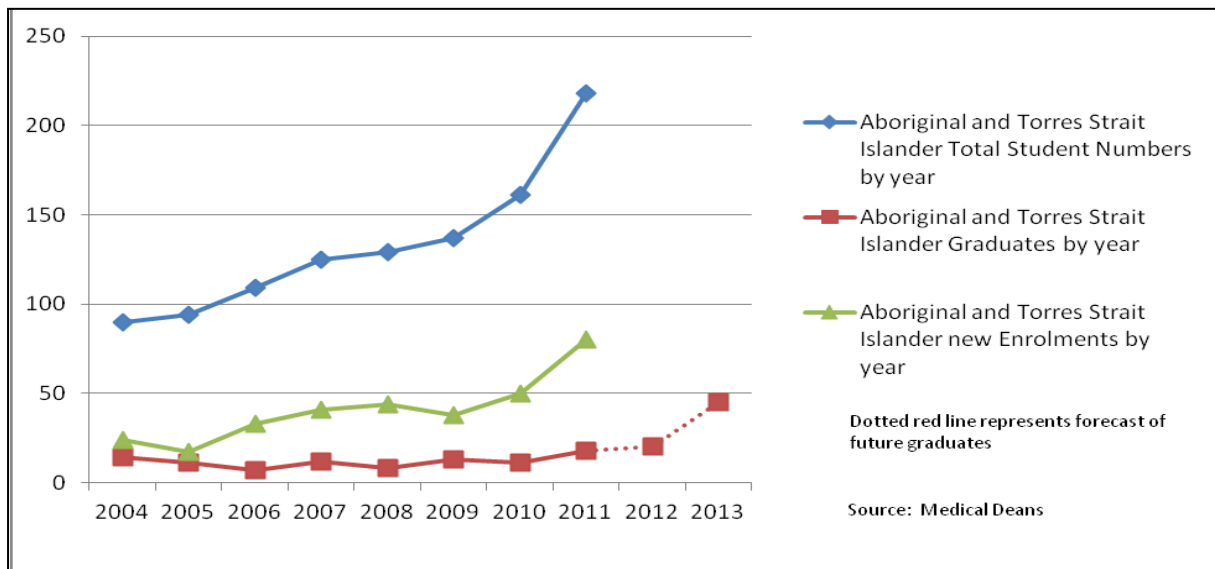
While these existing initiatives are beneficial, many stakeholders have argued that given the demographics of the Aboriginal and Torres Strait Islander population, described above, it is inappropriate to include objectives and activity areas for health education and training for Aboriginal and Torres Strait Islander people as a subset of designated university “rural” training programs. Instead, these stakeholders have suggested that a separately funded program should be created targeting:

- higher student enrolments;
- curriculum development and evaluation;
- placements for students in Aboriginal and Torres Strait Islander health settings; and
- mentoring and support services to increase the number of Aboriginal and Torres Strait Islander students graduating from health courses.

Evidence supplied by the Australian Indigenous Doctors’ Association (AIDA) supports the view that while efforts to increase enrolments of Aboriginal and Torres Strait Islander medical students have met with increasing success in recent years, this will not necessarily translate into substantial increases in the number of new graduates. AIDA and some other Aboriginal and Torres Strait Islander health workforce stakeholders argue that universities need to enhance their focus on student support, both academically and in terms of cultural safety and personal support, to ensure that the trend in increasing medical school enrolments is matched by growth in graduates in coming years, and that Government programs need to support this by introducing mandatory targets for universities.

Figure 5.1 below, provided by AIDA (using data from Medical Deans Australia and New Zealand (MDANZ)) illustrates this situation.

*Figure 5.1: Aboriginal and Torres Strait Islander medical student and graduate numbers*



### Mentoring

This review's consultation process identified the importance of mentoring mechanisms for Aboriginal and Torres Strait Islander health students undertaking tertiary education. Mentoring and support programs can significantly contribute to the recruitment and retention of Aboriginal and Torres Strait Islander students studying health-related disciplines. Consultations identified that mentoring and support programs need to occur along the entire educational pathway and continue into the workforce. The Indigenous Transitions Pathway (ITP) is an example of a support program which mentors Aboriginal and Torres Strait Islander students through their medical studies. It should be noted however that the ITP was developed specifically to support the NT Medical Program, which differs from other medical school programs and which operates within the particular geographic and other challenges of the Northern Territory.

#### Box 5.3: Indigenous Transitions Pathway (ITP)

The objective of the ITP is to support the retention of Aboriginal and Torres Strait Islander medical students in the NT Medical Program and to increase the number of Indigenous doctors in Australia. The total funds committed from 2009-10 to 2012-13 was \$3.5 million (GST exclusive). An additional \$0.5 million (GST exclusive) has been granted to extend the ITP until December 2013.

The ITP complements the key aims of the Aboriginal and Torres Strait Islander Health Services Program, by seeking to build Aboriginal and Torres Strait Islander health workforce capacity. The ITP also directly aligns with Australian Government policy to strengthen Aboriginal and Torres Strait Islander health workforce capacity and to recruit and retain Aboriginal and Torres Strait Islander medical students.

As part of the ITP, participating students have access to a financial and cultural support program, as well as bursaries to financially support students entering graduate entry medical programs. The ITP is expected to assist between five and 15 medical students per year through to graduation. As at 2012, 12 were students supported by the ITP. Of these 12 students, two had progressed to year two of the NT Medical Program, eight were consolidating their medical sciences in year one and two were new commencing students. In addition, six Aboriginal and Torres Strait Islander students who accepted places for 2013 are expected to be supported by the ITP.

The first cohort of ITP students only commenced in 2011 so the workforce benefits will not necessarily be measurable until students complete their qualifications. However, it is expected that the program will have a positive effect on rates of retention for participating students.

Other support programs directed at Aboriginal and Torres Strait Islander health courses (including medical) currently in place in Australian universities should also be considered in terms of effectiveness and efficiencies. These models should be considered along with the ITP model. For example, the University of Western Sydney and James Cook University can claim success with less intensive models than the ITP.

If the ITP model is found to be effective and cost-effective, consideration should be given to applying the lessons from this program to other health disciplines, not only in rural and remote locations but also universities located in major cities

Indigenous Allied Health Australia (IAHA), the Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN) and the National Aboriginal and Torres Strait Islander Health Worker Association (NATSIHWA) also administer programs around

mentoring and support which focus on their respective health workforce members however these programs do have resource constraints.

### *Culturally appropriate curricula*

Currently there is no standardised approach to incorporating Aboriginal and Torres Strait Islander health competencies as part of curricula in Australian universities. In many cases, it is left up to individual universities to incorporate these competencies into their programs. The attention given to Aboriginal and Torres Strait Islander health and cultural awareness appears to be variable between institutions. Developing Aboriginal and Torres Strait Islander health competencies and cultural competencies has the potential to improve the integration of Aboriginal and Torres Strait Islander health into health training.

This may assist Aboriginal and Torres Strait Islander people to access health services and improve health outcomes. Incorporating cultural understanding as part of health education and training programs was one of the key issues raised in consultations as part of the review.

Aboriginal and Torres Strait Islander health and cultural education should also be part of the ongoing training of all health practitioners in their formalised continuing professional development, not only in rural and remote areas but also in urban areas.

The Australian Nursing and Midwifery Accreditation Council (ANMAC) is one organisation which moved to strengthen Aboriginal and Torres Strait Islander health components within accreditation standards and criteria, having recently revised the standards and criteria for the accreditation of Australian nursing and midwifery courses. The revised standards and criteria have strengthened the requirement for undergraduate curricula to address Aboriginal and Torres Strait Islander health and culturally safe care by including a criterion that curricula must include a discrete subject specifically addressing Aboriginal and Torres Strait Islander peoples' history, health, wellness and culture. While this is a valuable improvement, it will also be important to ensure that this component of nurse training is adequately assessed in the accreditation process.

### **Student targets for universities**

As with curriculum development, there are no standardised Aboriginal and Torres Strait Islander health student targets in Australian universities. Currently, it is up to the individual universities to set their Aboriginal and Torres Strait Islander student admissions. Setting or incentivising targets would lead to growth in the Aboriginal and Torres Strait Islander health workforce more quickly, allow progress to be more easily measured, and increase accountability for outcomes.

A consultation process should be undertaken with Aboriginal and Torres Strait Islander peak bodies and other relevant stakeholders to consider appropriate Aboriginal and Torres Strait Islander student targets. It is important to take into account the capacity of jurisdictions and universities to provide education opportunities for Aboriginal and Torres Strait Islander people in different demographic areas.

This consultation process should also include a review to determine how faculties of health science in Australian universities are incorporating Aboriginal and Torres Strait Islander health into the curricula of health-related disciplines. It would be



beneficial for the findings of such a review to report to an advisory/guidance group consisting of representatives from DoHA, the Department of Education, Employment and Workplace Relations (DEEWR), the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), and the Department of Industry, Innovation, Climate Change, Science, Research and Tertiary Education (DIICCSRTE), the Australian Health Practitioner Regulation Agency, Deans and Colleges. An advisory/guidance group focusing on Aboriginal and Torres Strait Islander health education would allow better collaboration.

It is essential that DoHA (across all divisions) engage with and work more closely with DEEWR, FaHCSIA and DIICCSRTE. This is consistent with research, undertaken by the Lowitja Institute, of the funding arrangements for Aboriginal community-controlled registered training organisations.

Amongst other findings, the researchers recommended that responsibility for core funding for registered training organisations should be allocated to a single funding agency, noting that DIICCSRTE and DEEWR is the logical 'funding home' for the sector.<sup>123</sup> Closer collaboration within DoHA and other Government portfolios is also recommended by the Battye Review (the Battye Review is discussed in the final part of this Chapter).

### Funding for Aboriginal and Torres Strait Islander health education

As identified above, supporting specific Aboriginal and Torres Strait Islander mentoring and support programs, student targets and standardised culturally appropriate curricula should be a central component of the Commonwealth's Aboriginal and Torres Strait Islander health education and health workforce policy development. Currently there are various programs across the Health portfolio and other Commonwealth agencies which incorporate some of these elements into the program design.

For example, the Indigenous Chronic Disease Package (ICDP) has a workforce expansion and support component, with an aim of encouraging Aboriginal and Torres Strait Islander secondary students to pursue a career in health and to encourage health professionals to work in Aboriginal and Torres Strait Islander health. There are also mainstream programs and initiatives which have an Aboriginal and Torres Strait Islander health component linked to it, such as the RCTS program.

Increasing the enrolment of Aboriginal and Torres Strait Islander health students and more importantly, the number of new graduates, will in turn increase the Aboriginal and Torres Strait Islander health workforce. For this to be achieved, the Commonwealth should consider developing and implementing a new dedicated funding allocation to a more targeted health workforce program. Alternatively, there may be an opportunity to expand the workforce and support component of the ICDP, provided this can be re-designed with specific targets and enhanced activity areas.

In any case, a new funding allocation or an expansion to an existing program should also focus on the development and inclusion of culturally appropriate curricula into all health-related disciplines. This will complement the increase of the Aboriginal Torres

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<sup>123</sup> A Martini., U Marlina, J. Dwyer, J. Lavoie, K. O'Donnell, & P. Sullivan, *Aboriginal Community Controlled Health Service Funding: Report to the Sector 2011*, The Lowitja Institute, Melbourne, 2011.



Strait Islander health workforce by providing the current and future health workforce with increased understanding of how to deliver culturally safe and appropriate care.

A National Aboriginal and Torres Strait Islander Health Education approach would directly complement a key priority of the HWF by increasing the capacity of the Aboriginal and Torres Strait Islander health workforce and better equipping the broader health workforce to address the needs of Indigenous people.<sup>124</sup>

Currently, there are disparities between universities in their performance under the Aboriginal and Torres Strait Islander Health target of the RCTS program. Some universities focus more of their attention in this area as they have a larger cohort of Aboriginal and Torres Strait Islander people and/or potential student pool. If a new program model is introduced it is important to ensure that this does not disrupt the activities of those universities currently producing good outcomes. Potential redirection of funding in this way will also provide greater incentives for those universities to ensure a stronger focus on Aboriginal and Torres Strait Islander health education.

Any new program model should also complement the current activities of the ICDP. For example, 'Health Heroes' is an advertising campaign that commenced in 2011 to encourage Aboriginal and Torres Strait Islander secondary students to pursue a career in health and to encourage health professionals to work in Aboriginal and Torres Strait Islander health. It is important not to duplicate but rather expand on these existing activities. Further consultation between HWD and OATSIH is vital to the success of any new program or expansion of an existing program.

The cost of a new national program could be partially offset if a portion of the RCTS program was redirected and an individual program model focusing on increasing opportunities for Aboriginal and Torres Strait Islander students, as well as providing all health students with a comprehensive understanding of Aboriginal and Torres Strait Islander health issues was implemented. However, careful consideration would need to be given to the implications a redirection of funding would have on key stakeholders.

It is also important that a national program extends to all tertiary health professional courses (as opposed to medicine only). Program targets should have key performance indicators, such as percentage of students commencing and graduating that are of Aboriginal and Torres Strait Islander background relative to the Aboriginal and Torres Strait Islander population at either a national or geographic regional level. Implementing a new program across all health disciplines could not be fully funded by the redirection of RCTS funds alone, and would require additional support.

Possible mechanisms to achieve the program outcomes should be further explored including options for delivery of support to students such as virtual online resources and/or support units with physical office locations. Extending the Aboriginal and Torres Strait Islander support units which are currently in place in various universities should be considered rather than duplicating current efforts. Support units will need to vary from location to location, taking into account the service delivery environment and, where appropriate, encouraging collaborative regional support hubs. These regional support hubs should incorporate partnerships between universities.

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<sup>124</sup> Department of Health and Ageing, Flexible Fund Guidelines – Health Workforce Fund, April 2012.

As the RCTS program is a rural-focused initiative, any funding that is redirected to create a new funding stream should also have a rural parameter attached to it and reflect particular needs of Aboriginal and Torres Strait Islander populations in regional and remote locations. Inclusion of a rural parameter would ensure that a rural focus is maintained, whilst creating a broader Aboriginal and Torres Strait Islander health education and training initiative.

This will be important to ensure that valuable rurally focused Aboriginal and Torres Strait Islander health activities currently supported by the RCTS program can continue, noting that the health needs of rural and urban population groups differ. The proposed new funding stream should also include core performance indicators which may vary from location to location.

Consultation with key stakeholders to determine appropriate Aboriginal and Torres Strait Islander targets for any redirection of funding should be undertaken. Consultations should consider student intake targets for various health disciplines, curricula development and expanding Aboriginal and Torres Strait Islander academic positions.

### Placements - cultural education

Incorporating later-year elective placements in Aboriginal and Torres Strait Islander communities appears to be an effective way to increase non-Aboriginal and Torres Strait Islander students' ability to provide culturally safe care, provided students are well prepared in terms of cultural knowledge and have well-supported access to clinical training. Box 5.4 illustrates how the Commonwealth is allocating funding to support general practice training placements in Aboriginal Medical Services (AMSs) and Aboriginal Community Controlled Health Services.

#### Box 5.4: Indigenous Health Training (IHT)

In November 2008, COAG committed up to \$1.6 billion over four years to close the gap in life expectancy between Indigenous and non-Indigenous Australians within a generation. As part of this package, General Practice Education and Training Limited (GPET) received approximately \$2 million per year to establish an additional 38 general practice training placements in AMSs (Indigenous Health Training Posts) each year, bringing the total number of general practice training places in IHTs to 139. Funding to GPET for this initiative commenced in January 2010. GPET delivered 46 posts in the 2010 training year (8 above the target of 38) and 37 health training posts in the 2011 training year. The targets for 2012 and 2013 remain at 38 posts, with the 2012 data due to DoHA in April 2013.

GPET has now begun substantial planning work with the Regional Training Provider (RTP) network to boost training in AMSs and Aboriginal Community Controlled Health Services. This has been undertaken in collaboration with the National Aboriginal Community Controlled Health Organisation (NACCHO) and the state affiliates.

Through this planning work, GPET is seeking to:

- Sustain partnerships between NACCHO affiliates and Aboriginal and Torres Strait Islander communities to improve the development and delivery of general practice training in Aboriginal and Torres Strait Islander health facilities.
- Increase the number of accredited training facilities and the number of prevocational and vocational doctors undertaking a placement.

The first step in this process was for RTPs to submit three-year Aboriginal and Torres Strait Islander Health Training Strategic Plans developed in consultation with state affiliates. All 17 RTPs have submitted their plans. These have now been approved by GPET, NACCHO and its affiliates with work to commence this year. An additional \$27 million has been allocated by GPET for the development and implementation of the strategic plans over the period 2013–15.

Funding for the IHT is important given the significant role general practice plays in primary health care for Aboriginal and Torres Strait Islander people. Not only does the IHT increase the health workforce in AMSs, it also provides essential cultural educational training for medical practitioners. As mentioned earlier in this chapter, increasing health practitioners' education and training in cultural aspects can assist in breaking down current barriers that impact on Aboriginal and Torres Strait Islander people accessing primary health care services. The training and education gained by the participating medical practitioner can be transferred to providing better informed health care to Aboriginal and Torres Strait Islander people in other general practice settings.

### Leadership

Aboriginal and Torres Strait Islander leadership is recognised internationally as a key factor in the development and sustainability of programs aimed at increasing Aboriginal and Torres Strait Islander workforce capacity, and influencing the non-Aboriginal and Torres Strait Islander health workforce to provide culturally safe and appropriate services. Aboriginal and Torres Strait Islander leadership is also relevant in guiding tertiary education for Aboriginal and Torres Strait Islander students and developing health courses that integrate Aboriginal and Torres Strait Islander health competencies.

Leadership support is provided through the Leaders in Indigenous Medical Education (LIME) Network of medical educators. The network seeks to support members in the delivery of quality Aboriginal and Torres Strait Islander health content within medical curricula and to encourage Aboriginal and Torres Strait Islander students to take up medical education. The LIME network and AIDA have been successful in working collaboratively with all medical schools to implement student support mechanisms and integrate Aboriginal and Torres Strait Islander health into the curriculum of medical and health science schools. However, AIDA has expressed the view that there needs to be better coordination between medical schools to decrease curricular variability. This is where leadership can play an important role.

To better support Aboriginal and Torres Strait Islander health education, the LIME network could adopt a more multidisciplinary approach and provide support to non-medical Aboriginal and Torres Strait Islander health students. This would require the current funding allocations to the LIME network to be reconfigured and potentially expanded. If this option is pursued by the Commonwealth it would be important to label the network accordingly to reflect its representation.

Alternatively, the activities of the LIME network could be adopted by other networks in their specified health discipline. This approach may be more appropriate as the LIME network is not a single body rather a network of students and educators located within each medical school with the aim of supporting students and enhancing the learning environment. The benefits and costs of either extending the LIME network or replicating it for the other health disciplines should be discussed with key stakeholders.

Aboriginal and Torres Strait Islander academic leaders/champions in all universities could also provide more of a focus on issues within health-related studies and help to provide advice to Government. However, this approach should be carefully considered as stakeholders have reported that it is difficult to fill Aboriginal and Torres Strait Islander academic positions in Australian universities. Consideration of the activities of the 'Health Heroes' (mentioned above) and the LIME network regarding Aboriginal and Torres Strait Islander leadership and knowledge should be explored as it is important to build on rather than duplicate current efforts.

### Supporting education and training of nurses and midwives

DoHA supports a range of peak Aboriginal and Torres Strait Islander bodies to support and mentor Aboriginal and Torres Strait Islander health professionals, including the Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN).

Nurses make up the greatest percentage of the health workforce; 40–50% globally and 55% in Australia.<sup>125 126</sup> As identified under the discussion regarding medical students (above), mentoring, culturally appropriate curricula, student targets and leadership are key underpinnings to building the Aboriginal and Torres Strait Islander nursing and midwifery workforce. In 2008 a review *Blueprint for Action: Pathways to the health workforce for Aboriginal and Torres Strait Islander people* (the Pathways Paper) was undertaken seeking to explore linkages between education and the health workforce. The Pathways Paper also underpins the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2011–15 and subsequently, jurisdictional and Aboriginal and Torres Strait Islander community-controlled sector implementation plans. Key recommendations within the Pathways Paper include:

- The need to provide training in career guidance to Aboriginal and Torres Strait Islander education workers and roles to supplement those of existing careers advisors;
- Education institutions and Aboriginal and Torres Strait Islander health personnel and communities should work in partnership to develop a culturally-inclusive Aboriginal and Torres Strait Islander health curriculum in a multidisciplinary manner; and
- Tertiary education providers should consult with Aboriginal and Torres Strait Islander communities on a whole-of-institution strategy to increase the number of Aboriginal and Torres Strait Islander students in health courses. Strategies should include student support and curriculum matters.<sup>127</sup>

In 2011, seed funding to establish a Leaders in Indigenous Nursing and Midwifery Education Network was approved to build on the Battye Review recommendations and the Pathways Paper. However, this approach has not proven feasible or practical, apparently due to the vast array of nursing education providers covering higher and vocational education systems and public and private providers.

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<sup>125</sup> Productivity Commission, *Australia's Health Workforce*, Research Report, Canberra, 2006.

<sup>126</sup> World Health Organization, *The World Health Report 2006 - working together for health*, WHO, 2006

<sup>127</sup> National Aboriginal and Torres Strait Islander and Health Council, *Blueprint for Action: Pathways to the health workforce for Aboriginal and Torres Strait Islander people*, 2008

An alternative avenue to enhancing nursing and midwifery education and support could be to enhance the role of CATSIN and existing established nursing peak bodies, by funding an Aboriginal and Torres Strait Islander Nursing and Midwifery Policy Adviser position within one of the nursing peak bodies. A policy adviser would inform the development of policy, policy analysis and organisational representation on Aboriginal and Torres Strait Islander nursing and related matters.

Establishing a dedicated policy adviser position in one of the peak nursing organisations would increase coordination and leadership, and raise the profile of Aboriginal and Torres Strait Islander health issues within nursing.

The policy adviser would consult and work with relevant organisations including, but not limited to, CATSIN, the Australian College of Nursing (ACN), the Australian College of Midwives (ACM) and the Australian College of Mental Health Nurses (ACMHN). A submission received as part of this review outlined key strategies, based on research findings with an aim of increasing the enrolment and graduation of Aboriginal and Torres Strait Islander people in university nursing courses.<sup>128</sup> The strategies highlighted in the submission are supported in the discussion of this chapter and should also be considered not only for nursing but for all health-related disciplines.

**Box 5.5: *Submission - Indigenous registered nurses and midwives leading Australia's health workforce in Closing the Gap***

Based on the research outlined in the 'Indigenous Registered Nurses and Midwives leading Australia's health workforce in Closing the Gap', five enablers were identified that contribute to the retention of Aboriginal and Torres Strait Islander nursing students in university nursing courses. The five enablers are:

1. Individual student characteristics, such as motivations, personal attributes, life and work experiences and appropriate timing.
2. Academic knowledge, awareness and understanding – the positive supporting role that Aboriginal and Torres Strait Islander nursing academics and mentors can provide to students.
3. Relationships, connections and partnerships – additional support through other Aboriginal and Torres Strait Islander students and/or other nursing schools and Indigenous Education Support Units.
4. Institutional structures, systems and processes – providing flexibility, appropriate support and understanding of Aboriginal and Torres Strait Islander people and students.
5. Family and community knowledge, awareness and understanding of the university requirements.

From the above enablers the submission identified the following strategies that should be considered by the Commonwealth for future nursing education and training programs. The strategy included:

- Appoint Indigenous nurse academics in all Schools of Nursing.
- Develop and implement resilience-building training tailored for Aboriginal and Torres Strait Islander nursing students.

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<sup>128</sup> Roianne West, *Indigenous registered nurses and midwives leading Australia's health workforce in Closing the Gap*, Submission to the Independent Review of Australian Government Health Workforce Programs, 2012.



- Develop partnerships between Schools of Nursing and University Indigenous education support units.
- Develop and implement a cross-cultural awareness program specifically for academics in Schools of Nursing.
- Develop a critical nursing curriculum that is inclusive of Aboriginal and Torres Strait Islander cultural awareness aspects.
- Develop pathways from secondary school through the VET sector and university sector.

The submission identified that some of these strategies are beginning to be implemented in North West Queensland, commencing with development of improved education pathways through secondary schools in the region. The submission recommends that the above strategies, if adopted more broadly, will increase the number of Aboriginal and Torres Strait Islander students graduating from nursing courses in Australia.

### Stakeholder funding

Funding to Aboriginal and Torres Strait Islander health professional organisations and networks is vital to promote health careers, and for mentoring and supporting students throughout their studies. In addition to the funding provided through the Aboriginal and Torres Strait Islander Training Package (outlined below), HWD provides funding each year to a number of health workforce bodies to support a variety of operational activities of organisations.

Some of these organisations provide support through advocacy and/or program delivery. An example of this support is the Basic Emergency Care for Aboriginal and Torres Strait Islander Health Worker courses administered by the Council of Remote Area Nurses Australia (CRANaplus). (Refer to the stakeholder funding section in Chapter 9 for further information on this program.)

Commonwealth investment in Aboriginal and Torres Strait Islander health peak organisations is valuable. To increase the effectiveness of activities in this area, it may be worth considering one-off capital assistance for several of these agencies to co-locate to enable them to share administrative resources and enhance collaboration.

There may also be some merit in obtaining a current snapshot of funding provided to these agencies across DoHA and other Commonwealth agencies to reduce the potential for multiple contracts and funding agreements.

### Collaboration

The Commonwealth should continue to encourage peak Aboriginal and Torres Strait Islander health education and workforce bodies to take a collaborative approach to their forums rather than continuing to run separate events.

The Commonwealth should also continue to consult with the National Congress of Australia's First People's National Health Leadership Forum (NHLF), which is the collective and consultative forum of peak Aboriginal and Torres Strait Islander health workforce bodies. A nationwide consultation with communities is now being undertaken by the NHLF, with the draft National Aboriginal and Torres Strait Islander Health Plan and recommendations due at the end of April. As consultations to date are understood to have raised numerous workforce development issues it will be important to keep faith with these communities and integrate ongoing implementation



of strategies identified by those consultations (when accepted by government) with the implementation of recommendations arising from this review.

Engagement between the NHLF and cross-jurisdictional health workforce groups such as the Health Workforce Principal Committee could also be beneficial.

Without cutting across the role and work of the NHLF, to keep the momentum of implementation of operational initiatives, there may be merit in establishing a regular working group akin to those operating through the Coalition of National Nursing Organisations.

A greater focus should be placed on the interconnectedness within the education pathway, including secondary school education, VET training and university courses. Improving the number of Aboriginal and Torres Strait Islander people in the Australian health workforce requires collaboration across the entire education pathway. It is important to develop strategies for collaboration with key stakeholders involved in both the university and VET sectors to address the low participation rates of Aboriginal and Torres Strait Islander people in health-related disciplines.

### Vocational education and training

The majority of Aboriginal and Torres Strait Islander health students are enrolled and complete their studies through the VET sector. It is therefore important to take into account the courses delivered and applicable students in the VET sector when considering Aboriginal and Torres Strait Islander leadership, mentoring, culturally appropriate curricula and student targets.

DoHA has a limited formal relationship with the VET sector. Nevertheless, it is a sector of enormous importance if the development of the Aboriginal and Torres Strait Islander health workforce is to be progressed. The most common health-related courses for Aboriginal and Torres Strait Islander VET students in 2010 were public health, followed by nursing. The lowest number of courses studied in the VET sector by Aboriginal and Torres Strait Islander people were pharmacy, optical sciences, dental and complementary therapies.<sup>129</sup>

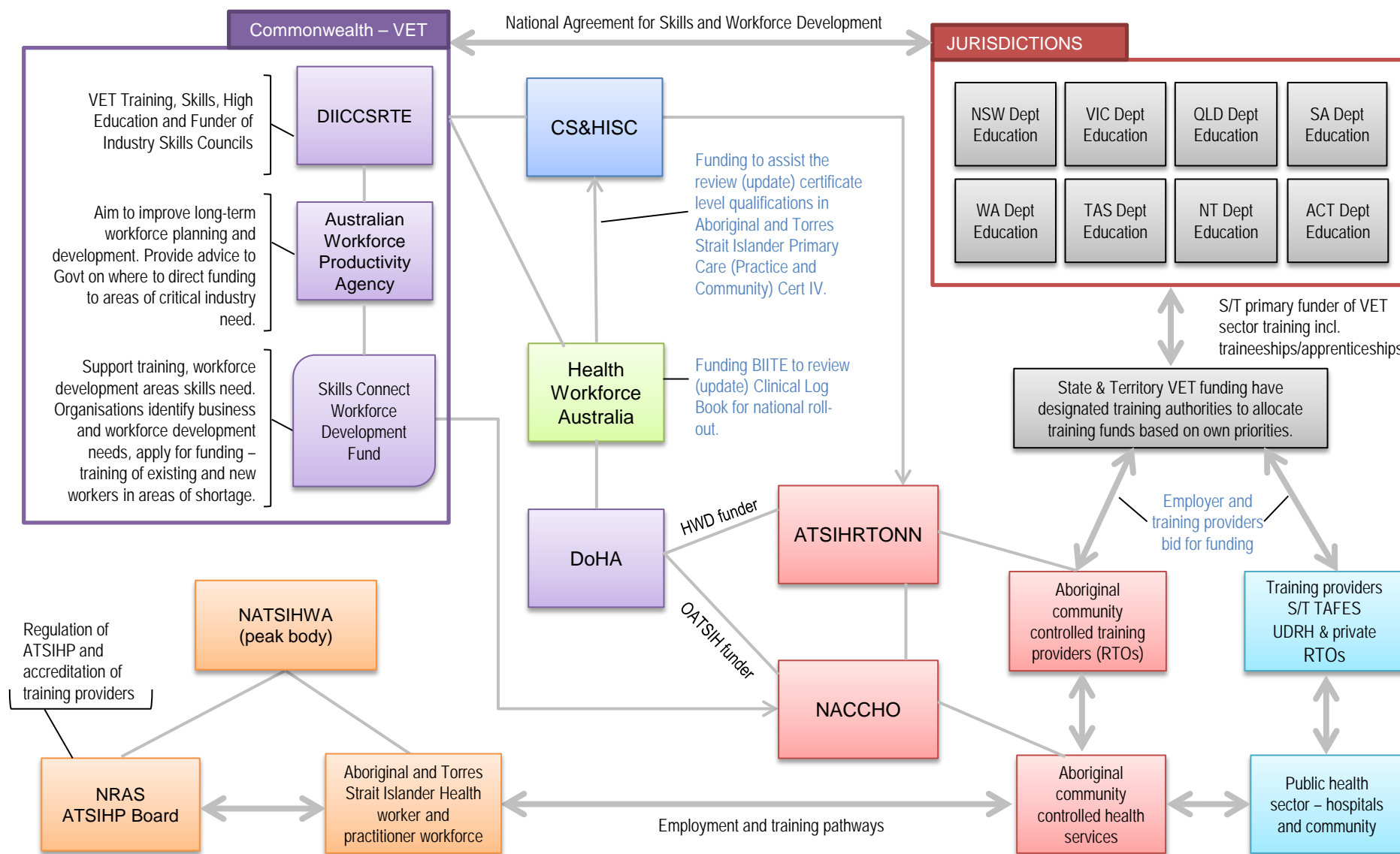
Career pathways in health, from high school, through to the VET sector, and the need to enhance the support for these students, are consistent themes promoted by the peak bodies. This is of particular interest and recognised in reports such as the Review of Higher Education Access and Outcomes for Aboriginal and Torres Strait Islander People.<sup>130</sup> Figure 5.2 below illustrates the financial arrangements and complexity of the VET sector and how it relates to the Aboriginal and Torres Strait Islander health workforce.

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<sup>129</sup> Australian Health Ministers' Advisory Council (AHMAC), *Aboriginal and Torres Strait Islander Health Performance Framework 2012 Report*, AHMAC, Canberra, 2012

<sup>130</sup> L. Behrendt, S. Larkin, R. Griew & P. Kelly, *Review of Higher Education Access and Outcomes for Aboriginal and Torres Strait Islander People: Final Report*, report to the Minister for Tertiary Education, Skills, Science and Research, Canberra, 2012.

Figure 5.2: Financial arrangements and complexity of the VET sector and Aboriginal and Torres Strait Islander Health workforce



## ***5.4 Health workforce recruitment into Aboriginal and Torres Strait Islander communities***

### **Remote Area Health Corp**

The Remote Area Health Corp (RAHC) program commenced in 2008 under the Expanding Health Service Delivery Initiative, which was part of the Closing the Gap in the Northern Territory measure. The RAHC program now operates under the Stronger Futures in the Northern Territory National Partnership Agreement (NPA). The RAHC aims to address critical health workforce shortages in remote Indigenous communities in the Northern Territory by attracting and recruiting urban-based health practitioners and placing them in short-term placements in those communities where there is demand.

A total of \$36.6 million has been committed for the RAHC program from July 2008 through to June 2014, with funding identified through to 2021-22. However, from 2014-15, funding delivery will be informed by an evaluation of the Stronger Futures in the Northern Territory measure.

The administrator of the RAHC, Aspen Medical Services, provides data to DoHA on a weekly basis, showing the number and type of practitioners placed. However, this data does not capture how the practitioners are utilised as part of their placements.

A cost comparison between the RAHC Funding Agreement and the Nursing and Allied Health Rural Locum Scheme (NAHRLS), which is operated by Aspen Medical Services, who also administers the RAHC, shows that the cost per placement of the two schemes is comparable, with the RAHC costing \$13,222 per placement and the NAHRLS costing \$12,781 per placement.

The independent review of the RAHC in 2009-10 found that the program complements other government initiatives by providing a mobile health workforce, which can be deployed at short notice to fill short-term gaps. This in turn enables better delivery of all government programs that are administered in remote Indigenous communities in the Northern Territory.

The RAHC program also increases the exposure of urban-based health professionals to working in remote settings with Aboriginal and Torres Strait Islander people. The experience gained from working in these environments can provide vital on-the-job training that health practitioners can extend to their work with Aboriginal and Torres Strait Islander people in urban areas. Some of these health practitioners may also choose to stay on in remote communities in a permanent capacity, thus increasing the size of the permanent workforce in remote areas.

The RAHC is considered to be successful in providing health practitioners who are motivated, effective, culturally sensitive and clinically competent to Aboriginal and Torres Strait Islander communities in the Northern Territory. It is important to monitor the outcomes of the evaluation of the RAHC as part of the Stronger Futures in the Northern Territory measure, as the future of RAHC funding will be determined as part of that evaluation.

### Aboriginal and Torres Strait Islander Health Workforce Training Package

Funding support of \$50.9 million is allocated from 2012-13 to 2015-16 under the HWF to promote and improve pathways for Aboriginal and Torres Strait Islander people into the health workforce.

Funding for the National Aboriginal and Torres Strait Islander Health Workforce Training Package (Training Package) constitutes the bulk of HWF funding. Funding of \$37 million over five years has been committed to implement the Training Package which includes support for the following organisations (some of which have been referred to already within this chapter):

- Australian Indigenous Doctors Association (AIDA);
- Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN);
- the Medical Deans Australia and New Zealand for the LIME network;
- the Workforce Information Policy Officers (WIPOs) in each National Aboriginal Community Controlled Health Organisation affiliate;
- the Aboriginal and Torres Strait Islander Health Registered Training Organisation National Network (ATSIHRTONN);
- Indigenous Allied Health Australia (IAHA); and
- National Aboriginal and Torres Strait Islander Health Worker Association (NATSIHWA).

DoHA also funds a number of Aboriginal community-controlled registered training organisations (RTOs) under the Training Package. Some of this funding is provided through OATSIH state and territory offices whilst other RTOs are funded directly. The funding is historically-based, and like much grant and application based funding, there is a possibility that it is not being deployed strategically or in an equitable manner across regions or communities. In addition, the quantum of funds is not proportional to the student load of the RTOs, the range of qualifications they are able to provide, or the level of remoteness.

The HWF allocates funding to four Aboriginal community-controlled RTOs, including:

- Central Australian Remote Health Development Services;
- Kimberly Aboriginal Medical Services Council;
- Nganampa Health Council Registered RTO – located in the APY lands; and
- Aboriginal Health Council of South Australia.

Funding to RTOs has not been reviewed until recently (as part of the Battye Review). In line with the Battye Review's recommendation (discussed below), the provision of funding to RTOs would be better aligned with the expertise of education portfolio(s).

Several of the organisations/networks funded under the Training Package existed for some time prior to its implementation in 2009. Prior to the Training Package, funding was allocated to organisations and networks from various divisions across DoHA. The organisations are not funded for the broader work that some are currently attempting to undertake (e.g. broader advocacy activities in international fora) and this is said to have created some difficulties for the funded organisations in achieving the required activities set in their respective funding agreements. However, advocacy is not an activity that is currently specified as part of the Training Package and therefore is not set out in the organisations' funding agreements. Further investigation into the best way that DoHA can assist these organisations with

resources for appropriate advocacy work, whilst not impeding the current activities funded through the Training Package, should be explored in discussions between HWD and OATSIH.

Table 5.3 outlines the funding provided to the peak bodies/networks and RTOs under the Training Package, as well as the broader activities they are currently undertaking.

*Table 5.3: Peak bodies/networks and RTOs under the Training Package*

<b>Organisations/Networks</b>	<b>Funds Committed 2012-13*</b>	<b>Activities</b>
<i>Peak bodies/networks</i>		
Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN)	\$440,000	CATSIN provides support to Aboriginal and Torres Strait Islander nurses with an aim of increasing the recruitment and retention rates of the nursing workforce.
Australian Indigenous Doctors Association (AIDA)	\$2,436,291	AIDA represents Aboriginal and Torres Strait Islander medical graduates and students in Australia. It provides support to Indigenous doctors and medical students, whilst providing advice to government, medical and education sectors on Indigenous health issues.
National Aboriginal and Torres Strait Islander Health Worker Association (NATSIHWA)	\$1,323,300	NATSIHWA is the peak body for Aboriginal and Torres Strait Islander health workers and practitioners in Australia. The aim of NATSIHWA is to achieve recognition of this workforce as a vital and valued component of a strong professional Aboriginal health workforce.
Indigenous Allied Health Australia (IAHA)	\$1,540,000	IAHA is the peak body for Aboriginal and Torres Strait Islander allied health professionals in Australia. IAHA contributes to improved knowledge and competencies of allied health practitioners working with Aboriginal and Torres Strait Islander peoples and their communities.
Aboriginal and Torres Strait Islander Health Registered Training Organisations National Network (ATSIHRTONN) Secretariat	\$572,530	The ATSIHRTONN secretariat provides a mechanism for a consistent, streamlined and collaborative approach between Aboriginal RTOs in the planning and delivery of culturally relevant education and training in Aboriginal and

Organisations/Networks	Funds Committed 2012-13*	Activities
		Torres Strait Islander health.
Medical Deans Australia and New Zealand for the Leaders in Indigenous Medical Education (LIME) Network	\$500,483	The LIME network seeks to promote collaboration between medical schools to support the implementation of high quality development, delivery and evaluation of Indigenous content in medical curricula. It also seeks to build multidisciplinary and multi-sectoral linkages. It recognises and promotes the primacy of Indigenous leadership and knowledge.
Committee of Presidents of Medical Colleges – Indigenous Health Subcommittee	\$80,084	Develop and report on the National Aboriginal and Torres Strait Islander Medical Specialist Framework to improve Indigenous health in specialist training.
Workforce Information Policy Officers (WIPOs)	\$1,221,089	WIPOs are funded in each of the state and territory NACCHO affiliates to work with key stakeholders to encourage recruitment into the Indigenous health workforce.
<i>Registered training organisations</i>		
Central Australian Remote Health Development Services	\$330,000	Community-controlled RTOs providing formal (under the VET sector) and informal education and training to Aboriginal and Torres Strait Islander health workers.
Kimberly Aboriginal Medical Services Council	\$372,267	
Nganampa Health Council Registered RTO – located in the APY lands	\$261,320	
Aboriginal Health Council of South Australia	\$298,100	

\* Figures include GST.

## 5.5 Battye Review

DoHA engaged an independent consultant, Kristine Battye Consulting, in 2011-12 to evaluate a number of Aboriginal and Torres Strait Islander health workforce initiatives, with a final report provided to the Department in April 2012. The evaluation included two components. The first component considered the Training Package, including the funding provided to the WIPOs and peak organisations (AIDA, IAHA, CATSIN, NATSIHWA and LIME network). The Committee of



Presidents of Medical Colleges (CPMC) Indigenous Health Subcommittee Program and Indigenous Transition to Medicine Pathways Program (ITMPP) were not included in the evaluation because they were funded after the announcement of the Training Package and not formally part of the Package. The second component of the evaluation covered the RTOs, which included the four RTOs currently funded under the HWF.

The purpose of the RTO evaluation was to:

- provide an overall assessment of the effectiveness of the Training Package in reaching its key goals;
- ascertain if organisations have met the required deliverables of the funding agreements developed as part of the Training Package;
- provide recommendations to inform future activities under the Training Package; and
- provide the Department with a report and recommendations detailing:
  - possible sustainable business models aimed at supporting RTOs;
  - standard reporting measures that could be used in the future across all community-controlled RTOs measuring organisational effectiveness; and
  - possible strategies for implementing the RTO recommendations in an effective way.

There are many crossover points in Aboriginal and Torres Strait Islander health workforce funding, not only within DoHA but also between other Commonwealth agencies. It is important to take a more collaborative approach to the training of the Aboriginal and Torres Strait Islander health workforce.

This review supports the recommendations outlined in the Training Package Evaluation and the Registered Training Organisation Evaluation of the Battye Review (refer to *Appendix ix*). The recommendations put forward by the Battye Review for each of the two components should be pursued as a priority. In summary, the Battye Review recommended:

- DoHA implement a process to ensure stronger collaboration across divisions, particularly between HWD and OATSIH, in the development of Aboriginal and Torres Strait Islander health workforce policy and program development. Issues around funding workforce program implementation roles and advocacy roles for peak organisations need to be resolved, with the different groups subsequently funded on a clear and sustainable basis for the full range of activities they are expected to perform.
- DoHA work more closely with DEEWR, FaHCSIA and DIICCSRTE rather than taking on responsibilities that are outside of the Health Portfolio.
- To achieve stronger collaboration both internally and with key whole of government partners, an Intradepartmental Committee within DoHA could be established which would then actively work with DEEWR, FaHSCIA and DIICCSRTE. This committee should then work to address relevant recommendations made by the Battye Review in relation to RTOs.
- HWD, in consultation with OATSIH, continue to work with organisations to identify the activities that are required under the funding agreements of the Training Package and/or the funding allocated to the RTOs.

*Recommendations*

Recommendation	Affected programs	Timeframe
<p><b>Recommendation 5.1:</b> There must be better coordination of activities aimed at increasing the capacity of the Aboriginal and Torres Strait Islander health workforce, across the Department of Health and Ageing and across other Commonwealth agencies working in this area including Health Workforce Australia, the Department of Families, Housing, Community Services and Indigenous Affairs, the Department of Education, Employment and Workplace Relations and the Department of Industry, Innovation, Climate Change, Science, Research and Tertiary Education. This should include the formulation of clear implementation plans, timelines and reporting processes to avoid the current potential for policy stalemates.</p>	All Aboriginal and Torres Strait Islander health workforce programs	Short term – enhanced coordination should commence as soon as possible.
<p><b>Recommendation 5.2:</b> The Commonwealth should continue to fund peak Aboriginal and Torres Strait Islander bodies/networks (under the Training Package) to help drive progress in Aboriginal and Torres Strait Islander health education and training for both health students and the health workforce.</p>	Aboriginal and Torres Strait Islander Health Workforce Training Package	Short term – ongoing.
<p><b>Recommendation 5.3:</b> The Commonwealth should continue to consult with the National Congress of Australia's First People's National Health Leadership Forum, as the collective and consultative forum of peak Aboriginal and Torres Strait Islander health workforce bodies. This forum should continue to assist in collaboration and coordination within and between these organisations.</p> <p>The Commonwealth should also ensure that it continues to work closely with the National Health Leadership Forum on the ongoing implementation of strategies arising from community consultations and the recommendations of this review of health workforce programs.</p> <p>Engagement between the National Health</p>	Discussions between HWD and OATSIH on consultation activities.	Medium term – allowing appropriate time for consultation with key groups.

Recommendation	Affected programs	Timeframe
<p>Leadership Forum and cross-jurisdictional consultative groups such as the Health Workforce Principal Committee should also be considered in this context.</p> <p>Complementary consultative arrangements, through a regular working group similar to those of the Coalition of National Nursing Organisations, may be beneficial in achieving implementation of identified strategies.</p>		
<p><b>Recommendation 5.4:</b> The Commonwealth should build on the success of the Leaders in Indigenous Medical Education (LIME) Network by extending its reach or reconfiguring this group to include support and mentoring for all Aboriginal and Torres Strait Islander tertiary level health professional students, including nurses and midwives, dentists and allied health professions.</p> <p>Alternatively, activities of the LIME Network could be adopted by other networks in their specified health discipline.</p>	<p>Aboriginal and Torres Strait Islander Health Workforce Training Package</p>	<p>Short term</p>
<p><b>Recommendation 5.5:</b> The Commonwealth should develop and implement a new national program specifically aimed at:</p> <ul style="list-style-type: none"> <li>increasing Aboriginal and Torres Strait Islander health student enrolment and graduate numbers; and</li> <li>pursuing the development and inclusion of culturally appropriate curriculum into all health courses.</li> </ul> <p>Alternatively, there may be an opportunity to extend the existing workforce and support component of the Indigenous Chronic Disease Package to achieve the above aims.</p> <p>Possible mechanisms to achieve the program outcomes should be further explored including options for delivery such as virtual support and/or support units with physical office locations.</p> <p>Extending the Aboriginal and Torres Strait</p>	<p>Indigenous Chronic Disease Package</p> <p>RCTS program</p> <p>Funding source to be identified through cross-portfolio discussions.</p>	<p>Medium term – this reform and extension of the current RCTS targets should be considered when existing agreements with universities expire. Additional funding beyond the RCTS program is likely to be necessary to achieve a sustainable investment across health disciplines.</p> <p>Longer term – subject to the</p>

Recommendation	Affected programs	Timeframe
<p>Islander support units which are currently in place in various universities should be considered rather than duplicating current efforts. Support units will need to vary from location to location, taking into account the service delivery environment and, where appropriate, encouraging collaborative regional support hubs. These regional support hubs should incorporate partnerships between universities.</p> <p>The program should extend to all tertiary health professional courses (as opposed to medicine only). Program targets should have key performance indicators, such as the percentage of students entering or graduating that are of Aboriginal and Torres Strait Islander background relative to the Aboriginal and Torres Strait Islander population at either a national or geographic regional level.</p> <p>Partial funding for this Aboriginal and Torres Strait Islander health program could be redirected from the current Rural Clinical Training and Support (RCTS) program.</p>		<p>availability of funding and engagement with both Aboriginal and Torres Strait Islander groups and the university sector.</p>
<p><b>Recommendation 5.6:</b> Recommendation 5.5 should be complemented by the development of Aboriginal and Torres Strait Islander academic leaders/champions and Aboriginal and Torres Strait Islander student support networks that would provide culturally appropriate mentoring, counselling and, if appropriate, pastoral care type activities to all Aboriginal and Torres Strait Islander health students. This may also include providing support to students' direct family members, which may assist the student to remain in study and graduate.</p> <p>This could be achieved by further developing the "Health Heroes" (part of the Indigenous Chronic Disease Package).</p>	<p>Funding source to be identified through DoHA and cross-portfolio discussions.</p> <p>"Health Heroes" (Indigenous Chronic Disease Package).</p>	<p>Longer term – as above.</p>
<p><b>Recommendation 5.7:</b> The Commonwealth should take action to</p>	<p>Aboriginal and Torres Strait</p>	<p>Medium term – implementation</p>

Recommendation	Affected programs	Timeframe
implement those recommendations directed to Registered Training Organisations as outlined in the Battye Review. There does not appear to be any compelling reason to further postpone implementation of these recommendations, which were well considered.	Islander Health Workforce Training Package.	should commence on a case-by-case basis as existing funding agreements expire.
<b>Recommendation 5.8:</b> The Commonwealth should consider options for the establishment of an Aboriginal and Torres Strait Islander Nursing and Midwifery Policy Adviser role within one of the nursing peak bodies.	Aboriginal and Torres Strait Islander Health Workforce Training Package.	Short term
<b>Recommendation 5.9:</b> The NT Medical Program's Indigenous Transitions Pathway program should be further evaluated to assess its outcomes before considering future options for mentoring Aboriginal and Torres Strait Islander students.  If the evaluation demonstrates positive outcomes in terms of increased students graduating and increased retention of these students in the surrounding communities, an increase in numbers and funding should be considered.	Aboriginal and Torres Strait Islander Health Workforce Program, NT Medical Program	Medium term
<b>Recommendation 5.10:</b> The Commonwealth should further investigate activities related to the connectivity of the education and training sectors from school, through the vocational education and training (VET) sector and on to undergraduate studies, with multiple entry points supported for younger and mature students. This will encourage more Aboriginal and Torres Strait Islander students studying health professions (over 7000) in the VET sector to progress to tertiary-based study programs by building on their success in prior health education and training programs.	Nil  This is in part a DEEWR program responsibility.	Short term – this policy work should commence following this Review.





## Chapter 6: Managing the supply of health workers to meet community needs

Increasing the supply of health workers and facilitating a more even distribution of the workforce, both in terms of geography and of the types of services provided, is a key focus of Government investment in health workforce support.

The majority of programs offered by the Department of Health and Ageing (DoHA), including the education and training activities examined in Chapter 3 and the education, retention and distribution initiatives targeted specifically to rural areas, dealt with in Chapter 4, all contribute to the overarching goal of ensuring there are enough health professionals available to meet the needs of the Australian community.

Overseas trained health professionals continue to play a significant role in the delivery of health care in Australia, particularly in rural and remote areas. This chapter will examine the Government's regulatory approach to, and support for, overseas trained health professionals, including consideration of the District of Workforce Shortage (DWS) classification system, which is used to determine the locations in which overseas trained doctors are eligible to provide Medicare-subsidised services.

This chapter will also consider programs that address the undersupply of medical practitioners in areas of workforce shortage through the use of return of service obligations, and through the provisions of the Medicare Provider Number legislation.

### 6.1 *International recruitment, support and regulation*

Overseas trained health professionals comprise a significant proportion of the Australian health workforce. According to the Australian Institute of Health and Welfare, approximately 25% of medical practitioners and 15% of nurses who are currently practising in Australia having completed their training overseas.<sup>131</sup>

Despite Australia holding the stated aim of health workforce self-sufficiency since 2004,<sup>132</sup> it is generally accepted that Australia's reliance on international health professionals will need to continue in the short to medium term to meet the forecast demand for health services.<sup>133</sup> This is supported by the modelling of *Health Workforce 2025*.<sup>134</sup>

Further information regarding the make-up of the international health professional workforce in Australia is included in Appendix vi.

The government engages a range of strategies to recruit, retain and support overseas trained health professionals – most particularly, overseas trained doctors

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<sup>131</sup> AIHW *Medical Labour Force 2009*; AIHW *Nursing and Midwifery Labour Force, 2009*. Comparable figures are not available for the allied health professions.

<sup>132</sup> Council of Australian Governments, *National Health Workforce Strategic Framework*, 2004

<sup>133</sup> See, for example, pages 16 – 20 of the House of Representatives Standing Committee on Health and Ageing report, *Lost in the Labyrinth*, 2012

<sup>134</sup> HWA, *HW2025 Vol 1* p. 24

(OTDs) – and to achieve workforce distribution aims, primarily in rural and remote areas.

In November 2010, the House of Representatives Standing Committee on Health and Ageing (the HoR Standing Committee) commenced an inquiry into registration processes and support for OTDs, in response to concerns about the transparency and complexity of the arrangements an OTD must go through to be eligible to practise in Australia. In March 2012, the HoR Standing Committee released its report *Lost in the Labyrinth: Inquiry into the registration processes and support for overseas trained doctors*. The inquiry focused on issues affecting OTDs practising within general practice settings and as specialists within DWS or state-based Areas of Need (AoN) for their specialty.<sup>135</sup> A short summary of the key findings of the inquiry is included in Appendix vii.

This section presents an outline of the current initiatives supporting the recruitment of overseas health professionals. It then examines some of the issues relating specifically to OTDs that were identified in the *Lost in the Labyrinth* report.

### Activities supporting the recruitment of international health professionals

Currently, both DoHA and Health Workforce Australia (HWA) administer initiatives to recruit and support international health professionals.

HWA administers the International Health Professionals Program (IHPP), which was funded as part of the Commonwealth's commitment to the National Health and Hospital Reform Partnership Agreement in 2009-10. The IHPP (known under the Partnership Agreement as the International Recruitment Program) aims to improve and coordinate nationally consistent international recruitment of health professionals, inclusive of national policy, and improve awareness and marketing, retention and recruitment, and pathways to practice.

These objectives relate to facilitating a supply of health professionals in areas of workforce shortage/need, over the short to medium term.

HWA has streamlined the IHPP into four elements:

- *National Policy* – aims to identify potential opportunities to improve the efficiency and effectiveness of international health professional migration and identify more effective and efficient approaches to their attraction and deployment.
- *Retention and Deployment* – aims to improve deployment, retention and the contribution of nurses and allied health professionals to primary health care services and Aboriginal and Torres Strait Islander health services in rural and remote Australia.
- *Attraction and Marketing* – aims to increase the capacity of the health workforce by streamlining and coordinating international health professional attraction and marketing through a collaborative approach with jurisdictions. HWA is pursuing this element through the establishment of Health Careers Australia as a 'one stop shop' for international recruitment into Australia.

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<sup>135</sup> The process for determining 'districts of workforce shortage' (DWS) and how these differ from state-based 'Areas of Need' determinations is discussed later in this chapter.

- *Pathways to Practice* – aims to increase the capacity of the workforce by streamlining and creating a more efficient pathway into practice for international health professionals.

In implementing the retention and deployment component of the IHPP, HWA have developed the Rural Health Professionals Program (RHPP), which provides recruitment, orientation, and retention support services to nurses and allied health professionals into rural and remote Australia and Aboriginal and Torres Strait Islander health services. HWA is coordinating the program with Rural Workforce Agencies (RWAs) in each state and territory delivering the program.

The RHPP was announced, with funding of \$16.18 million, on 4 October 2012 by Minister Butler, then acting Minister for Health.<sup>136</sup> Since January 2012, 229 nursing and allied health professionals have commenced work in rural and remote Australia under the RHPP. Over 380 placements are anticipated by 30 June 2013. It is important to note that the RHPP provides placement services for domestic as well as international candidates.

In delivering the pathways to practice element, HWA has contracted with six agencies. The program responds to a number of recommendations made by the Standing Committee to address the complexity of registration processes for international medical graduates. The projects commenced in July 2012 and include:

- Establishment of a National Clinical Examination Centre (Melbourne) to increase availability and ensure timely access to assessments for OTDs – assessments that inform decisions about registration to practise in Australia.
- Expanding access to medical training and supervision for OTDs that supports attainment of general medical or vocational registration. This will be delivered by General Practice Education and Training Limited (GPET) through the Overseas Trained Doctors National Education and Training (OTDNET) program – a new program established under IHPP.
- Expansion of existing workplace based assessment (WBA) programs in Western Australia and Hunter New England; and development of new WBA programs in Hobart, Tasmania, and rural Western Australia, and in rural general practice through the Australian College of Rural and Remote Medicine (ACRRM). The WBA programs provide orientation, inter professional teamwork, acclimatisation to Australian medical practice, and a mix of formative and summative assessments of candidates.
- Simplifying the red tape processes associated with processing applications for OTDs, progressed through working with the Australian Health Practitioner Regulation Agency (AHPRA) and other regulatory authorities to establish a single documentation bank for the administration of international health professional registration and accreditation.

In addition to these activities managed by HWA, the Commonwealth's efforts in international medical recruitment are delivered through the International Recruitment Strategy (IRS), funded by DoHA. The IRS was established as a part of the 2004

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<sup>136</sup> The Hon Mark Butler MP, "\$17.69 Million to Boost Health Workforce in Regional and Remote Areas", Media release, 4 October 2012

Strengthening Medicare initiative to increase the supply of appropriately qualified OTDs to DWS areas throughout Australia. It provides a financial incentive for the recruitment and placement of OTDs into designated DWS locations. In addition to the recruitment of OTDs, the IRS also includes the following support components:

- The Five Year OTD Scheme provides assistance and incentives to attract OTDs to regional, rural and remote locations that have experienced difficulties in recruiting and retaining OTDs. The Five Year OTD Scheme provides a reduction in the ten year moratorium on provider number restrictions under s. 19AB of the *Health Insurance Act 1973* (the Act) (discussed in further detail below).
- The Rural Locum Relief Program (RLRP) aims to ensure that Australian regional, and remote communities, especially the more isolated regions, have experienced and skilled medical practitioners in hard to fill locations. The RLRP is an approved program under s. 3GA of the Act and enables Australian-trained and OTDs to undertake rural locum work while working towards postgraduate qualifications. Doctors can be on the program for a maximum of four years without obtaining fellowship.
- The Additional Assistance Scheme (AAS) seeks to provide support to permanent resident OTDs and Australian-trained doctors to enable them to access education and upskilling opportunities to facilitate their work towards gaining fellowship of the Royal Australian College of General Practitioners (RACGP) or ACRRM. The AAS is available to participants of the Five Year OTD Scheme and the RLRP.

Rural Health Workforce Australia (RHWA) administers the IRS, and subcontracts RWAs in each state or territory to deliver the program.

Although the IRS has underachieved on the Government's recruitment targets (recruiting 82 doctors in 2011-12 against a target of 108<sup>137</sup>), it has had some success in placing doctors in rural areas, a number of which are now long-term placements. Of the 282 doctors recruited under IRS since October 2008, 94% were recruited to rural and remote locations, and of these, 95% stayed in their placement for longer than 12 months. RHWA argues that the case management approach used by RWAs has been successful in increasing retention of doctors in the longer term.

The recruitment targets set for RWAs have been criticised as unrealistic, given the intensive nature of the work required for each recruit. RHWA is currently compiling evidence to better quantify the resource investment required over a number of years to secure the successful recruitment of an OTD. RHWA also argues that because the placement of an OTD may occur after up to two years of involvement by RWAs, a funds release provided only on completion of recruitment activities leaves RWAs financially exposed during the period between recruitment activity and payment. This would create particular difficulties for the organisation if the IRS were to be substantially cut back or ceased. Such issues will need to be addressed in any amended future contractual arrangements for the IRS.

In terms of recruitment, placement and retention efforts, HWA's RHPP is most strongly focused on nursing and allied health placement and retention, whereas the

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<sup>137</sup> Department of Health and Ageing, *Annual Report 2011-12*, Commonwealth of Australia, p. 260

RHWA's efforts under the IRS are targeted towards the placement of OTDs in primary care. Both programs aim to place international health professionals in locations where there are workforce shortages, such as rural and regional Australia. (It should also be noted that private recruitment agents, state and territory governments, and individual institutions also undertake recruitment action of various kinds, sometimes in competition with one another.)

Given that funding under both HWA's RHPP and the Department's IRS is directed to RWAs to undertake international recruitment of health professionals, it appears logical to streamline these arrangements through a single fund-holder. This would allow for greater flexibility in funding priorities, along with the potential for simplified contracting and reporting arrangements.

#### **Box 6.1: Who are overseas trained doctors?**

The terms overseas trained doctor (OTD) and international medical graduate (IMG) are often used interchangeably and apply to several categories of medical practitioner. In this chapter, the term OTD refers to medical practitioners who have restrictions on providing services that are subsidised by Medicare rebates. This may be due to:

- being registered in Australia after 1 November 1996; and
- receiving their primary medical training outside of Australia or New Zealand; or
- not being a permanent resident or citizen of Australia or New Zealand on the day of commencing their primary medical training at an accredited medical school in Australia or New Zealand.

This definition is useful when discussing medical registration processes and the operation of the Medicare provider number restrictions.

Under the National Registration and Accreditation Scheme (NRAS), limited registration is available to medical practitioners whose qualifications were obtained outside Australia or New Zealand, and this is most commonly given to OTDs to enable them to practise in a DWS or state government Area of Need (AoN) position. This type of registration is for medical practitioners who have been assessed as being qualified to practise safely in positions that remain unfilled despite other recruitment efforts.

The Medical Board of Australia (MBA) grants limited registration for a period of 12 months and may renew this up to three times. However, it is expected that OTDs who intend to practise in Australia in the longer term will progress towards and achieve general or specialist registration.

Broadly, there are four areas of employment for OTDs who hold limited registration. These are as:

- hospital non-specialists (e.g. interns, residents and career medical officers);
- doctors in general practice;
- specialists in public hospitals; and
- specialists in private practice (including private hospitals).

Assessment pathways and medical registration requirements vary for OTDs seeking employment opportunities that fall into these categories.

#### ***Operation of section 19AB of the Health Insurance Act 1973***

OTDs and foreign graduates of Australian medical schools (FGAMS) are subject to s. 19AB of the Act, which prevents the payment of Medicare benefits for services provided by OTDs or FGAMS for a period of ten years after registration (commonly referred to as the "ten year moratorium"), except where an exemption has been granted. The conditions under which an OTD or FGAMS may be granted an exemption are set out within Guidelines for s. 19AB of the Act. Under the guidelines, exemptions are



generally only granted to OTDs and FGAMS who opt to practise within “district of workforce shortage” (DWS) for their medical specialty.

### Issues relating to the use of overseas trained doctors in addressing workforce maldistribution

The use of OTDs to address medical workforce shortages and the maldistribution of the medical workforce raises many issues that have been explored in considerable detail within the *Lost in the Labyrinth* report. While the issues identified in that report are all pertinent and contribute to the difficulties encountered by OTDs seeking to join the Australian medical workforce and the various organisations seeking to employ them to serve the Australian public, they do not all fall within the remit of DoHA and hence of this review. The issues discussed in this report are those that relate to the Health portfolio, and which have been identified by stakeholders within the course of the review. These centre on providing appropriate support for OTDs and the operation of the Medicare Provider Number restrictions under the Act.

The impact of the operation of the DWS classification system, which is discussed below, is particularly significant for the placement of OTDs.

#### *Ensuring appropriate support for OTDs*

##### Awareness raising

Stakeholders consulted as part of this review expressed the view that support for this workforce is key to the successful provision of medical services in DWS and AoNs.

A clear theme emerged about the need to increase awareness of OTDs as individuals from diverse backgrounds with different specialist interests and skill levels, and who require differing levels of support upon making the commitment to relocate to Australia. The term OTD encompasses several very different cohorts of medical practitioners.

##### Information about Medicare provider number restrictions

The DoctorConnect website contains information about operation of the Medicare provider number restrictions under sections 19AA and 19AB of the Act which is important for potential OTDs to be aware of, particularly if they are seeking employment in private practice. Whilst this information is technically accurate it is not always presented in a way that is easily understood. Stakeholders are concerned that many medical practitioners (particularly OTDs) significantly misunderstand the position on eligibility for Medicare rebates.

Queries received by DoHA reinforce stakeholder views that OTDs are receiving mixed messages about the Medicare provider number restrictions. This seems to occur when advice is sourced both from the Department or the MBA, and from private recruitment agents who may have an incorrect understanding of the legislation.

##### Interplay between assessment systems

With increasing numbers of internationally trained medical practitioners and FGAMs and the status of medicine as an area of national skills shortage, there is a resultant need for constant review of permanent and temporary visa status issues in order to maintain the balance between supply and demand. If OTDs are to be recruited, the process should be as efficient and effective as possible. At present, the interplay



between the immigration, registration and assessment systems presents a barrier to OTDs potentially wanting to practise in Australia.

Several submissions to the HoR Standing Committee Inquiry noted the protracted recruitment period for OTDs and the potential for OTDs to find alternative employment before registration and visa issues have been finalised. It is reported that such delays can, in part, be due to the time taken by the Australian Medical Council and the specialist medical colleges to verify qualifications and experience.

Barriers to timely consideration of applications include the need to present duplicate information to several organisations. For example, the MBA and its accreditation body, the Australian Medical Council, require the same documentation to be presented to each as part of the registration process. This documentation is also required by prospective employers and the Department of Immigration and Citizenship.

Similarly, many specialist colleges lack a combined Area of Need and specialist comparability assessment. This leads to duplication of effort by both the college and the applicant. It can also result in inconsistent information being provided to the applicant about the requirements for further training prior to complete recognition of their expertise and subsequent full medical registration.

As described above, initiatives such as HWA's International Health Professionals Program are seeking to minimise the need to provide duplicate information to several organisations.

### Access to Medicare rebates

Access to Medicare rebates for OTDs and their families was raised by stakeholders both in the House of Representatives Inquiry and the consultation process for this review. While able to provide Medicare-rebateable services, those holding 457 visas (temporary residents) are not eligible for Medicare rebates for services they access as patients.

As a condition of their visa, temporary resident OTDs are responsible for all health costs for themselves and their families. They are required by law to maintain adequate insurance for these health costs for the length of their visa.<sup>138</sup>

It has been suggested that access to Medicare rebates for temporary resident OTDs working in regional and remote areas (ASGC-RA 3–5) may encourage more OTDs to move as a family unit to live and work in rural and remote areas, thereby building the sustainability of medical services in these communities. While this proposal has clear attractions, it is important to tease out the legal and flow-on implications of such a step, particularly for the broader 457 visa scheme. It may be preferable to consider some package of family support measures for OTDs tailored to individual needs.

### Professional support and peer mentoring

As noted above, RHWA is currently funded by the Department, through the International Recruitment Strategy, to support the OTDs they recruit as they navigate the immigration and professional registration pathways.

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<sup>138</sup> Costs for Overseas Visitors Health Cover in 2009 for a standard policy were approximately \$5,400.

The Department also provides funding to the medical specialist colleges through the Specialist Training Program for a range of support activities to develop system-wide education and infrastructure projects to enhance training opportunities for eligible trainees. This includes educational support for OTDs such as the development of online learning models, training workshops and assistance with navigating college fellowship training requirements. Further activity in this area in partnership with the specialist colleges is recommended and should involve continuing engagement with the Committee of Presidents of Medical Colleges.

Another important component of a comprehensive professional support model is access to peer mentoring. Peer mentors are able to provide impartial, confidential advice on issues OTDs may face while providing medical services, for example, appropriate Medicare item use, culturally appropriate communication in a rural or remote setting, identifying gaps in the OTDs knowledge or skills, etc. This is particularly pertinent for overseas trained specialists working in rural and remote areas who have limited access to their peers, other than their supervisor.

Peer mentoring programs that target OTDs working in more isolated areas may facilitate access to professional advice and support as they progress to general and specialist registration and alleviate any sense of professional isolation. In the longer term, this will improve the quality of the OTD workforce.

### Access to training

OTDs who hold limited registration have four years in which to achieve or make significant progress towards achieving general or specialist registration. OTDs can apply for permanent residency once they have achieved general or specialist medical registration. Therefore, there is a significant incentive for temporary resident visa holders to achieve general or specialist registration if they wish to stay in Australia beyond the four years allowed by their visa and the medical registration regime.

OTDs in inner or outer metropolitan areas (ASGC-RA 1–2) are readily able to access bridging courses for the Australian Medical Council's (AMC) examinations and other professional education courses. However, access to appropriate training becomes more difficult with increased distance from major cities. Greater support from the specialist medical colleges for OTDs working in rural and remote areas may render these locations more attractive to OTDs.

Unfortunately, at present a catch-22 situation exists where an OTD may be unable to gain permanent residency because he or she has not met the requirements for general or specialist registration. This may be because the individual is a temporary resident and therefore unable to access appropriate training. There are several medical training programs which carry this limitation, and there are others that aim to meet the professional and education needs of OTDs, for example the recently commenced OTDNET program funded through GPET.

Since 2009, as part of the Council of Australian Governments (COAG) agreement to establish nationally consistent assessment processes for OTDs, the AMC and a number of other organisations have been funded to undertake pilot programs of workplace based assessment (WBA) specifically aimed at OTDs who have limited registration and are required to achieve general registration within the time limit specified by the MBA. The express intention is to provide an alternative route to registration to the AMC's clinical examination, which is currently oversubscribed.

(The AMC is at full capacity at 1,600 clinical examination places per year with intense demands being placed on the time of existing examiners. Advice is that the AMC is unable to increase places to meet current demand.) A number of submissions to the HoR Standing Committee Inquiry supported a comprehensive rollout of WBAs as a way of OTDs meeting the requirements for general registration.

Recent increases in the number of health students have placed additional pressure on the availability of clinical training placements across all health professions, including medicine. Stakeholders have highlighted the continuing difficulties for OTDs in obtaining the requisite level of supervision as a barrier to meeting the MBA requirements for general registration, both in metropolitan and rural areas. The COAG Health Workforce Reform package and HWA's Clinical Training Program are to an extent addressing this issue, which is now attaining some urgency.

### *Issues relating to section 19AB of the Act*

Historically, access to medical services has always diminished with distance from major centres, and some rural and remote areas will always find it particularly difficult to attract and retain suitably qualified medical practitioners. Interventions to address maldistribution include incentives to work in areas that are difficult to recruit to, and restriction on where some medical practitioners can work if they wish to access the Medicare benefits arrangements. Workforce distribution levers such as s. 19AB of the *Health Insurance Act 1973* have been successful in directing OTDs into priority areas such as general practice, districts of workforce shortage, after-hours clinics, locum services and accredited Aboriginal Medical Services.

Workforce location is also influenced by registration requirements. OTDs are able to enter and work in Australia with limited professional registration if they agree to practise in an AoN. They can obtain a Medicare provider number if they work in a DWS. Together, these requirements mean that many newly arrived OTDs will have their first years of professional life in Australia in rural and remote areas often with minimal opportunity for professional support and ongoing training.

### *Ten year moratorium*

The operation of the ten year moratorium requirement under s. 19AB (described in Box 6.1) continues to be criticised by a number of stakeholders most notably OTDs who are subject to provider number restrictions. The report of the HoR Standing Committee Inquiry recommended that the options for a 'planned, scaled reduction in the length of the 10 year moratorium'<sup>139</sup> be examined so that it aligns with the average length of the return of service obligations (RSO) applying to Australian participants of the Bonded Medical Places scheme.

There is some evidence to suggest that the ten year moratorium requirement has had a positive impact in achieving a more equitable distribution of the Australian medical workforce by increasing the number of medical practitioners practising within DWS areas. However, it is difficult to differentiate between the impact of this requirement and the impact of other medical workforce distribution initiatives such as

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<sup>139</sup> House of Representatives Standing Committee on Health Ageing, *Lost in the Labyrinth: Report on the inquiry into registration processes and support for overseas trained doctors*, Recommendation 27.

the bonded schemes and the introduction of scaling<sup>140</sup> in improving access to doctors in rural areas.

Any change to the operation of the ten year moratorium requirement would also need to be considered against the operation of s. 19AA of the Act. Currently, temporary resident medical practitioners are considered to satisfy the vocational recognition requirements of s. 19AA of the Act if they hold a valid exemption under s. 19AB(3) of the Act.

If the ten year moratorium requirement were to be reduced, this may have negative impacts on some OTDs who may not easily transition to permanent residency or hold general medical registration. Specifically, these medical practitioners may have difficulties in obtaining approved specialist program placements and obtaining a Medicare provider number.

### Backdating arrangements

The current operation of s. 19AB of the Act requires that OTDs and FGAMS who are subject to the ten year moratorium requirement hold a valid s. 19AB(3) exemption in order to access a Medicare provider number. Section 19AB of the Act states that applications for s. 19AB(3) exemption are processed within a statutory timeframe of 28 days by the Department and that a s. 19AB(3) exemption cannot be backdated under any circumstances.

The inability to backdate s. 19AB(3) exemptions has led to situations where OTDs and FGAMS have experienced problems for failing to renew a Medicare provider number, meaning that their patients are not eligible for Medicare rebates. These matters can be resolved through the discretionary 'Act of Grace' compensation process offered by the Department of Finance and Deregulation under s. 33 of the *Financial Management and Accountabilities Act 1997*, however this is often a long and protracted process.

As the majority of the OTDs and FGAMS are practising within DWS areas for their specialty, there is a perception that the Department is penalising these medical practitioners unduly for an oversight.

If the no-backdating provisions under the Act could be legally amended to provide some flexibility to account for simple oversights, OTDs and FGAMS who are practising within DWS areas would have a greater sense of support and a degree of assurance that their patients are able to access rebates for their services. The department should therefore investigate the ways in which this no-backdating provision may be amended.

### Use of different geographical classification systems across programs

All stakeholders consulted during the course of this review demonstrated a clear understanding of the maldistribution of Australia's medical workforce. Several of the Department's programs seek to address this by providing incentives for medical

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<sup>140</sup> The scaling initiative was announced in the 2009-10 Federal Budget as part of the Rural Health Workforce Strategy. It applies to a range of government programs including rural incentive payments and programs with a return of service obligations such as the BMP Scheme, based on the principle of providing greater incentives for more remote areas. For OTDs and FGAMS it is a non-cash incentive that provides opportunities to reduce the ten year moratorium restriction period such as through the Five Year Overseas Trained Doctor Scheme.

practitioners to practise in communities within DWS or regional, rural or remote areas. As discussed in Chapter 4, DoHA utilises a number of different geographical classification systems across its programs. Combined with the use of DWS and the state-based AoN determinations for establishing an OTD's eligibility for registration, the current arrangements add an unreasonable level of complexity for OTDs who are attempting to navigate an unfamiliar framework of legislation and regulatory requirements imposed by different levels of government and the medical profession.

The complex issues relating to the continued concurrent use of multiple geographic classification systems for the purpose of workforce distribution programs and activities are discussed below.

### *Recommendations*

<b>Recommendation</b>	<b>Affected programs</b>	<b>Timeframe</b>
<b>Recommendation 6.1:</b> the Department should continue to work with medical professional groups, including the specialist colleges, to identify opportunities to improve professional support for overseas trained doctors (OTDs) in rural and remote areas. Support should be targeted to help doctors to meet the requirements for general and specialist medical registration, and provide ongoing peer mentoring particularly for OTDs in rural and remote areas.	Nil	Short term – ongoing.
<b>Recommendation 6.2:</b> Funding for Rural Workforce Agencies (RWAs) to deliver the International Recruitment Strategy (IRS) and recruitment and retention activity under Health Workforce Australia's (HWA's) International Health Professionals Program (IHPP) should be consolidated through one fund-holder.  The most appropriate organisation to take on the fund-holder role should be negotiated with Rural Health Workforce Australia, HWA and the RWAs. If RWAs are to have a continuing role in this program, consideration should be given to enabling them to receive recruitment payments at the end of each funding period.	IRS, HWA (IHPP)	Medium term
<b>Recommendation 6.3:</b> The Commonwealth should explore opportunities to provide additional information about Medicare provider	Nil	Short term

Recommendation	Affected programs	Timeframe
number restrictions to ensure OTDs have full and accurate information before accepting job placements.		
<b>Recommendation 6.4:</b> The Commonwealth should give detailed consideration to the legislative changes and practical implementation requirements that would be needed to enable OTDs and their families to access Medicare rebates for health services received as patients. If access to Medicare cannot feasibly be delivered other support mechanisms should be considered to ensure reasonable access to health care for providers supporting the community. Consideration of this issue may also need to be extended to other overseas trained health professionals.	MBS	Medium term – subject to costing analysis, consideration of implications for Medicare and other policy areas (e.g. Immigration) and available funding.
<b>Recommendation 6.5:</b> The Commonwealth should consider amending s. 19AB of the <i>Health Insurance Act 1973</i> to allow for the backdating of s. 19AB(3) exemptions, under limited circumstances.	MBS	Longer term
<b>Recommendation 6.6:</b> The Commonwealth, through its role on the Standing Council on Health, should continue to encourage efforts to deliver a shared electronic repository for documents relating to the registration and employment of new OTDs, noting HWA's current work with the Australian Health Practitioners Regulation Agency and the medical profession on this issue. The current requirements for multiple lodgement, inconsistent lodgement dates and formats are significant obstacles to effective workforce administration.	HWA	Longer term



## 6.2 District of Workforce Shortage classification system

The concept of DWS was introduced in 2001 to support the workforce distribution aims of s. 19AB of the Act. As outlined in Box 6.1, OTDs and FGAMS need to apply for an exemption under s. 19AB(3) of the Act in order to provide services that attract a Medicare rebate.

DWS determinations are used to support a range of workforce programs and initiatives, including consequential classification systems employed by state and territory jurisdictions.

### Box 6.2: DWS methodology

A DWS is broadly defined as a geographic area in which the population has less access to medical services when compared to the national average. DWS status is defined for each of the medical specialties by consulting the latest available Medicare billing statistics for the relevant medical specialty and Australian Bureau of Statistics (ABS) population data.

DWS classifications for general practice are provided for geographic areas that are referred to as statistical local areas (SLAs) or aggregations of SLAs in metropolitan areas. SLA boundaries are determined by the ABS. The Medicare billing statistics and ABS population data are used to develop a full-time equivalent (FTE) GP-to-population ratio for each SLA and compared to a national average ratio. DWS classifications for general practice are intended to be updated quarterly.

When determining DWS, the Department compares the FTE GP-to-population ratio for each SLA or where applicable, aggregations of SLAs with that of the national average ratio. If an SLA has a lower FTE-to-population ratio than the national average (i.e. more people for every GP within the area) it is considered to be a DWS and an eligible location for the employment of OTDs and FGAMS into full-time private practice with access to Medicare rebates.

A similar methodology is used to determine DWS for the other medical specialties. Such classifications are provided for larger geographical areas, known as statistical sub-divisions (SSDs) which are also defined by the ABS.

The Medicare billing statistics and ABS population data are used to determine the average number of FTE equivalent specialists of a type within the SSD per 100,000 persons within the area. The number of FTE specialists per 100,000 persons within each SSD is then compared with the national average number of specialists per 100,000 persons to determine which areas are classified as DWS. An SSD is considered to be a DWS for a medical specialty if it has a lower number of FTE specialists per 100,000 persons when compared to the national average for that specialty. DWS classifications for the medical specialties other than general practice are intended to be updated annually.

The current operation of DWS has been a source of concern for many stakeholders. This is reflected in the *Lost in the Labyrinth* report which found that there was a lack of transparency in the way that DWS status was determined, that quarterly updates to DWS classifications have produced uncertainty for service providers and OTDs, and that there was significant confusion regarding the interaction of DWS and the state-based Area of Need determinations (see Box 6.3).

### Box 6.3: Area of need (AoN) determinations

AoN determinations are made by state and territory governments, and processes vary amongst the jurisdictions. AoN determinations relate to a specific vacant medical position that has been unable to be filled over an extended period of time.

While the concept of AoN pre-dates the introduction of NRAS, Section 67 of the state-based National Law (e.g. *Health Practitioner Regulation National Law Act 2009* in Queensland) allows for limited registration to be granted to medical practitioners practising in an AoN.

This registration category allows a medical practitioner to practise under supervision in a specific vacant medical position. The state and territory health departments are responsible for granting AoN determinations to a medical practice.

Generally, the state and territory health departments will not give an AoN determination to a medical practice located in a non-DWS area for the relevant medical specialty.

An AoN determination may be granted to a medical practice in cases where a vacant medical position remains unfilled, despite recruitment attempts. An AoN determination allows the medical practice to employ conditionally recognised medical practitioners to fill the vacant position, which has the effect of expanding the pool of potential applicants to fill the vacant position.

With these concerns in mind, the calculation and operation of the DWS system has been considered as part of this review. On 9 November 2012 a working group of key stakeholders was convened to workshop options for reform (referred to henceforth as the DWS working group). In addition to the Department, the following organisations were represented at this meeting:

- The Rural Doctors Association of Australia;
- The Australian Medical Association;
- The Royal Australian College of General Practitioners;
- Rural Health Workforce Australia;
- The Medical Board of Australia/AHPRA;
- The Committee of Presidents of Medical Colleges; and
- The Area of Need Unit of the Western Australian Government.

While there was lack of unanimity on several issues, the majority of participants agreed that there was a continued need for a DWS-type system for identifying areas of Australia that experience the most acute unmet needs for non-government/private medical services, and that the system needs to be evidence-based to avoid the potential for distortions created by a discretionary system.

The most significant concerns that have been raised in relation to the current system, including those discussed at the DWS working group meeting, relate to the process for making DWS determinations for general practice (although in the course of the review generally, particular concerns were raised about the operation of DWS as it pertains to some specialties). The following proposal therefore places a specific focus on the systemic requirements for producing accurate determinations of workforce shortage for general practice.

It is also timely to consider an updated methodology for DWS given that the Australian Bureau of Statistics (ABS) is transitioning to the Australian Statistical Geography Standard (ASGS) in 2013, as noted in Chapter 4. This transition will render the geographic boundaries utilised in the current DWS methodology obsolete.

## Proposal

The methodology proposed in this review for an updated DWS system is outlined in table 6.1 below, followed by a rationale for the core elements.

*Table 6.1: Comparison of core features of current DWS system and proposed refined system*

<b>Feature</b>	<b>Current system</b>	<b>Proposed System</b>
<b>Population data</b>	2004 Census data	2011 Census data
<b>Update frequency</b>	General Practice: Quarterly	Annual (all specialties)
	Other specialties: Annually	
<b>Geographic requirements</b>		
<b>Area classification boundaries</b>	General Practice: 2004 Statistical Local Area Boundaries	General Practice: 2011 Statistical Area 2 (SA2) Boundaries under ASGS
	Other Specialties: 2004 Statistical Sub- District Boundaries	Other Specialties: 2011 Statistical Area 3 (SA3) Boundaries under ASGS
<b>Interaction with Remoteness Area classifications</b>	General Practice: No interaction	Stage 1: ASGS-RA3, RA4 and RA5 areas are DWS for other specialties.  Stage 2: ASGS-RA2 and RA3 with populations under 15,000, along with RA4 and RA5, are DWS for all specialties (including general practice).
	Other specialties: ASGC-RA3, RA4 and RA5 areas are DWS	
<b>Interaction with metropolitan area classifications</b>	General Practice: Inner metropolitan areas are automatically classified as non-DWS	Removes interaction with metropolitan area classifications.
	Other specialties: No interaction	
<b>Workforce measures</b>		
<b>General practice workforce measure</b>	Comparison of Population to FTE ratio of each SLA against national average	Three step approach:  1. Compare population to FTE ratio of each SA2 area against national average; 2. Apply a 10% buffer to all SA2 ratios; and 3. Apply FWE-to-GP ratio to SA2 areas that fall within the buffer zone.
<b>Other specialist workforce measure</b>	Compare FTE specialists per 100,000 persons within SSD to national average	Compare FTE specialists per 100,000 persons within SA3 to national average

### *Frequency of updates*

The proposed model includes annual updating of the DWS classification for each of the medical specialties, including general practice. This represents a departure from the current system where DWS classifications for general practice are updated each quarter.

A significant concern expressed by stakeholders about the current system is that quarterly updates present a logistical challenge when planning general practice recruitment activities. A system of annual updates to DWS status for general practice, coupled with other proposed reforms, should alleviate this concern.<sup>141</sup>

While most stakeholders support removal of the quarterly update system, some concern has been expressed that moving to a system of annual DWS updates for general practice will remove capacity to produce a timely measure of unmet medical service needs. While these concerns are recognised the new methodology for determining DWS for general practice should present more accurate workforce shortage classifications, thereby reducing a need for quarterly updates to ensure sensitivity of classifications.

### *Geographic requirements*

As any DWS system relies on an analysis of the level of Medicare-rebated service provision within a defined area, the Department is required to consider how to appropriately define areas for the purpose of a revised DWS system. Making an appropriate determination of an area requires the Department to consider three core issues:

1. the interaction between the proposed revised DWS system and remoteness area classifications;
2. the need for updated geographic boundaries for DWS classifications; and
3. the interaction between the proposed revised DWS system and “metropolitan area” classifications.

### *Interaction with remoteness area classifications*

Under the current DWS system, all areas that are classified under ASGC-RA as outer regional (RA3), remote (RA4) and very remote (RA5) are considered to meet the requirements of DWS for all medical specialties other than general practice.

The use of automatic classifications for certain areas as DWS, based on level of remoteness, has the benefits of efficiency for the administering department and enhanced certainty and stability for those communities and the health workforces within them. There is therefore a strong argument for the introduction of automatic DWS classifications, based on remoteness areas, for general practice.

One option is to extend the current arrangements for specialties (i.e. DWS status for all locations classified as RA3 to RA5) to general practice (noting this would be based on the new ASGS methodology). However, this may provide DWS status for general practice to larger regional centres, such as Cairns and Townsville, which might not otherwise meet the criteria for DWS, and arguably, do not experience the

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<sup>141</sup> The revised *Health Insurance (Section 19AB Exemptions) Guidelines 2012* have gone some way towards addressing these concerns by allowing for the delegate to consider the DWS status of an area at the time recruitment activity commences when making a decision on an application for a s. 19AB exemption.

same level of difficulty in attracting medical practitioners as smaller, more remote areas.

Some stakeholders have also presented opposition to this option, on the basis that such an approach would not account for the unique models of medical service provision that have been established within individual regional, rural or remote communities. In particular, it has been argued that the proposed change may encourage corporate practices, often staffed by OTDs, to operate in towns where this is not currently feasible due to the inability to attract sufficient medical professionals. Stakeholders have raised concerns that this could lead to corporate practices “cherry picking” general practice work, leaving after-hours and on call work to already hard pressed local practitioners.

An alternative may be to draw upon the amended geographical classification system proposed in Chapter 4 (the ‘modified Monash model’), which would allow for automatic DWS status to be better targeted towards regional and rural areas with smaller populations. Using the ‘modified Monash model’, the following areas could be classified as DWS:

- RA2 and RA3 areas with populations less than 15,000;
- RA4; and
- RA5.

This categorisation would address the relative disadvantage of small towns that was identified in Chapter 4. It is also likely to reduce the potential for corporate “cherry picking” discussed above.

It should be noted that any classification system will have its disadvantages. The DWS system is simply one tool designed to produce classifications based on the level of access to Medicare-subsidised services within an area. No tool has been devised which would produce classifications according to a preferred or desired model of medical service provision, which need to be achieved using other policy levers.

In revising the model, it is proposed that the application of automatic DWS status for other medical specialties be aligned with that of general practice, in order to simplify the system. While the implementation of the model outlined above will result in some RA3 areas (those with populations above 15,000) no longer having automatic DWS status for other specialties, the impact of this is likely to be minimal, given the overall shortage of specialists in non-urban areas. It is also noted that those areas experiencing a genuine shortage will be assessed as DWS according to the methodology outlined in Table 6.1.

The classification of some regional, and all remote and very remote areas as DWS for general practice and other specialties will:

- provide equality of treatment for regional, rural and remote communities in terms of DWS classifications;
- provide follow-on efficiencies for workforce programs that use DWS classifications, such as the Rural Locum Relief Program and the AoN Program; and
- provide DWS status to all rural and remote public hospitals and other public health services that have been granted an exemption to Section 19(2) of the Act, which allows them to offer some primary care services that are eligible for



Medicare rebates.<sup>142</sup> DWS status would ensure that these services may effectively access the intended provisions under the s19(2) determination.

There is no question that there will need to be significant development work undertaken to implement a new rural classification methodology under the modified Monash model, and the administrative complexities in applying this to the DWS system should not be underestimated. While supported in a theoretical sense, the practicalities of applying automatic DWS status for areas in RA2 and RA3 with populations under 15,000, and for RA4 and RA5 under the new ASGS will need to be considered in the light of the implementation arrangements for the modified Monash model.

### Updated geographic boundaries

As stated above, the current SLA and SSD boundaries that are used for the purpose of DWS classifications under the current system will become obsolete upon the transition to the ASGS in 2013. This creates a need to identify appropriate geographic boundaries for the purpose of establishing DWS classifications for general practice and the other medical specialties within areas that have a major city (RA1) or inner regional (RA2) remoteness area classification.

It is proposed that the revised DWS system would use Statistical Area (SA) 2 boundaries when determining DWS for general practice and SA3 boundaries when determining DWS for the other medical specialties.<sup>143</sup> This approach to establishing updated geographic boundaries is suggested for the following reasons:

- SA2 areas are similar in size to the SLAs that are used when determining DWS for general practice;
- SA3 areas are similar in size to the SSDs that are used when determining DWS for the other medical specialties; and
- there is no evidence to suggest that the size of current SLA or SSD boundaries produces either unintended or inequitable outcomes when applying the DWS process.

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<sup>142</sup> Under Section 19(2), Medicare benefits are not payable for public hospital and other public health services unless the Minister otherwise directs. The *COAG Improving Access to Primary Care Services in Rural and Remote areas – s. 19(2) Exemptions Initiative* was introduced in 2006 and allows Medicare benefits to be claimed for some state-remunerated professional non-admitted services (including eligible nursing and midwifery services) and eligible allied health and dental services provided in emergency departments, outpatient and community clinics at approved rural and remote public hospitals. Queensland, Northern Territory, Western Australia and New South Wales currently participate in the initiative. To be eligible, a locality must have a population of less than 7,000 people, not be in a major city, and be in an area of workforce shortage.

<sup>143</sup> The ASGS is structured with six hierarchical levels of geographic region. The levels are based on population size, and each level directly aggregates to the level above:

- Mesh block: the smallest geographic region captured by AGSS, made up of 30 to 60 dwellings (347,000 units covering the whole of Australia);
- Statistical Area Level 1 (SA1): areas with populations in the range of 200 to 800 persons (54,805 regions);
- SA2: areas with populations in the range of 3,000 to 25,000 persons (2,214 regions);
- SA3: areas with populations in the range of 30,000 to 130,000 persons (351 regions);
- SA4: areas with populations in the range of 100,000 to 500,000 persons (106 regions);
- States and territories.

For further information, see <http://www.abs.gov.au/ausstats/abs@.nsf/mf/1270.0.55.001>



### Interaction with “metropolitan area” classifications

If an area is identified as an inner metropolitan area it is currently automatically designated as non-DWS for general practice. The rationale for this has been that inner metropolitan areas have better access to a broad range of public and allied health services when compared to outer metropolitan, regional, rural and remote areas. These services are not captured within Medicare billing statistics used to determine DWS as they are delivered by salaried health professionals. The non-DWS classification for general practice in inner metropolitan areas therefore went some way towards creating parity with the level of medical service provision within other areas of Australia.

This was a policy decision that was implemented primarily to ensure equitable determinations under the previous Preliminary Assessment of District of Workforce Shortage (PADWS) application process. A designation of ‘inner metropolitan’ meant that medical practices were restricted from accessing the special circumstances provisions available under the PADWS to employ an OTD.

It is proposed to discontinue the practice of basing DWS classifications for general practice on “metropolitan area” classifications as a feature of the proposed new system. This change is proposed for three reasons:

- the workforce measure proposed to support the modified system is robust and is likely to identify where there is a genuine general practice workforce shortage within areas that hold an inner metropolitan classification;
- “metropolitan area” classifications, as currently defined and operationalised, are based in part on population data circa 1992 and are therefore out-dated; and
- the value of continuing to consider metropolitan classifications as part of the process of providing DWS determinations has diminished after the discontinuation of the PADWS application process on 28 September 2012.

The proposed refined DWS system therefore abandons the use of a blanket non-DWS classification for metropolitan areas. This change will ensure that general practice workforce shortage needs are identified and appropriately classified against a national average measure, no matter where they are located.

### *Population data*

The transition to the use of the ASGS will provide an updated analysis of the composition/dispersion of the Australian population based on 2011 census data.

As the revised system will be based on the ASGS system, the population data that is used to inform the Medicare billing statistics and DWS classifications will be updated accordingly. This proposal does not seek to make any additional changes to the population data that would be used for DWS classifications beyond the updates that will be achieved upon the transition to the ASGS.

### *Proposed workforce measures*

A mechanism for measuring the composition of the medical workforce will continue to be a core requirement of any revised DWS system. As with the current system, this proposal is based on two workforce measures:

- a measure of the general practitioner workforce; and
- a measure of the specialist medical workforce.

The possibility of including some measure of local hospital staffing within the methodology for a revised DWS was discussed during the DWS working group meeting, as the level of access to primary care delivered through smaller local hospitals will often impact upon the workload of local medical practitioners.

However, it is proposed that the workforce measures should continue to be based on an analysis of medical services that are subsidised by a Medicare rebate within the relevant specialty, given the complexity involved in developing and maintaining meaningful and up to date measures of (state-based) hospital staffing in a multitude of locations, and the potential for creating perverse incentives. Medicare billing statistics, while often criticised, are at least a quantifiable source of information in relation to medical service provision within a geographic area.

It is also noted that DWS classifications do not directly affect employment of medical practitioners within positions that do not require access to a Medicare provider number.

### General practice workforce measure

The current DWS classification system produces classifications that are based on a full-time equivalent (FTE) measure of the portion of the medical workforce who are providing Medicare-rebated medical services. The FTE measure is applied to all medical specialties for two reasons:

- a single medical practitioner cannot be counted more than once within a local area; and
- the partial contributions of medical practitioners who practise on a less than full-time basis within a local area may be accurately accounted for.

Concerns have been raised in regard to the efficacy of continuing to base DWS solely on an FTE measure of the medical workforce who provide Medicare-rebated medical services. These questions have been focused on the fact that the use of an FTE measure, as derived from Medicare billing statistics, does not provide a means to consider the actual workload of individual medical practitioners within a local area. In particular, it does not account for situations where a medical practitioner is working extended hours (beyond a standard full-time load). This issue has been raised with a particular focus on the specialty of general practice.

It is proposed that the revised system would be based on a three step process for measuring the general practice medical workforce within areas that are classified as major cities (RA1) or inner regional (RA2), as outlined in Table 6.2.

Table 6.2: Proposed process for measuring the general practice workforce under revised DWS arrangements

Step	Outcomes
<b>Step 1:</b> Compare the Medicare billing statistics local area with the national average <ul style="list-style-type: none"> <li>This step is the same as the current analysis of Medicare billing statistics that is used for determining DWS.</li> <li>The Department to compare the population-to-FTE equivalent GP ratio for the local area with the national average.</li> </ul>	1. Each area identified as having less or more people per FTE GP than the national average.
<b>Step 2:</b> Apply a 10% buffer to the billing statistics <ul style="list-style-type: none"> <li>The Department identifies each area that has less people per FTE GP. Any of these areas that are within 10% of the national average are identified (i.e. those areas that fall within the buffer zone).</li> </ul>	1. Some areas classified as DWS. 2. Some areas classified as non-DWS 3. Areas that are near to the national average are identified for further consideration.
<b>Step 3:</b> Apply FWE-to-GP ratio <ul style="list-style-type: none"> <li>For those local areas that are identified by the 10% buffer are examined in this third step.</li> <li>The number of FWE GPs is divided by the number of active Medicare provider numbers to produce a ratio.</li> <li>Any local area that falls within the 10% buffer and has an FWE-to-GP ratio above 1.3 will be classified as DWS.</li> </ul>	1. Some additional areas classified as DWS. 2. Remaining areas are classified as non-DWS.

There are two key differences in the revised process. The first is the application of a buffer in the comparison of an area's access to GPs with the national average. Approximately 30% of all areas (SLAs) have GP access rates that fall within 10% of the national average. Using a 10% buffer would mean these areas are identified with each annual update and are subject to additional scrutiny before being classified as a DWS or non-DWS area. By applying this buffer, an area will not be classified as non-DWS solely due to having marginally better access to services than the national average.

Any area that has a better FTE-to-GP ratio than the national average and that does not fall within the buffer zone is classified by the Department as a non-DWS area. These areas have substantially better access to Medicare-rebated general practice services when compared to the national average.

The second key difference in the revised process is the application of a full-time workload equivalent (FWE)-to-GP ratio to those areas falling within the 10% buffer zone. This will identify those local areas that would otherwise be classified as non-

DWS for general practice as a result of local GPs providing substantially more than full-time services.

If areas falling within the 10% buffer zone have a FWE-to-GP ratio greater than 1.3, the area will be classified as DWS. This value has been identified as a cut-off because it:

- means that each GP within the area is on average providing up to a third more than the recognised full-time equivalent level of medical services (i.e. substantially more services);
- is unlikely to be produced by seasonal changes that affect some local areas; and
- is unlikely to be negated by the presence of short-term locum medical practitioners.

The proposed methodology continues to use a comparison with the national average as a basis for producing classifications. Most stakeholders represented at the DWS working group were supportive of the continued use of a national average measure as part of the process for identifying relative medical workforce shortage. This methodology uses this basis and a buffer to effectively identify marginal areas, and examines Medicare billing behaviour of general practitioners who practise privately within these areas.

The Department currently collects all necessary Medicare billing information to complete this proposed workforce measure.

### The specialist medical workforce

As described in Box 6.2, DWS for each of the medical specialties is currently determined according to the use of ABS population data and the Medicare billing statistics. A FTE measure of the specialist medical workforce is used.

Any medical specialty that has a national average of less than three FTE specialists per 100,000 persons is considered to be in acute shortage. All areas of Australia are considered to be DWS for specialties that are considered to be within acute shortage, with the objective being to increase the number of specialist medical practitioners practising privately within this specialty.

It is proposed that the revised DWS classification system continue to adopt this measure for the specialist medical workforce. This measure continues to be appropriate when considering the relatively small numbers of practitioners practising privately within each specialty compared to general practitioners.

The majority of concerns relating to DWS classifications for specialties other than general practice are based on an argument that such classifications are only appropriate when considering general practice. It is not proposed to remove DWS classifications from any medical specialty as the acute shortage provisions continue to ensure that DWS does not adversely affect those specialties that have small numbers of doctors.

### Impacts of revised general practice workforce measure

It is anticipated that the revised methodology for determining DWS will result in a higher number of areas being declared DWS for general practice. Prior to the introduction of the ASGS and obtaining updated population data and statistical area boundaries, it is impossible to determine the exact nature of the overall changes to the number of DWS areas.

However, the proposal to classify some regional, and all remote and very remote areas as DWS is likely to increase the overall number of DWS areas. It is also anticipated that there will be a slight increase in the number of DWS areas located within areas that would be classified as outer metropolitan due to the proposed use of a buffer when determining DWS.

The key features of this methodology appear to respond to the major concerns raised by external stakeholders. While it is unlikely that the proposal will win universal acceptance, it is anticipated that the proposed methodology will produce robust workforce shortage determinations and therefore achieve acceptance amongst stakeholders.

### *Further policy considerations*

#### Future system name

Several external stakeholders, including a majority of the representatives of the DWS working group, have expressed the view that the term “District of Workforce Shortage” is itself unhelpful and in some cases may be actively misleading. The term DWS does not provide the best reflection of either:

- the information (specifically Medicare billing statistics) taken into account when making DWS determinations; or
- the statistic modelling that governs the process for making DWS determinations.

Based on these concerns, and given the scope of the proposed reform of the scheme, consideration could be given to renaming the revised system. For example, the term “targeted workforce areas” could be a suitable title for a relaunched scheme as it more accurately reflects the intent of the scheme.<sup>144</sup> Other options could reflect the Medicare data basis of the classification, for example, ‘Lower Medicare Access Areas’.

While there are clearly some identifiable benefits to renaming the revised system, these need to be weighed against the flow on administrative costs of reconfiguring programs that currently utilise the DWS classification, for example, the Bonded Medical Places (BMP) scheme.

#### Cost implications

While there are no direct program costs resulting from the proposed DWS changes, there may be flow-on impacts on the Medicare Benefits Scheme. The model proposed above is likely to increase the number of areas classified as DWS for general practice, meaning that some practices that have struggled to fill positions with Australian GPs will be able to employ OTDs subject to the ‘ten year moratorium’, leading to a higher rate of billable service provision. There may be an increase in Medicare expenditure if the revised DWS scheme increases the attractiveness of some locations within Australia as a work destination for OTDs.

#### Impacts on distribution

There is a potential risk that if the proposed system increases the number of areas classified as DWS in metropolitan or regional areas, this could exacerbate existing

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<sup>144</sup> Note that this term has previously been discussed with key stakeholders in relation to an alternative DWS proposal.

difficulties experienced in the most remote areas in recruiting medical practitioners. However, the increasing numbers of participants in the BMP Scheme attaining fellowship and becoming eligible to complete their return of service obligation in DWS areas may offset this. It is also the case that the practice of locating newly recruited OTDs in the most remote areas of Australia has been strongly criticised, including in submissions to this review. The impact of the revised system on workforce distribution will need to be carefully tracked.

#### Timing of transition to proposed new system

If approved, it is suggested that an appropriate time for the rollout of the first stage of this proposal would be following transition to the ASGS. The ABS data to support the ASGS was due to be provided to the Department in early 2013 with a more formal date for the transition to be advised. The possible implementation of a second stage, involving the “modified Monash model” of geographical classification proposed in Chapter 4, is dependent upon the arrangements for that system, which is likely to take at least 18 months, given the need for changes to information technology and other infrastructure.

#### Grand parenting arrangements

There is a potential that the introduction of a revised methodology for DWS may result in some locations losing DWS status. The Department may therefore need to consider a period of grand parenting arrangements to ensure that local communities are not subject to perceived disadvantage upon the transition to the revised classification system.

### Recommendations

Recommendation	Affected programs	Timeframe
<p><b>Recommendation 6.7:</b> The Commonwealth should introduce a revised system to replace the current districts of workforce shortage (DWS) classification system. It should be introduced in 2 stages.</p> <p>Under the first stage, the geographic classification requirements of the revised system should be based on the Australian Statistical Geography Standard (ASGS), these requirements being:</p> <ul style="list-style-type: none"> <li>• Remoteness area classifications as provided under the ASGS; and</li> <li>• SA2/SA3 boundaries to be used as ‘area’ boundaries for workforce shortage classifications.</li> </ul> <p>2011 census data (i.e. the most up to date data) should be used as the population measure for the revised system.</p> <p>The revised system should abandon the</p>	<p>DWS, allocation of MBS provider numbers, BMP</p>	<p>Short term – transitional arrangements, further discussions with stakeholders and the development of communication and data system should commence immediately post-Review.</p> <p>Medium term – it is likely that the work outlined above will necessitate medium term implementation of</p>



Recommendation	Affected programs	Timeframe
<p>use of the additional overlay of the “metropolitan areas classification system” for general practice.</p> <p>The revised system should use a modified general practice workforce measure within major cities (RA1) and inner regional areas (RA2) comprised of:</p> <ul style="list-style-type: none"> <li>• a comparison of the population-to-full-time equivalent (FTE) ratio of each area against the national average;</li> <li>• the application of a 10% buffer to the raw population-to-FTE ratios; and</li> <li>• a full-time workload equivalent (FWE)-to-GP ratio to areas that have better than the national average but fall within the 10% buffer zone.</li> </ul> <p>The second stage should consider the introduction of the use of the “modified Monash model” proposed in chapter 4 to determine automatic DWS status for certain remoteness categories.</p> <p>If the “modified Monash model” of geographical classification is implemented and its methodology can be applied to DWS in an administratively efficient manner, the following areas should be granted automatic DWS status for both general practice and other specialties:</p> <ul style="list-style-type: none"> <li>• RA2 and RA3 areas with populations less than 15,000;</li> <li>• RA4; and</li> <li>• RA5.</li> </ul> <p>Additional discussions with stakeholders should be undertaken to assist in the implementation of the new system, including transition arrangements. This should include discussions with jurisdictions around how this new DWS system will overlap with their current Area of Need determinations.</p> <p>An implementation working group should be established.</p>		<p>the full DWS changes.</p>

### ***6.3 Achieving workforce distribution aims through return of service obligations***

The imposition of conditions upon individuals receiving Commonwealth support is one of the mechanisms available to the Commonwealth to achieve certain outcomes, for example, increasing the supply of medical practitioners in underserviced areas. The Department administers two programs that impose a return of service obligation (RSO) on participants. The Medical Rural Bonded Scholarships (MRBS) scheme, which provides a scholarship to medical students in return for working in a rural or remote area for up to six years, is dealt with in Chapter 3 as part of the discussion on scholarship support offered by the Department. The operation of the more controversial Bonded Medical Places (BMP) scheme is explored below.

#### **The Bonded Medical Places scheme**

The BMP scheme commenced in 2004 to address the shortage of doctors in outer metropolitan, rural and remote areas of Australia. Twenty five per cent of all first year Commonwealth-supported medical school places are allocated to the scheme. BMP scheme participants are contracted by means of a Deed of Agreement with the Commonwealth, managed by DoHA together with the Department of Human Services (DHS), the Australian College of Rural and Remote Medicine (ACRRM), the Department of Industry, Innovation, Climate Change, Science, Research and Tertiary Education (DIICCS RTE), and universities.

The BMP scheme has over 4,500 participants managed through individual Deeds of Agreement for periods of up to 25 years, with a further 700 participants commencing in the 2013 academic year. In 2009 the program was modified to enable participants to reduce their RSO more quickly by working in more remote areas. This was known as the scaling initiative. Any changes that affect current participants will require agreement by both parties to proceed.

Students who accept a BMP scheme position are required to work in a DWS of their choice (under the current definition, outer metropolitan, rural and remote areas for GPs and including inner metropolitan areas for other specialists) for a period of time equal to the length of their medical degree less eligible pre-vocational and vocational training and any credit obtained through Scaling.

The RSO only becomes compulsory once a participant gains fellowship of a specialist college. If a BMP participant completes their medical training but does not undertake their RSO they may be required to repay 75% of the total sum of the Commonwealth contribution amount of their medical degree.

#### **Effectiveness of the scheme**

Originally the BMP scheme aimed to deliver a specific number of additional first year medical school places. Currently the scheme is meeting this target, with all places filled. However, the effectiveness of the scheme will be measured by determining the number of bonded doctors who meet their obligations under their agreement with the Commonwealth. The period of medical training for doctors from commencement of their medical undergraduate course until achievement of fellowship in their chosen specialist field is a minimum of eight years so it is too early to be able to determine its success. BMP participants are obliged to commence their RSO within one year of attaining completion of their specialist training and the award of fellowship to the relevant medical college.

The BMP scheme has not yet been formally reviewed or evaluated. However, there are some early signs that the program may not meet its objectives. As at February 2013 only one participant has commenced his/her RSO and three participants have bought out of the scheme. Given that the scheme has been running for almost a decade, there has clearly been limited impact to date on the distribution of medical practitioners from this activity, although as indicated, due to the length of undergraduate and postgraduate training very few practitioners as yet would be eligible to commence.

The Department is not currently able to adequately monitor and report on completion of RSO requirements while graduates are undertaking vocational training. Such monitoring would give a better indication of bonded students who are seeking out return-of-service credit during this time, and by extension might be expected to fulfil their obligation post fellowship.

The impact of the introduction of scaling on the BMP scheme is also not yet known given that as already stated only one participant has commenced his/her RSO. Scaling is being promoted to BMP participants through the Bonded Support Program (BSP).

The administrators of the BSP, ACCRM, undertake an annual survey of BMP participants. In their most recent survey for 2012 approximately 74% of respondents indicated a commitment to undertake the full RSO with 26% indicating that they are considering withdrawing from the scheme once they become fully qualified.

The unintended consequence of the scheme could be that for a substantial minority of participants it becomes an alternative to a full-fee-paying medical course. Since the cost of 'buying out' represents approximately 75% of the total cost of the medical school placement, it may be perceived by participants as a low cost or interest free loan that can relatively easily be repaid once fully qualified.

Surveyed participants who expressed intentions to withdraw also said that they believed that the current geographical requirements did not allow them to follow their career ambitions and limited options for their families in terms of employment and education.

### Impact of Districts of Workforce Shortage

BMP participants must undertake their RSO in a DWS for either general practice or other specialties. As outlined above, under the current scheme, DWS for general practice is updated every three months, which has made it difficult for BMP participants to make long-term plans. As DWS for general practice currently excludes inner metropolitan areas and also substantial parts of rural and regional Australia, BMP participants report that they are confused by the system, and do not fully understand how it works. (Once they commence their employment in a DWS, bonded doctors can remain there for the full term of their RSO even if the area is no longer a DWS.)

It is reported that a substantial number of BMP doctors in training may consider a specialty other than general practice, as many specialties have DWS status within metropolitan areas, allowing BMP participants to fulfil their RSO in cities.

The revised arrangements for determining DWS proposed above may alleviate a number of these concerns.

## Stakeholder views

Universities, ACRRM and Australian Medical Students' Association (AMSA) have provided feedback that there is in some quarters a stigmatising perception of BMP participants as 'second rate' students who failed to meet the requirements for a non-bonded Commonwealth Supported Place (CSP). This stigma could have a detrimental effect on students and also on their future offers of employment, or provision of access to specialist training in a competitive environment.

An alternate perspective is that some specialist colleges have indicated an interest in developing opportunities specifically targeting bonded students/trainees in order to build a long-term rural workforce with strong connections to the local community by prioritising training opportunities within the rural health sector.

All stakeholders consulted raised concerns and noted that the BMP scheme requires significant modification in order to achieve the desired outcome of improving the distribution of the medical workforce. The main issues included:

- The need for a commitment from a young person often 18 years of age, who is (arguably) ill equipped to make such a decision which will affect their life for up to 22 years (critics of this argument point out that young people over 18 are legally capable of voting, joining the armed forces and signing other enforceable contracts, including mortgages);
- The complexity of the scheme, particularly relating to the DWS;
- The perception that this is a coercive program that stigmatises rural practice;
- The implication that participants are in some sense "second class" with the use of the term 'bonded' having specifically negative connotations;
- Perceived lack of personal support and mentoring, compared to participants in scholarship schemes;
- Lack of communication with participants due to limited resources for support;
- The lack of priority entry into the rural generalist pathway; and
- Inequity between the penalties applicable to BMP and MRBS scheme participants. While BMP scheme participants can withdraw from the Scheme and pay a proportion of the Commonwealth's contribution for their medical school place, MRBS scheme participants who breach their contract face a Medicare ban of up to 12 years. This therefore is one element under which the BMP may be seen as more favourable than the MRBS.

AMSA expressed concern during the consultation process that there is insufficient evidence to indicate that the BMP scheme will produce a long-term increase in numbers of doctors practising in rural areas. AMSA supports abolition of the bonding schemes, or at minimum modifications including removal of the Medicare Provider Number penalties, changing the MRBS RSO to be commensurate with the length of medical degrees and enabling participants to complete their RSO at any stage of postgraduate training.

The Australian Medical Association (AMA) does not support the BMP scheme and would prefer expansion of the MRBS and HECS Reimbursement Scheme in its place.

## Reform or abolition of the Bonded Medical Places scheme?

This review has given careful consideration to the strong reservations about the BMP scheme expressed by many stakeholders and has considered a number of options,

including abolition of the scheme, or its replacement with a more equitable scheme of universal RSO for all medical graduates (discussed below). There is international evidence, some of which is discussed later, that coercive schemes are ultimately counterproductive in terms of securing the employment of a medical workforce in difficult locations in the longer term. Some of this evidence has been taken into account in formulating the recommendation discussed in Chapter 4 to phase out the MRBS and replace it with non-bonded scholarships.

However, on balance, it would be premature to abandon the scheme given the depth of need in some locations, the lack of effective alternate policy levers, and the (at least) indicative evidence from the ACCRM survey of participant intentions that nearly three quarters of BMP participants intend to undertake the full RSO.

What is clear however, is that some immediate reforms should be undertaken to ameliorate some of the inequities of the current scheme, and to provide BMP participants with more support and opportunities for engagement with the communities in which they will be undertaking RSO. The aim is to reduce the impact of the stigmatising and coercive elements currently associated with the scheme. Whilst various stakeholders who made submissions to the review discussed termination of the BMP, others made useful suggestions on ways to redesign the scheme to better meet the needs of the participants and also the communities in which they will be employed. Priority areas for change include the duration and location of the RSO together with the penalties applied to participants wishing to withdraw from the scheme.

### Options for reform

There are a number of reform options that could be pursued to reduce the complexity of the BMP scheme for participants and the cost to the taxpayer of administering it.

#### *Broadening the settings for return of service*

Allowing a broader range of areas or settings that a BMP participant can complete his or her RSO should be considered. RSO should not be a stigmatising process, but the opportunity to learn generalist skills and provide medical care to communities with demonstrable need. This could include allowing employment within:

- Rural and remote communities;
- Some difficult to recruit settings such as GP superclinics and Aboriginal Medical Services;
- The Australian Defence Force; and
- Organisations headquartered in metropolitan areas providing outreach service to rural and remote communities.

Increasing the number of eligible areas or settings would make it easier for participants to complete their RSO and may reduce the number of participants contemplating 'buying out' of the scheme.

#### *Reducing the period of the Return of Service Obligation*

Currently the RSO is equal to the length of the medical degree so can range from four to six years. Scaling allows for this obligation to be worked off more quickly by working in a rural or remote area. However, it is still considered to be onerous and the option to buy out is considered to be very attractive at this time. If the obligations



were reduced (possibly by one half), and – possibly – the sanctions increased it is anticipated that participants would be more likely to complete their RSO in full. Other things being equal BMP scholars may also be more attracted to practising in remote areas with the potential for completion of their RSO in the shortest time possible (one to two years).

#### *Changing the point of commencement for the RSO*

BMP participants are able to apply to have part of their prevocational or vocational training (if they work in a DWS) considered as part of their RSO (for up to one half of the length of their degree). The processing of these applications relies upon a manual data collection based on direct contact with each student, which is resource intensive, unreliable and not sustainable without significant extra administrative costs once the number of graduates increases. AHPRA is unwilling to track BMP participants through this period because of the significant administrative burden it would involve, and DHS cannot track all levels of training, as not all trainees are able to bill Medicare.

Most BMP participants who are eligible to reduce their RSO through their prevocational or vocational training do not inform the administrators at the commencement of the employment, although such notification is required by their agreement. Due to (potentially) frequent changes in the DWS status of a particular location there is presently no administrative means of retrospectively crediting these periods of training (within current program resources) and this period of time is therefore not recorded. This aggravates eligible BMP participants who perceive that they have ‘done the right thing’ but will not be rewarded for it. Ultimately, the value of this RSO option is questionable.

The most straightforward way to proceed would be to alter the RSO requirement so that it commenced only once fellowship of a specialist college had been achieved. The RSO would then be undertaken in a single block over a set period of time. MRBS participants have identified this as one of the positive aspects of the scheme as they are very clear about the point at which their obligation commences.

The majority of BMP participants undertaking their RSO could then be monitored through their Medicare billing which will reduce the cost of the program administration significantly and simplify the process for participants. For those BMP participants working within the public health sector alternative monitoring would still be required.

Clearly, however, some current BMP participants may feel aggrieved by such a change. It would be useful to seek to quantify the likely future cost of administration of the current provision as well as any options for automating administrative options which have been proposed (recognising that capital costs of information technology are likely to be high).

#### *Buying out of the Bonded Medical Places Scheme*

If the scheme were to be reformed in other ways, the ease with which participants are currently able to buy out of the scheme would need to be reconsidered.

Preferably, although existing participants would be reluctant to give up the ability to buy out of the scheme, it would be more efficient for existing participants to be transitioned to a new funding agreement in order to reduce administrative overhead and avoid the inequity (and administrative burden) of multiple levels of participants.



Inducements for existing BMP participants to accept more stringent buy-out conditions could take the form of:

- A reduction in the overall RSO to two to three years (half of the length of medical degree) following the award of fellowship; and/or
- Broader geographical areas from which to choose their RSO location.

It is suggested that if comprehensive changes are to be made to the BMP scheme, these changes should be introduced quickly to limit the impact on those participants who have commenced or are about to commence their RSO. Currently the numbers are very low but it is anticipated that in the near future significant numbers would become eligible to commence their RSO.

### The role of the Bonded Support Program

The Bonded Support Program (BSP) was established to ensure that all bonded students and doctors can access support, networking and communication activities that will help prepare MRBS and BMP scholars for their future work. The Support Program is delivered by ACRRM which undertakes a range of activities including networking functions, the use of various media, and the provision of a conference program. The level of support offered under the BSP is the same for MRBS and BMP participants.

Many bonded participants comment on the lack of information provided by the Department and demonstrate a limited knowledge of the BSP. Participants and some senior educational administrators consulted in the course of the review appeared to believe that only MRBS participants were eligible for BSP support – when in fact BMP participants are eligible for the same level of support under the BSP as MRBS participants.

The overall value of the BSP has been questioned by some stakeholders. While some BMP participants and stakeholders consider the conference support opportunities that are available through the BSP to be excellent it should be noted that a relatively small percentage of bonded participants apply each year to attend such conferences. In 2012, 366 bonded participants (BMP and MRBS) attended conferences supported by the BSP, equating to about 6% of the total pool of bonded participants (applications to attend the conferences were in almost identical numbers). It is suggested that the focus of the BSP should be moved away from resource intensive activities targeting a small number of participants to broader tools to engage and assist all bonded scholars on the pathway from student to rural practitioner.

Alternative models of support should be developed through consultation with key stakeholders to ensure that the needs of the BMP participants are appropriately met. Models need to include active and positive strategies aimed at all levels of participants to ensure they understand their options under the BMP, are well equipped to potentially work in non-metropolitan settings and fully understand the positive opportunities that working outside the city centre presents. This could include establishing opportunities for building positive experiences in rural communities and building linkages with employer groups. A broad spectrum of organisations involved in medical education, including the medical specialist colleges should be consulted regarding the provision of training support opportunities. Both the colleges and RWAs currently provide support and mentoring to medical practitioners, particularly OTDs and these models should be explored for possible

application to BMP medical students and trainees at the various stages of education and employment.

The support models need also to work towards changing the perception of BMP participants as being in some way “second rate” and providing participants with opportunities that may not be available to non-bonded participants. While this could be achieved via the BSP, delivered through ACRRM with further involvement from the universities, funding for the current program should only continue until options for alternative, broader models of BMP student support are fully developed and a subsequent competitive funding process to implement and manage these services is undertaken.

### Following a different path - considering universal Return of Service Obligation requirements for medical graduates

A more radical alternative to bonding medical students using the current schemes (BMP and MRBS) would be to consider requiring all new medical graduates (CSP and international medical students) to undertake a community service period, similar to RSO arrangements operating in a number of other countries. This potentially addresses the perceived inequity of requiring only 25% of graduates (plus MRBS recipients) to complete an RSO period while the majority are able to work wherever they choose. Conceptually, this approach could also have benefits for the delivery of health services in under-serviced areas, particularly more rural and remote locations.

Consideration of this type of system offers an alternative to continuing with the current approach of enhancing rural training initiatives and providing financial incentives to support the relocation and retention of doctors in under-serviced areas. While the earlier chapters of this review outline proposed enhancements to existing Commonwealth interventions in order to improve the outcomes of existing programs, it is sensible to recognise that other options may be available to the Government to ensure new doctors are directed to those parts of the country where community need is the greatest. However, it is recognised that there are substantial risks involved in attempts to translate international RSO systems into the Australian context. These issues are discussed further below.

### *Analysis of International RSO Initiatives*

The World Health Organisation (WHO) has completed a country-by-country inventory of all Member States regarding compulsory service programs for recruiting health workers in remote and rural areas. A literature search and formal interviews were conducted by the WHO as well as informal questioning of relevant informants to identify countries with compulsory service programmes and their details in each of the WHO regions.<sup>145</sup> More than 70 countries were identified with current and past compulsory service programmes. The WHO study identified that both compulsory service with and without incentives and/or with financial or other penalties for breach of contract are in use. Without discussing the findings of this study in detail, it is clear that establishing RSO requirements for medical graduates is not uncommon internationally and that aligning where new graduates are able to work with community health needs is not a completely radical concept.

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<sup>145</sup> Frehywot et al, “Compulsory service programmes for recruiting health workers in remote and rural areas: do they work?” *Bulletin of the World Health Organisation* (88),2010, pp. 364-370

While a variety of international programs have been identified by the WHO, the outcomes of the different approaches appear to be variable and are likely to be highly dependent on conditions in each country. However, results from the available data generated by the WHO project appear to indicate that statistically (less than one in five in Norway) most practitioners do not remain in their bonded location after the conclusion of the RSO period. Even when the bonding period occurred prior to specialisation such as in South Africa, retention was poor. Thirty four per cent of compulsory service doctors intended to leave South Africa after completing their obligation, and an additional 13% planned to go into private practice.<sup>146</sup>

### Box 6.4: Case study of the Canadian approach to RSO

Canada, which faces similar challenges of a rurally distributed population to Australia, has a long history of providing financial incentives in exchange for return-for-service (RFS) by medical practitioners. Scholarship type programs (or bursaries as they are known locally) have existed there in some form since 1969. Although conditions and level of financial support varies across provinces, all except the Yukon require a service commitment in return for medical training funding support. In accordance with previous US studies, Neufield and Mathews found that trainees who had concerns about their finances were more likely to opt for an RFS bursary, with 93% of respondents indicating that their need for financial assistance had at least a moderate to major influence in their decision to apply for the program. Further, 80% of trainees who opt for a bursary already planned to work in the province after their service commitment supporting the hypothesis that the RFS bursary largely rewards physicians who had already intended to remain and practise in the relevant location.<sup>147</sup>

The Canadian approach has more similarities to Australia's MRBS scheme than to the BMP in that direct financial support is provided to students during their training to offset the RSO requirement.

The Community Service system operating in South Africa appears to have the greatest similarity to the concept of requiring all Australian medical graduates to complete a RSO period.

### Box 6.5: Case study of the South African approach to RSO

The South African model requires medical practitioners to complete an intern period (at present 2 years) and then a Community Service year prior to achieving full registration. During the Community Service year, trainees are sent to an area of medical need to provide services to communities who might otherwise not have access to a doctor full time, or whose primary care is usually provided by nurses or other health workers.

However, there are reports that this scheme is undermining the rural health system in South Africa with qualified doctors replaced with students fresh out of medical school providing only a basic level of health service. In particular, those who had completed their internships in academic (tertiary teaching hospitals) were at a distinct disadvantage in rural hospitals, whereas those who had been interns at regional hospitals had confidence and necessary skill levels.<sup>148</sup>

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<sup>146</sup> *ibid.*

<sup>147</sup> Neufield and Mathews, "Canadian Return-for-Service Bursary Programs for Medical Trainees" *Healthcare Policy Vol 7. No.4*, 2012

<sup>148</sup> Reid and Conco, "Chapter 17 - Monitoring the implementation of community service". *1999 South Africa Health Review*, 1999

An unintended consequence of the community service requirement is that doctors who left South Africa before completing the registration process (internship + community service) are indefinitely lost to the local health system. At present, even if they wish to return and/or are more qualified than is necessary to achieve registration, the legislation which underpins the scheme prevents them from practising without completing the community service year. For many practitioners who are based overseas, personal commitments and professional preference act as strong disincentive to comply with the new requirements, despite the desire to return to South Africa.

In examining whether a universal RSO requirement should be introduced for medical graduates, it may also be pertinent to consider the outcomes of a similar approach that was adopted for Australian teachers in previous decades. While medical workforce development is clearly different in many major respects to the salaried staff of the public education sector, there are parallels in terms of the success of government intervention to address workforce shortages in rural and remote areas.

### Box 6.6: Case study – bonding from the education perspective

Up until the mid-1970s the Department of Education in New South Wales awarded scholarships to encourage teacher training, usually benefiting students from rural communities.<sup>149</sup> These scholarships were bonded with the consequence that schools in rural and remote areas were staffed by teachers in their first few years of service. Rural service was also used as a vehicle for promotion, with rural teachers given preference for popular locations elsewhere in the state after a suitable period of service. Teachers therefore remained in rural areas after the bonding period in the firm expectation that when they requested a transfer the Department would provide a position in their preferred location. As teachers' scholarships were phased out, an oversupply of non-bonded teachers began to emerge, exacerbated by a lack of quotas on teacher training courses in the 1980s and decreasing student numbers. As such, filling rural positions was not a challenge for the Department and the preferred transfer system (which had by this point progressed to a points based system) was no longer policy. Coupled with devolution of teacher selection and recruitment to the individual schools and principals, rural teachers feared that opportunities for transfer would be shut off, effectively locking them in to rural and remote posts.

"Teacher perceptions and reactions to the reforms led long-staying rural teachers to re-appraise their decision to remain in rural schools. They feared entrapment in the rural situations with little or no prospect of a transfer to their preferred location later on in their career."<sup>150</sup>

Consequently, the rate of rural teacher turnover through transfer, promotional or promoted appointment over the 1989-1990 period exceeded the figure for the state as a whole. More damagingly, the turnover rates at that time for rural long-staying teachers were far in excess of the rates for all teachers.

Later work on rural retention demonstrated that connections to a rural community had the most impact on the likelihood of teachers staying long term rurally. In one cohort of 1,100 long staying teachers, 73% had lived in rural communities for some part of their own upbringing and 46% had attended the local regional rural teacher education institute for their teacher training.<sup>151</sup>

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<sup>149</sup> Boylan and King, "Educational reforms: impact on rural teachers" *Rural Society Journal*, Vol1. Issue 2;010-014, 1991

<sup>150</sup> *ibid.*, p. 11

<sup>151</sup> Boylan et al, "Teaching in Rural Schools" in Boylan and King "Educational reforms: impact on rural teachers" *Rural Society Journal*, Vol1. Issue 2;010-014, 1991

### *Potential Barriers in Australia*

In the Australian context the constitutional prohibition on medical conscription may require consideration. The Commonwealth of Australia Constitution Act – Section 51(xxiiiA) states that:

“The Parliament shall, subject to this Constitution, have power to make laws for the peace, order, and good government of the Commonwealth with respect... to the provision of medical and dental services **(but not so as to authorize any form of civil conscription)**” (emphasis added).

This civil conscription clause is likely to be the most significant barrier to the creation of a compulsory community service year for medical practitioners. It may be that there are contractual methods which could be devised which would facilitate some sort of universal RSO provision for medical graduates that would survive a potential High Court challenge on the basis of section 51(xxiiiA), but this requires further, more detailed, legal advice.

More pertinently, it is likely that even if a universal service requirement could be lawfully devised, the administrative and other costs may outweigh the potential benefits. For example, if implemented in Australia, the South African approach (RSO without financial inducement, commencing from medical registration) would result in around 3,000 postgraduate year (PGY) 2 doctors undertaking a Community Service year annually in an area of medical need. The financial implications (in terms of salary cost) of this are not known, since state and territory governments are the usual employers of PGY2 doctors at present. Commonwealth financing, either via provision of a Medicare provider number or as direct salary during this period would need to be derived from arrangements which are currently in place, taking into account the differences in salary rates between jurisdictions.

More significantly, junior doctors require a level of supervision that is unlikely to be available consistently across rural and remote Australia. Given the current challenges in expanding prevocational training places in rural and regional areas (as discussed in Chapter 4) the ability to meet accreditation requirements and provide appropriate supervision capacity appear to present significant barriers to the adoption of a large scale RSO requirement at any stage doctors have completed their full postgraduate training pathway and are able to work across all settings without supervision.

For this model to be considered extensive consultation with stakeholders, agencies and governments to identify the infrastructure changes that would be needed to support the adoption of such a scheme. It is not recommended that the Commonwealth should investigate this option further at the present time, given the current barriers identified. However, if the recommended approaches to improving medical workforce distribution (involving a combination of investment in training and incentives) prove to be unsuccessful the potential adoption of a universal RSO requirement may need to be reconsidered.

*Recommendations*

Recommendation	Affected programs	Timeframe
<p><b>Recommendation 6.8:</b> Major reform to the operation of the Bonded Medical Places (BMP) scheme should be considered to address stakeholder concerns and escalating administrative challenges.</p> <p>The return of service obligation (RSO) required of medical students should be substantially altered to help make the scheme fairer and more certain for students as well as more efficient to administer. This should involve:</p> <ul style="list-style-type: none"> <li>• Making designated rural areas permanently eligible for completion of the RSO period, removing the use of the districts of workforce shortage (DWS) system in these areas;</li> <li>• Aligning eligible metropolitan areas for RSO with the reforms to the DWS system outlined elsewhere in this review, as well as allowing flexibility for graduates to work in high need metropolitan areas, such as community health settings like Aboriginal Medical Services; and</li> <li>• Changing the RSO period to commence from attainment of fellowship to make the scheme administratively sustainable through basing it around access to Medicare provider numbers. To offset this change the Commonwealth should halve the maximum RSO period and retain the use of ‘scaling’ to encourage graduates to work in more remote areas.</li> </ul>	BMP	Medium term – changes to the operation of the program could commence for new entrants from 2014, subject to consultation with universities and other stakeholders.



## 6.4 Workforce distribution programs targeted at non-vocationally recognised medical practitioners

### Section 3GA workforce programs

In 1996, the *Health Insurance Act 1973* (the Act) was amended to include a number of new sections – 19AA, 3GA and 3GC –collectively known as the Medicare Provider Number Legislation. These amendments were introduced to recognise and support general practice as a vocational specialty and to provide a framework for achieving long-term improvements in the quality of the permanent medical practitioner workforce. Under s. 19AA, a medical practitioner is unable to access a Medicare Provider Number unless they hold vocational recognition (by the RACGP, ACRRM, or another specialist medical college) or are participating in an approved training or workforce program under s. 3GA of the Act.

The provisions of the Act allow medical practitioners who are working towards vocational recognition to access Medicare benefits. Approved training programs include the Australian General Practice Training (AGPT) Program, the Remote Vocational Training Scheme (RVTS), the Prevocational General Practice Placements Program (PGPPP), and fellowship programs offered by the specialist medical colleges. These have been discussed in Chapters 3 and 4.

Alongside these, there are a number of approved programs under s. 3GA that are aimed primarily at addressing workforce shortages in particular locations or settings. These are open to both Australian doctors and OTDs who are permanent residents who do not hold vocational recognition, and include:

- The Approved Medical Deputising Service (AMDS) program, which allows participants to provide Medicare-rebatable services in metropolitan ‘after hours only’ accredited medical deputising services offering home visits;
- The Approved Private Emergency Department (APED) program, which was established to overcome a shortage in emergency physicians available to practise in private emergency departments, and enables access to the sessional pool of non-emergency physicians; and
- The Rural Locum Relief Program (RLRP), which is described above.

The remaining s. 3GA programs have been introduced as mechanisms to address certain exceptional circumstances that preclude access to a provider number:

- The Special Approved Placements Program (SAPP) provides access to Medicare benefits for those doctors who are unable, due to extreme personal circumstances, to participate in any other s. 3GA program; and
- The Temporary Resident Other Medical Practitioners (TROMPs) program was established in 2001 to address an anomaly created by amendments to the Medicare Provider Number legislation which would have seen a number of long-term temporary resident medical practitioners lose access to a provider number.

Medical practitioners can participate in more than one s. 3GA program at a time.

It should be noted that the SAPP and TROMPs program do not place any restrictions over where participants can practise. There has been a significant increase in the number of medical practitioners participating in the SAPP, from seven participants in 2004-05, to 49 in 2008-09 and 159 in 2010-11.

For the most part, these s. 3GA workforce programs also support the intent of s. 19AA to improve the quality of the medical workforce by requiring participants to work towards vocational recognition (the TROMPs program is the exception).

The exception to this is the TROMPs program, which does not require participants to pursue vocational recognition. However, the number of TROMPs participants has declined substantially from 93 in 2010-11, to five current participants, and it is unlikely that there will be any increase in the future. It is likely that many previous participants have completed their fellowships and are no longer subject to Medicare benefit restrictions. Alternative arrangements should be pursued for this small number of temporary resident doctors.

The balance between the goals of workforce distribution and quality applying to the AMDS was raised by a medical deputising service during the course of the review, who urged caution about placing too great a focus on participants achieving vocational recognition. AMDS participants are eligible for the After Hours Other Medical Practitioners (AHOMPs) program, which also includes a requirement to pursue fellowship.

Under the Act, the operation of sections 19AA, 3GA and 3GC (relating to the Medical Training Review Panel) must be reviewed every five years. The most recent review was completed in December 2010, and DoHA advises that implementation of its recommendations is currently proceeding (where these are consistent with government policy). A summary of the findings of the 2010 Review of the Medicare Provider Number Legislation is included at Appendix vii.

Given the similarity in the operational arrangements of the s. 3GA workforce programs, there could be merit in pursuing the amalgamation of these programs to realise administrative efficiencies, and provide less complexity for participating medical practitioners.

### Other medical practitioners programs

Non-vocationally recognised (non-VR) medical practitioners who have been granted a Medicare Provider Number through participation in a s. 3GA workforce program are only entitled to claim the lower A2 Medicare rebate. The Commonwealth supports a number of programs targeted at these 'other medical practitioners' (OMPs) that provide a financial incentive – access to the higher A1 Medicare rebate – in return for working in an area of workforce shortage.

The OMPs programs currently available are detailed in the following table.

Table 6.4: Programs targeted at Other Medical Practitioners

Program	Required Area of Practice	Participants Nov 2012
After Hours Other Medical Practitioners program (AHOMPs)	Across Australia providing after-hours general practice services	848
Medicare Plus Other Medical Practitioners program (MOMPs)	Districts of workforce shortage	294
Outer Metropolitan Other Medical Practitioners program (OM-OMPs)	Outer metropolitan	28
Rural Other Medical Practitioners program (ROMPs)	RRMA 4 to 7	1,549

The OMPs programs target three key groups of non-VR medical practitioners:

1. Temporary residents who are practising within districts of workforce shortage under valid s. 19AB(3) exemptions;
2. Permanent resident and citizen medical practitioners who are working towards obtaining vocational recognition as a general practitioner on an approved s. 3GA workforce program, primarily the AMDS program or the RLRP; and
3. Medical practitioners who were registered in Australia prior to 1 November 1996 (i.e. prior to the introduction of the Medicare Provider Number legislation) and who are not subject to the vocational recognition requirements of s. 19AA of the Act.

There are a number of differences in the eligibility and professional development requirements between the OMPs initiatives.

While eligibility for the ROMPs and AHOMPs programs is open to all three categories of non-VR practitioners, eligibility for the MOMPs and OM-OMPs programs is restricted to the third category listed above. These two programs were implemented to ensure that non-vocationally recognised medical practitioners who were registered in Australia prior to 1 November 1996 had a mechanism by which they could access Medicare rebates at a level comparable to the level they were entitled to prior to the introduction of s. 19AA of the Act. Under s. 19AA, these medical practitioners are not legally obliged to work towards obtaining vocational recognition.

Given that the pool of non-VR practitioners registered prior to 1 November 1996 is a limited one, it is likely that participation in the MOMPs and OM-OMPs programs will decrease over time. There is also no requirement under the MOMPs program to pursue vocational recognition.

The ROMPs and AHOMPs programs have experienced increased rates of participation and this is expected to continue, due to the increasing number of graduating medical practitioners and limited capacity of general practice training programs such as the AGPT and the RVTs, which offer a fixed number of training places. These programs provide a way for these non-VR practitioners to access to A1 Medicare rebates while pursuing their fellowship.

When considered together, the OMPs programs provide support to increase the quality of the medical workforce (s. 19AA) and increase the supply of doctors in areas of workforce shortage (s. 19AB). The need for a sustainable medical workforce beyond metropolitan areas is discussed in greater detail elsewhere in this report. Suffice it to say that the OMPs programs provide necessary support to a key component of the health workforce whilst they pursue specialist medical qualifications.

The OMPs programs have financial impacts on the MBS and there are associated administration costs borne by DoHA and DHS.

There are some inconsistencies within and between the OMPs programs that may confuse applicants or create unintended consequences. For example:

- Inconsistent use of geographical classification systems across the OMPs programs, with ROPs relying on the Rural, Remote and Metropolitan Area (RRMA) classification system and OM-OPs using an idiosyncratic definition of 'outer-metropolitan' based on the 2001 ASGC, whilst MOPs is based on DWS.
- AHOPs allows medical practitioners to access A1 Medicare rebates for an initial period of six years. To qualify for RACGP Fellowship, medical practitioners require a minimum of four years general practice experience with a maximum of two and a half years being in after-hours only engagements. This presents a disincentive to AHOPs practitioners to actively seek RACGP qualification and also discourages them from obtaining the additional one and a half years' experience on an alternate program.

### *Development of a single OMPs program*

A 2009 review undertaken by the Allen Consulting Group found that the OMPs programs have supported the workforce distribution aims of s. 19AB. The review also noted that the eligibility and participation inequities between the programs could be addressed through the creation of a single OMPs program. This was confirmed in stakeholder consultations for this current review. A single OMPs program would also deliver administrative efficiencies, consistent eligibility criteria and a minimum standard of professional development and service quality regardless of practice location.

To date, DoHA has not pursued the development of a single OMPs program, apparently on the basis that it may be criticised for treating the different groups of non-VR medical practitioners differently due to the operation of s. 19AA and s. 19AB. For example, MOPs participants are currently not required to work towards vocational recognition, but could be required to do so under a consolidated OMPs program.

The introduction of a single OMPs program, it has been argued, also has the potential to diminish the effectiveness of the rural element, by allowing a greater pool of non-VR practitioners to access A1 rebates in outer-metropolitan and DWS areas (currently limited to the pre-1996 non-VR practitioners). This issue would need to be considered within the design of a consolidated program.

However, on balance the benefits of a consolidated program would outweigh these concerns, which could be mitigated by careful program design. The unnecessary complexity of maintaining and administering several OMPS micro-programs appears difficult to defend.

Stakeholders consulted during this review noted that the operation of the inter-related AMDS program and RLRP should be considered in developing any streamlined arrangements for the OMPs programs. For example, any modification to the geographical classification system used in the ROMPs program would need to be aligned with that of the RLRP to ensure consistent treatment of medical practitioners.

### *Recommendations*

<b>Recommendation</b>	<b>Affected programs</b>	<b>Timeframe</b>
<b>Recommendation 6.9:</b> The Commonwealth should consolidate the existing Section 3GA workforce programs.	All 3GA programs	Medium term
<b>Recommendation 6.10:</b> The Commonwealth should combine the After Hours Other Medical Practitioners program, the Medicare Plus Other Medical Practitioners program, the Rural Other Medical Practitioners program and the Outer-metropolitan Other Medical Practitioners program into a single program. In developing the program, issues to consider include: <ul style="list-style-type: none"> <li>• use of the revised geographical classification system proposed elsewhere in this report;</li> <li>• grandfathering arrangements for pre-1996 medical practitioners;</li> <li>• standardised specialist college training and continuing professional development requirements;</li> <li>• expansion to include Aboriginal and Torres Strait Islander health services;</li> <li>• interaction with s. 3GA workforce programs, specifically the Approved Medical Deputising Service program and Rural Locum Relief Program; and</li> <li>• the potential for unintended negative outcomes for medical service provision in rural areas.</li> </ul>	All other medical practitioners programs	Medium term

Recommendation	Affected programs	Timeframe
<b>Recommendation 6.11:</b> The Department should undertake a process with individual participants on the Temporary Resident Other Medical Practitioners (TROMPs) program so that a timeline can be set for all participants to indicate a clear intention about engaging with the relevant college on a process to proceed to fellowship.	TROMPS	Short term – small number of program participants.



## Chapter 7: Nursing and midwifery workforce – education, retention and sustainability

Nursing and midwifery workforce issues are matters for both Commonwealth and state governments. As the major employer of nurses and midwives, the states and territories are largely responsible for recruitment and retention. The Australian Government has a less direct but very important role, contributing funding for the delivery of health services and for university education of nursing and midwifery students.<sup>152</sup>

The Commonwealth's function in planning and investing in the nursing and midwifery workforce of Australia has emerged relatively recently. Initially, the majority of funding and policies were directed through the Education portfolio driven by the transition of nursing to the tertiary education sector in the mid-1980s. Later, investment through the Council of Australian Governments (COAG) 2006 Health Reform Agenda has resulted in a much broader role for the Commonwealth with the ability to impact on the workforce through education and training reform. A history of nursing investment is located at Appendix iv.

More recently the Commonwealth has invested in nursing and midwifery supply and support measures. These include investments under the Health Workforce Fund (HWF) in practice nursing and nursing and midwifery scholarships. These nursing initiatives totalled about 34% of the funding under the HWF in 2011-12. These are complemented by Department of Education, Employment and Workplace Relations (DEEWR) and Department of Industry, Innovation, Climate Change, Science, Research, and Tertiary Education (DIICCRSTE) measures and Aged Care-specific measures.

As indicated elsewhere, *Health Workforce 2025 – Doctors, Nurses and Midwives* Volumes 1 and 2 (HW2025) predicts a shortage of nurses after 2016, culminating in an estimated shortfall of 109,000 nurses in 2025 based on “as is” policy settings. Relevantly for the purposes of this chapter, the forecast was that with current policy settings, work practices and retention rates, an additional 10,949 nurses per year (registered and enrolled) would need to graduate from 2016 if supply is to meet demand by 2025.<sup>153</sup> The findings of HW2025 are outlined in more detail at Appendix ii.

It is clearly very unlikely that an additional 10,949 nurses per year would graduate from 2016 under any circumstances. This means, among other issues, that there is a need for a policy focus on retention of the current nursing workforce; facilitating the return to the workforce of qualified nurses who have left the workforce, (often for family reasons) and addressing workforce rigidities. There is an ongoing need to test assumptions in the model and continue the drive for better and more reliable data.

While the total number of nurses predicted to be required is a growing concern, it should be noted the nursing and midwifery workforce is presently relatively evenly

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<sup>152</sup> Council of Australian Governments, [Communique 14 July 2006](http://archive.coag.gov.au/coag_meeting_outcomes/2006-07-14/index.cfm), accessed at [http://archive.coag.gov.au/coag\\_meeting\\_outcomes/2006-07-14/index.cfm](http://archive.coag.gov.au/coag_meeting_outcomes/2006-07-14/index.cfm)

<sup>153</sup> HWA, HW2025 – Vol 1, p. 98

distributed across regions of Australia. Nursing and midwifery supply across regions ranges from 1,102 full-time equivalent nurses and midwives per 100,000 population in major cities to 995 in outer regional areas to 1,336 in very remote areas.<sup>154</sup> As far as the future is concerned, HW2025 modelling suggested shortages of nurses in the aged care and mental health sectors and a shortage of midwives in regional and remote Australia.

## 7.1 Nursing and midwifery education

Historically, nursing and midwifery education in Australia was predominantly public hospital-based, with an apprenticeship style system, lasting three or more years, whereby the students were paid and had conditions which included full board and lodging.<sup>155</sup>

Nursing has a long tradition and history and change has been incremental in terms of nursing and midwifery training schemes over the years, despite more rapid change in other segments of the workforce. During the 1970s, there were efforts to change the way nursing education was delivered and to introduce a more theoretical component. During the mid-1980s, nursing education commenced a period of change from being hospital-based to being conducted in tertiary settings, with practical clinical experience components. By 1993, all registered nursing students in Australia were entering the profession via the university education pathway. Note the enrolled nursing pathway is discussed later in the chapter.

In 2001 the National Review of Nursing Education was initiated by the then Department of Education, Science and Training and the final report, titled *Our Duty of Care*, was released in 2002. This report highlighted a future shortfall in the nursing workforce. A number of strategies were implemented to ameliorate this concern, including the provision of scholarships and other financial assistance, an increase in the number of fully funded university places, increased infrastructure spending and a range of incentives to encourage regional and rurally based nurse education programs.

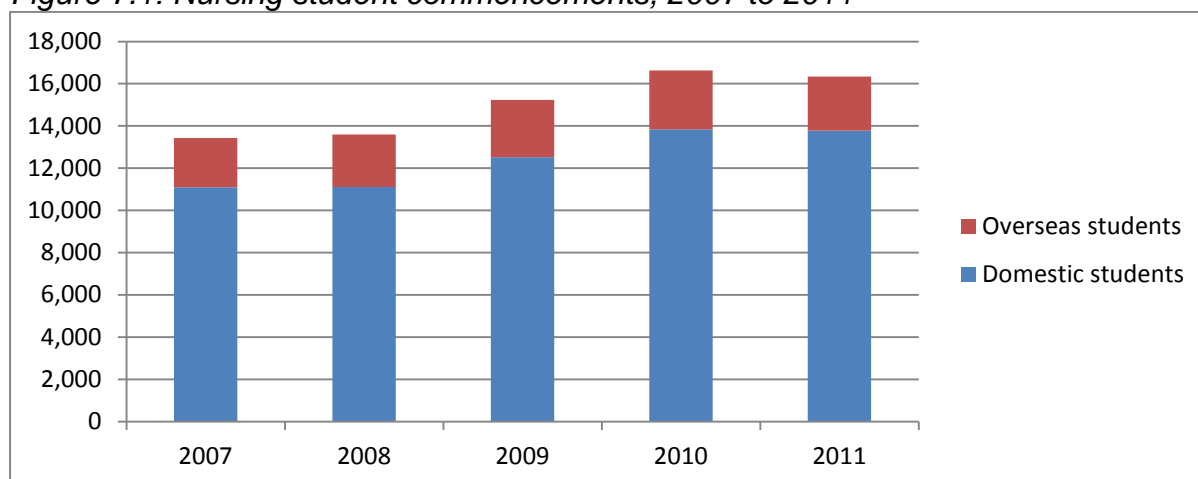
Entry level registered nursing courses are now demand-driven courses at university, but have been oversubscribed. In 2011, 21,937 applications were made for university nursing in Australia and 16,338 people were offered positions.<sup>156</sup> Even if all applicants were accepted and completed their studies, this would fall well short of the 18,953 additional places/applicants which HW2025 suggests will be necessary to meet health care needs on “as is” policy settings. The tables below represent the registered nurse enrolments and course completion data over recent years.

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<sup>154</sup> AIHW, *National Health Workforce Data Set: Nurses and Midwives 2011*, Canberra 2012

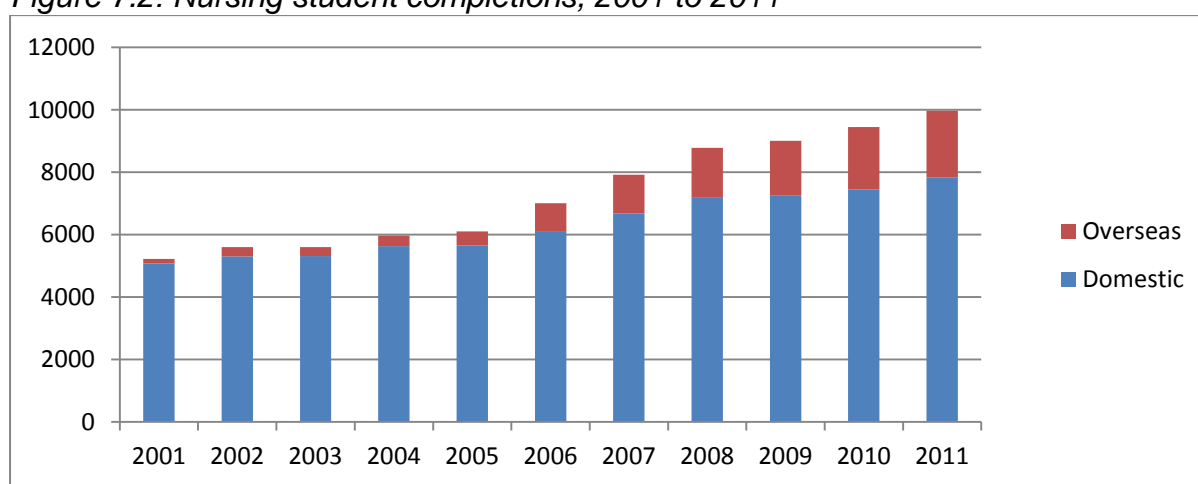
<sup>155</sup> Extract from L Russell (1990). *From Nightingale to Now: Nurse Education in Australia*, 2005

<sup>156</sup> Department of Health and Ageing, analysis of data from Department of Education, Employment and Workplace Relations 2011, February 2012

*Figure 7.1: Nursing student commencements, 2007 to 2011*

Source: Department of Innovation, Industry, Science, Research and Tertiary Education, Higher Education Statistics Data Cube (uCube), 2012

(Given the complexity of education pathways, there is no national data collection of commencements and completion of courses for midwifery.)

*Figure 7.2: Nursing student completions, 2001 to 2011*

Source: Department of Innovation, Industry, Science, Research and Tertiary Education, Higher Education Statistics Data Cube (uCube), 2012

Prior to 2009, the Government controlled the number of funded university places for nursing students. However, as a response to the Bradley Review, in 2009, universities moved to a demand-driven system for nursing students. Therefore, it is most likely a function of university and clinical training capacity that nursing enrolments are smaller than applications. Clinical facilities can only cater to a finite number of students and the numbers of supervisors for clinical placements is also limited.

Increasing the supply of registered nurses is not necessarily a question of increasing demand, as university nursing courses are oversubscribed. However, there have been some suggestions during the course of this review that the standard of students applying for nursing has declined. Some universities have been criticised for reducing their minimum tertiary entrance scores to attract more nursing applicants, with some minimum entrance scores falling below 50. The fundamental issue is one of sustainable expansion of nurse education capacity to meet forecast

demand while continuing to ensure quality educational delivery, when it is clear on current demographic trends that nurses will need to be trained to work in a diverse range of settings, including aged care, acute care and disability services.

In this regard the Department and HWA have provided support for clinical training facilities through various capital works and recurrent funding programs, including initiatives such as the University Departments of Rural Health (UDRH) and HWA clinical training grants.

The UDRH program supports and promotes nursing and midwifery practice, education and research in rural and remote areas. This program represents the Australian Government's primary investment in rural nursing and midwifery and allied health education and training under a multidisciplinary focus (within the Health portfolio).

Feedback from stakeholders, as well as the analysis of program performance to date, suggests that the network of eleven multidisciplinary UDRHs has significant potential to provide enhanced education services including re-entry courses for rural and remote nurses seeking to resume their career as well as in other postgraduate education fields. The UDRH program has been discussed in more detail in Chapter 4.

### Midwifery

Until recently, midwifery in Australia was a post-basic certificate or a postgraduate degree. That is, all registered midwives were registered nurses who held additional qualifications related to midwifery practice. However, in 2000, the first direct entry courses for midwives were established. Graduates from these courses practise only midwifery, unlike their predecessors.

This newer, more specialised model of midwifery education is demand driven, with some students choosing to pursue this specific career path rather than first completing a nursing degree. It has however, had a mixed reaction among the profession itself and employers. It has also complicated the reliability of workforce data modeling and planning processes, as under the National Registration and Accreditation Scheme (NRAS) there were previously not separate categories for these two professional groups. In future, data from NRAS will be able to separate nurses and midwives.

For the midwifery profession, tracking of students is difficult. There are three education and registration pathways by which midwives can enter the profession: Direct entry midwifery (Bachelor of Midwifery); Double degree (Bachelor of Nursing/Bachelor of Midwifery) or postgraduate qualification in midwifery following a nursing degree (Graduate Diploma and Masters level). Given these complex education pathways, there is no national data collection of commencements and completion of courses for midwifery. Improved data is expected to become available with the 2013 national registration survey. This will give a clearer picture of the 'status' of the midwifery workforce into the future.

During the course of this review, stakeholders noted that controversy exists in respect of the multiple education pathways for midwifery registration. While there is some support for direct entry midwifery as the optimum educational pathway, it is also acknowledged that employment options for the graduates of these programs may be limited.

In rural areas, for example, some employers are seeking employees who can provide both nursing and midwifery services due to the variable workloads of smaller facilities. Additionally, in the smaller rural and remote areas, safety issues with the single midwifery qualification are often raised. A single degree (direct entry) midwife will not be trained to manage some emergency situations that a nurse with a double degree qualification (registered nurse and midwife) may be able to respond to. Additionally, a single degree midwife is unable to be utilised in other areas of the hospital, should the maternity area be quiet, which is counter to the wider attempt in the health professions, including medicine, to promote a rural generalist model.

### Enrolled nurses

Enrolled nurse training takes place in the vocational education and training (VET) sector rather than the university sector. Prospective enrolled nurses undertake a Diploma qualification. In 2010, 3,794 students completed such a course.<sup>157</sup>

Enrolled nurses provide nursing care within the limits specified by education and the regulatory authority's license to practise.<sup>158</sup> Enrolled nurses retain responsibility for their own actions whilst remaining accountable to a registered nurse for delegated nursing functions. Enrolled nurses are an integral part of the nursing profession, delivering nursing care that is complementary to that delivered by registered nurses. Enrolled nurses work under the supervision of registered nurses: supervision is defined as including oversight, direction, guidance or support (whether directly or indirectly).

The lack of support for vocational education courses for enrolled nurses has been raised as a challenge during this review process, especially when the predicted nursing shortage may drive the need for utilising different models of care and innovative workforce arrangements, including increasing the role of enrolled nurses. (This issue is more fully discussed later in this chapter.)

Despite the existence of around 150 accredited enrolled nursing courses, participation levels in these courses are low, and the level of state government support for the continuation of these places has declined over the last decade. Stakeholders raised the issue of the cost of enrolled nursing courses in the VET sector as a reason for reduced enrolment (an enrolled nurse diploma costs approximately \$16,000, in comparison to a registered nurse degree of approximately \$23,000).

Submissions were made to this review that the Commonwealth agencies involved in nursing education should investigate the availability and cost of VET sector education as it relates to enrolled nurses. It was also argued that enrolled nursing students should also be eligible for scholarship support, provided it is targeted towards increasing enrolments in this section of the training pathway rather than simply supporting current students.

In recent times, it appears that many acute care hospitals have reduced or removed the enrolled nurse role, preferring to have registered nurses deliver patient care. It is likely that many VET sector providers are no longer offering places in their

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<sup>157</sup> Department of Health and Ageing, Analysis of data from the Department of Education, Employment and Workplace Relations 2011, February 2012.

<sup>158</sup> Royal College of Nursing Australia. [Position Statement, 2004](#), accessed at [www.rcna.org.au](http://www.rcna.org.au).

accredited programs due to a decrease in student demand as a result of reduced job prospects. If demand for new enrolled nursing positions begins to increase in the future, this may flow through to a reinvigoration of support for enrolled nurse education.

During the nursing workforce roundtable consultations, key stakeholder groups including the Australian College of Nursing, the Coalition of National Nursing Organisations and the Nursing and Midwifery Board of Australia all raised issues and concerns regarding the perceived lack of acknowledgement of the enrolled nurse role. Stakeholders agreed that there is a need to acknowledge the enrolled nurse and value and support their role. Stakeholders agreed that more research into the enrolled nurse scope of practice should be undertaken.

As noted above, the enrolled nurse role appears to have been diminishing due to lack of support and employment opportunities, particularly in the acute care sector. International experience in both the United Kingdom<sup>159</sup> and New Zealand,<sup>160</sup> where enrolled nurse positions and courses were phased out during the early 1990s, indicates that there is a workforce need for enrolled nurses. While the UK still has enrolled nurses working in its health care system, they have not yet reintroduced an accredited educational course that leads to this qualification. They are however, investigating options to recommence enrolled nursing education. New Zealand reintroduced enrolled nursing courses in 2002.

It is important to learn from the international experience of the removal and reintroduction of the enrolled nursing role in these countries, which have recently revised the enrolled nurse role in response to community needs and workforce pressures.

An analysis of the outcomes of the reintroduction of enrolled nurse education overseas and their role within the nursing workforce should be undertaken. This work could then inform policy development in Australia.

Some action is taking place in Australia and in 2010 an additional 600 enrolled nurse training places were funded through the More Nurses in Aged Care Program. This program also provides funds for aged care workers to upgrade their qualifications and provides scholarships for study. This is aimed at enhancing skill development and retention rather than increasing student numbers in the enrolled nursing courses. Nursing scholarships, including those relating to the aged care workforce are discussed in detail in Chapter 3.

### Scholarships and distribution

Several scholarships, described elsewhere, exist to support nursing and midwifery students. However, it appears likely that these programs have limited effects on increasing the size of the nursing and midwifery workforce by attracting additional student demand. Scholarships are certainly useful in providing financial support to

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<sup>159</sup> Francis, Becky; John Humphreys (August 1999). "Enrolled nurses and the professionalisation of nursing: a comparison of nurse education and skill-mix in Australia and the UK". *International Journal of Nursing Studies* 36 (2): 127–135

<sup>160</sup> Nursing Council of New Zealand, *Scope of Practice for Enrolled Nurses*, 2010. Accessed at [www.nursingcouncil.org.nz](http://www.nursingcouncil.org.nz)



individual students who have already decided to pursue a nursing or midwifery career.

Broad scholarship funding at the undergraduate level, while clearly a popular measure, will have limited impact on enrolments or workforce retention and is not a solution to meeting the looming workforce shortages identified in HW2025. This is primarily because the offer of a scholarship only occurs once a student has already applied for a university place and nominated their preferences for a particular course of study.

What limited evidence exists, suggests that the prospect of securing relatively modest financial support through scholarship funding is unlikely to be the determining factor in student career choice. It will have an impact in some cases and is certainly likely to assist with completion rates for students undertaking nursing courses. However, with nursing courses currently oversubscribed, the need to encourage more applications by offering broad and un-targeted scholarships appears to be minimal. There are risks that an over-reliance on providing broad undergraduate scholarships will distract attention (and divert resources) from potentially more effective mechanisms for influencing future workforce supply.

During the consultation phase of this review, key stakeholders noted that nursing and midwifery students seeking to undertake courses including re-entry to the profession, enrolled, registered, postgraduate and specialty studies, and nurse practitioner candidates, should be considered eligible to apply for a range of scholarships providing financial and/or non-financial assistance. Scholarships, including nursing and midwifery scholarships, are discussed in detail in Chapter 3.

Nursing and midwifery education does not face the same issues as medicine in terms of the need for additional rural training programs and longer rural educational experiences at the undergraduate level. Compared to medical education there are more numerous existing rurally based nursing schools that have been providing full undergraduate nursing courses for many years.

The substantial level of rural nursing education is likely to be one of the reasons for the better distribution of the nursing workforce when compared to medicine. Rural nursing students have the opportunity to transition straight from university training into employment at rural hospitals and other settings. This avoids the need to complete large sections of their training in the city, which in other disciplines tends to impact upon the life choices of new graduates.

The more even distribution of nurses and midwives is also of course likely to be heavily influenced by employment arrangements in rural district hospitals and other settings (as discussed elsewhere). It is obvious that the continued availability of rural employment opportunities, particularly in the public sector, is the key issue in rural workforce distribution for the majority of nurses and midwives.

In comparison medical practitioners and, more recently, nurse practitioners in private practice are required to set up a practice, with associated costs and the need to develop business management capability. Additionally in some smaller rural communities there may not be a large enough population to support an additional medical or nurse practitioner practice. It may be possible to consider developing alternative arrangements, including allowing these health practitioners access to rooms in rural hospitals and community health centres, or assist them to participate in “easy entry – gracious exit” business arrangements which are discussed in more

detail in Chapter 4. This would need to be developed in close consultation with all stakeholders, including all Australian governments.

### Clinical training

Stakeholders agreed that access to appropriate clinical placement opportunities was critical to producing work ready graduates. It was noted that access to clinical practice experience opportunities has been under considerable pressure in recent years. Under NRAS there is a requirement for nursing students to complete a minimum of 800 hours of supervised clinical experience placements to qualify and therefore register. Particular education providers require higher levels of clinical placement hours.

Some stakeholders have postulated that, with the increase in student numbers, the capacity of the health system to provide sufficient high quality clinical experience places has been compromised. While clinical training funding through HWA has assisted with this situation, some concerns were raised about the sustainability of these arrangements.

The impact that differential prices for clinical training supervision is having on the system was also raised in the Health Education Roundtable discussion. There was some suggestion that the rollout of HWA funding has inflated the costs that some settings are seeking to recover in supporting training and that this has impacted negatively on training arrangements not funded directly by HWA. This issue appears to have particular relevance for nursing and midwifery education.

The level of work readiness of registered nurse graduates was also raised as a key issue during the roundtable stakeholder consultations. Private sector stakeholders in particular argued that there is considerable variability in the quality of graduates from the various nursing schools and that anywhere up to 50% of new graduates are not fully work ready. This position was refuted by representatives of the Council of Deans of Nursing and Midwifery who pointed to the accreditation of undergraduate nursing courses against national standards set by the Nursing and Midwifery Board of Australia.

Nursing stakeholders did, however, agree that newly registered nurses need enhanced support as they enter the workforce. During the consultation undertaken as part of this review, virtually all the medical, nursing, and allied health professional groups noted that all new entrants to a work area require some transitional support. This is something unlikely to be limited to health graduates.

Considerable concern was raised about the perceived lack of support for graduate nursing positions within the jurisdictions. Key nursing stakeholders stated that the term “work readiness” had negative connotations and should be avoided. Stakeholders noted that the United Kingdom has developed a “fit for practice” model and that it may be useful to investigate that model for its ability to transfer to the Australian health care setting.

While there is no registration requirement for nursing graduates to undertake a transition to practice program, there is a perception that the inability to undertake a structured position of this nature was likely to have negative impacts on a graduate’s employment prospects. However, there is no evidence that the completion of a transition to practice program results in better clinical practice compared to a new graduate who commences practice through the direct employment pathway with the

normal supervision support any new entrant to the workforce could be expected to need.

Most newly graduated employees will need to be supported and mentored by organisational structures and day-to-day managers, to assist these new staff to adjust to the realities of the workforce. As is the case for other professions, nurses and midwives need well structured and well resourced recruitment, induction and orientation programs on commencement of their employment.

### Nurse practitioners

The role of the nurse practitioner is relatively new, and its development in Australia began to be discussed in the early 1990s. In 2001 the NSW Minister for Health announced the first nurse practitioner to be appointed into a position in remote NSW. Nurse practitioner roles were introduced in Australia with a range of objectives including improved access to health care services via a flexible, innovative, integrated care strategy, and increased continuity of nursing care at an advanced practice level.

The development of the nurse practitioner role has been a strong component of Commonwealth health workforce policy in recent years. In 2008 the Australian Government announced funding for Nurse Practitioner Scholarships to help build the nation's nurse practitioner workforce. Under a 2010 Budget measure, these nurses gained access to the Medicare and Pharmaceutical Benefits Schemes (MBS and PBS) for their patients. These measures provide opportunities for nurse practitioners to offer a solution to workforce shortages in more remote areas, particularly if interested members of the existing rural and remote nursing workforce can be supported to undertake the necessary educational programs for this role.

According to the Australian Health Practitioner Regulation Agency (AHPRA), as at May 2012, there are 731 nurse practitioners registered in Australia. Although the number of nurse practitioners working in primary care is currently small, numbers are growing in response to recent policies. However, barriers (both perceived and real) remain to the wider adoption of this role within the health system. These may include:

- Resistance from doctors' groups to this new role, limiting effective partnerships at the practice level between doctors and nurse practitioners. Groups like the Australian Medical Association have expressed strong concerns about any service model that involves independent practice for other health professionals outside of a doctor-led health care team.
- Length of the training pathway for nurse practitioners, which can take up to nine years from the point of entry into a nursing degree. This includes the need to complete a Masters qualification (with associated costs and lack of opportunities to complete this study in rural and remote areas).
- Inadequate remuneration for nurse practitioners working in primary care, particularly in terms of access to the highest level of Medicare rebate (A1 items compared to A2 of the Medicare Benefits Schedule).
- Potential community resistance to being treated independently by nurses and a reluctance to pay for a service which they may perceive to be of lower quality.

The Australian Government encourages primary care practices to consider working with nurse practitioners to improve the effectiveness and efficiency of the health care

system. Policy has supported the progression and promotion of nurses in general practice working at advanced levels, including that of nurse practitioners.

A significant barrier to achieving this outcome is access to appropriate clinical supervision, as well as the ability to source locum support while undertaking necessary training. Training modeled on the Remote Vocational Training Scheme (RVTS) model, discussed below, may be a potential solution in this regard, as the program offers an effective approach to remote supervision and support which could be extended beyond medicine to cover the needs of more isolated nurse practitioner candidates.

### The Remote Vocational Training Scheme

The RVTS is a vocational training program for medical practitioners which is designed to meet the requirements for fellowship of both Australian College of Rural and Remote Medicine and Royal Australian College of General Practitioners. The program delivers structured distance education and supervision to doctors while they continue to provide general medical services to a remote and/or isolated community. It also funds locum relief to allow doctors to attend face-to-face training.

This ensures that solo doctor towns or small communities are not affected by doctors leaving to complete vocational training requirements. The training includes weekly tutorials through video and teleconferences, twice yearly education workshops, remote supervision and individualised training advice.

During consultations undertaken as part of this review it was suggested that the RVTS program, which is designed around distance education and a remote supervision model, could be adapted to include nurse practitioner candidates or nurses who may wish to undertake specific procedures and work to an extended scope of practice.

The Commonwealth should therefore consider the development of a model similar to the RVTS, combining distance education and remote supervision, and access to nurse practitioner locums in conjunction with the nursing and midwifery education and accreditation bodies. This would allow highly qualified rural nurses working in the primary care setting to undertake this advanced training, while still delivering services to the community.

### Nursing and midwifery education summary

Increasing nurse student numbers is clearly not achievable at a level which would enable projected supply to meet forecast “as is” demand by 2025. Effort is required to enhance workforce retention, particularly offering nurses and midwives the opportunity to upskill and take on more senior and diverse roles. This should include a greater role for nurse practitioners, and roles commensurate with the skills for registered nurses, enrolled nurses and the care workforce. Access to education to enable easier re-entry to the nursing profession is also of high importance.

An integrated approach that examines factors affecting the retention of nurses within the health workforce, as well as productivity and workplace innovation, is required. These should include issues such as the use of alternative workforces and skill mixes and measures to improve the efficiency and consistency of nurse education, including the question of “work readiness”.

Educational investment also has implications for future workforce mix. In particular it appears that current limitations on the education of enrolled nurses will need to be addressed to ensure this is not an inhibiting factor in greater use of this workforce.

Achieving appropriate distribution of the nursing workforce is not as challenging an issue as predicted future national supply, in remote areas there is continuing demand for better access to education opportunities for nurses to enhance and maintain their expertise and play a greater role in service delivery. Greater investment in postgraduate nursing and midwifery education appears to offer the best value for money to address the workforce shortages identified by HWA.

In order to develop a more strategic and coherent approach to all aspects of nursing and midwifery education, the Commonwealth should work with the profession and across jurisdictions to establish a National Nursing and Midwifery Educational Advisory Network (NNMEAN). The NNMEAN would liaise closely with HWA to ensure that the respective activities are complementary and that plans are developed using the best available evidence and data. The membership of this group would need to be considered, but should be drawn from the profession, chief nursing officers, the university and VET sector, regulatory bodies and the Government. The role of this group may include consideration of matters such as supply planning, education and employment, new and/or extended roles, scholarship priorities, inter-professional collaboration and undertaking or commissioning research.

## ***7.2 Nursing and midwifery retention***

Workforce retention is a complex and potentially controversial issue confronting governments, employers and the nursing and midwifery professions. HWA modelling for HW2025 took into account an annualised nursing and midwifery workforce exit rate of around five to six per cent in the future. This takes into account both permanent and temporary exits. Currently, exit rates are estimated to be historically low, at around two per cent per annum.

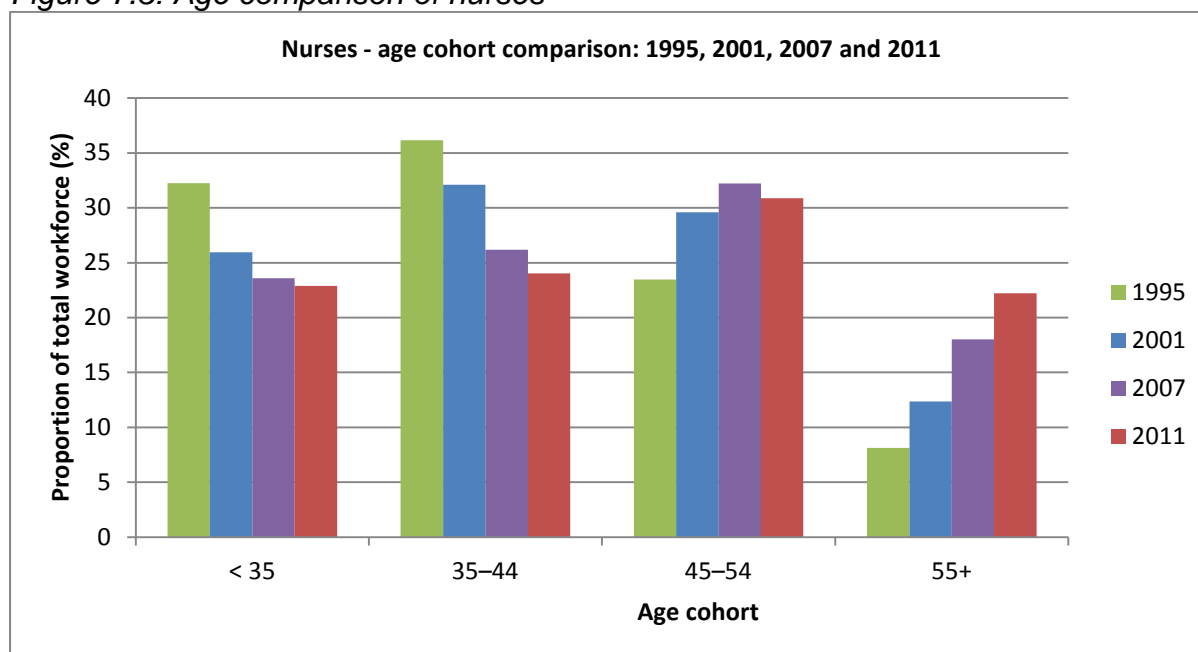
Some assumptions made to explain this low rate include the global financial crisis and its impact on retirement incomes, and recent increases in the retirement age. People born after 1 January 1957 will have to reach the age of 67 before they are eligible for the aged pension. The superannuation savings of many nurses and midwives is also considered to be inadequate to retire earlier.

It is of high importance that the modelling assumptions used for HW2025 are carefully examined in the light of changing retirement decisions. Future exit rates are likely to be volatile, given their dependence on a range of factors, including the economic circumstances described above, as well as potential changes to industrial frameworks and employment conditions. This presents challenges for workforce planners in terms of relying on previous data to make assumptions about the future workforce.

Figure 7.3 below notes the changing demographics and age profile for cohorts of nurses and midwives from 1995 to 2011. Of note however, is that the last category is 55+. In the future, given advances in the retirement age, this cohort may need to be divided into 55–64 and 65+ categories to identify any longer term trends in workforce participation and assist with nursing and midwifery workforce planning.



Figure 7.3: Age comparison of nurses



Source: AIHW Nursing and midwifery labour force 1996, 2001, 2007 and National Health Workforce Dataset: nurses and midwives 2011

Early indications are that the exit rate applied by HWA may have been an overestimate and the scenario to 2025, which has gained such wide currency, may not be as severe as first predicted. HWA has committed to revisit the modelling over the period following subsequent and more reliable data releases. This may potentially downgrade the original 2025 scenario. Nevertheless, the potential workforce shortages identified in the HW2025 report require serious investigation and appropriate policy responses across governments.

HWA's report indicates that the nursing and midwifery workforce supply is adequate until 2016. It needs to be noted that there are current concerns about the immediate employment prospects of newly graduated registered nurses and the potential impact on both the individuals and on future workforce supply if these qualified professionals fail to find employment on graduation and leave the profession. In keeping with the imperative to retain nursing and midwifery staff, as well as trying to increase intakes, various initiatives have been or are being rolled out. Most do so through the offer of further career development. Assistance with further career development may also provide the opportunity to adopt more advanced roles such as an eligible midwife or nurse practitioner, which not only benefits the individual from a career point of view but also increases access to health care for the population. These programs include:

- the Nursing and Allied Health Scholarship and Support Scheme (NAHSSS), which facilitates the continued professional development of nurses and midwives and encourages the pursuit of a health career in both geographic areas and professions where there are shortages. There are particular streams applicable to practice nurses, nurse practitioners, midwives and those working in Aboriginal and Torres Strait Islander communities;
- the Nursing and Allied Health Rural Locum Scheme (NAHRLS) has been established to enable rural nurses and midwives to take short-term leave from



their positions in rural Australia in order to access continuing professional development;

- UDRHs, which provide postgraduate rural training services. With further resources there is the potential for them to play a greater role in delivering support in areas like nursing re-entry programs, particularly in more remote areas such as Broken Hill; and
- the Rural Health Continuing Education (RHCE) program provides access to professional training and support in rural and remote areas for nurses (as well as for medical specialists, allied health professionals, general practitioners and Aboriginal and Torres Strait Islander health workers). Funding is allocated through competitive grant processes. (Note that this program is more fully discussed in Chapter 4.)

Scholarship funding for postgraduate education can provide an incentive to undertake additional professional education but in general, most students will have already decided to pursue a particular course of study before successfully applying for Commonwealth scholarship support. However, financial support for these postgraduate students may enable more students to complete their advanced education, or undertake the study more quickly (i.e. full-time study instead of part-time).

Postgraduate scholarship education programs and investments in continuing professional development have the potential to provide workforce retention benefits by encouraging nurses to upgrade their skills and move into more challenging and rewarding roles, including extended scope of practice roles. These retention benefits have not been conclusively measured to date and there would be value in analysing how successful this approach has been by developing better longitudinal data. This activity could be undertaken by the proposed National Nursing and Midwifery Education Advisory Network (NNMEAN), once established.

There are two other main activities that are aimed at retaining nurses and midwives within the workforce in general practice and primary care settings, where nurses and midwives can develop a range of clinical and leadership skills. These activities are in line with action to provide a sustainable health care sector by providing more population health activities and managing care in the community primary health care setting (as opposed to within the acute care or tertiary hospital environment). These activities are:

- the Nursing in General Practice Program (NiGP), implemented in 2001-02, which aimed to build the capacity of the nursing and midwifery workforce within general practice. It provides practice nurses with education and support, supports general practices to recruit and retain suitably qualified nurses and promotes the role of practice nurses to others in the community and within the health professions; and
- The Practice Nurse Incentive Program (PNIP), which commenced on 1 January 2012. This program is designed to improve patient access to clinically appropriate primary health care services and help ease the pressure on GPs. It specifically aims to expand and enhance the role of practice nurses. Payments are made to eligible GP practices, Aboriginal Community Controlled Health Services and Aboriginal Medical Services which employ one or more registered nurses or midwives, enrolled nurses or a qualified Aboriginal health worker. Allied health professionals may also be supported under this program.

The NiGP was funded under the 2001-02 Budget measure, *Additional Practice Nurses for Rural Australia and Other Areas of Need*. Funding was renewed in the 2005-06 Budget. In 2009-10 NiGP was rolled into a consolidated Nursing Education and Recruitment program to produce efficiencies. In 2011-12, NiGP became an activity funded under the Health Workforce Fund.

An analysis of NiGP over recent years indicates that over the last two funding agreements the administrators of this program had difficulty fully expending the available funding, which has resulted in significant underspends. In 2010-11, as a result of the underspend, the department authorised the Australian Medicare Local Alliance (AMLA) to fund a number of Practice Nurse Incentive Program Workshops. These were designed to provide information on PNIP to medical practitioners, practice managers and nurses to ensure the 2010-11 NiGP funding was expended in line with its policy purpose of supporting nurses and midwives in general practice settings.

In 2011-12 AMLA advised the department that there was an underspend in the vicinity of \$300,000 for the program. The 2012-13 funding agreement has an expected value of \$2.5 million and there are concerns that these funds will again not be fully expended. In light of the introduction of both PNIP and Medicare Locals, the appropriateness of the current NiGP funding is questionable. With PNIP becoming better established, further investment in communication activities (such as workshops) is unlikely to be necessary.

This review's analysis of the NiGP indicates that there are concerns about its effectiveness and this funding could be more effectively used on other activities to support nurses in general practice or other community settings. Administrative costs have increased substantially (19% of expenditure in 2012-13), reflecting the redirection of activities towards Medicare Locals. The direct flow of funds to support individual practice nurses, or even the wider GP practices in which they are employed, appears to be relatively low.

During the consultations, stakeholders suggested that NiGP has now been superseded by PNIP. PNIP has been very well received by general practices, as well as the nursing and midwifery professions and has provided a significant increase in funding to promote nursing care in the general practice setting.

There is a strong argument that NiGP funding should now be ceased and those activities rolled into the functions performed by Medicare Locals, with the funds redirected to new activities to promote the roles of the nursing and midwifery professions in the primary health sector, including some health prevention and health educational roles in the primary care setting. This would provide additional opportunities for nurses and midwives in primary care, as well as wider health promotion and/or illness prevention benefits, thus reducing strain on acute care service delivery settings.

The following case study, paraphrased from a recent article from the *Nursing Review*, outlines the way in which the PNIP can operate to produce a positive effect on both general practices and on the nurses and midwives whose employment it helps to support. This case study highlights the training opportunities and potential career pathway that is now available as a result of the investment in PNIP.

**Box 7.1: Case study – enhancing practice nurse roles and skills development**

A Medical centre in Sydney's inner west provides opportunities for enhancing practice nurse roles and skills development supported by the Practice Nurse Incentive Program (PNIP).

The clinic caters to a diverse demography, from the socio-economically disadvantaged to young professionals and is open seven days a week.

The practice nurse at this setting has just completed a course in women's health at Family Planning NSW, which has allowed her to expand her scope of practice at the centre, qualifying her to perform breast examinations and pap smears. The course was part funded by the clinic she works at and part by a government subsidy. The medical practitioners at the practice state they encourage the practice nurses to improve their skill set and believe that it is an investment in their staff.

The nurse in this example states that it is a completely different skill set in working as a practice nurse. She says being a practice nurse means less drama than working in the hospital system, but it offers a work/life balance that suits her better.

Practice nurses at this clinic perform additional services that the doctor may not have time for, including checking vaccines, ordering them and administering them, particularly to children, they also provide the opportunity for patients to ask questions and have things explained in a manner they understand. In this practice patients generally see the nurse before they see the doctor and half the work is done. This frees up the doctors to see more patients and helps to ensure patients get a complete holistic care experience.

This nurse states that she is positive about her career and the medical practitioners and the article used for this case study suggests that the Australian Practice Nurses Association (APNA) agrees that there are good career opportunities for practice nurses in these sorts of situations.

This case study demonstrates that there are a gamut of roles within private practice and opportunities for nurses to expand their skill sets and do more procedures in women's health, chronic disease management, diabetes, etc. Further, if the practices are large enough nurses will run and manage clinics, overseeing junior nurses. There are opportunities to become senior nurses and practice managers.

It is also suggested that many GPs have now had nurses in their clinics for a long time and that many have indicated that their practices wouldn't survive without them.<sup>161</sup>

There is some research support for the proposition that the main driver in retaining nurses and midwives in the workforce is the appropriate recognition of expertise and experience, as well as the promotion of leadership and management styles which encourage nurse autonomy and empowerment in decision-making processes.<sup>162</sup>

There are many factors that may also influence workforce retention. This is reflected in the evidence raised during the consultations for this review. These include:

- Trying work conditions;
- Inadequate remuneration and industrial relations issues;
- Professional burnout, work related stress, and lack of management action to address these issues;

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<sup>161</sup> Flynn Murphy, "Personal touch at the practice", *Nursing Review*, 1 January 2013

<sup>162</sup> MV Force, "The relationship between effective nurse managers and nursing retention", *Journal of Nursing Administration* Vol 35, No7/8 July/August 2005.

- Lack of opportunities for career progression, including lack of opportunities to participate in continuing professional development;
- Increasing workloads;
- Decreased job satisfaction due to lack of autonomy;
- Lack of professional and skill development opportunities; and
- Occupational violence.

The nursing and midwifery professions and their representing unions have, over the years, advocated that nurses and midwives are under-remunerated given the degree of training, professional responsibility that they face and the challenging nature of their workplace environments, leaving them vulnerable to stress, overwork and professional burnout. The recent decision by the Western Australian Government to grant nurses a substantial pay increase of 14% (over three years) appears to be an example where some of these concerns have been identified and addressed, which may assist to maintain the competitiveness of nursing as a career option compared to other sectors, such as the mining and related industries.

Appropriate nursing and midwifery leadership education is also suggested, as good clinical nurses and midwives may be promoted to leadership positions without skills, qualifications and/or support to undertake this important role.

Much research has been conducted, both in Australia and internationally, on the principles of nursing retention and its application to workplace cultures as a driver of change to reverse some of these trends.

A central pillar of labour force retention and increasing productivity is that of skills utilisation. Workforce development to enhance skills utilisation has been defined as:

*“Policies and practices which support people to participate effectively in the workforce and to develop and apply skills in a workplace context where learning translates into positive outcomes for enterprises, the wider community and for individuals throughout their working lives.”<sup>163</sup>*

The challenges facing the nursing and midwifery professions are multifactorial. Nurses and midwives are seeking to find a balance between the need to continue to provide strong leadership within effective health care teams and maintain an appropriate level of autonomy and empowerment as a professional group. At the same time individual nurses and midwives need continuing opportunities to enhance their mix of skills by having enough time within their increasingly busy service delivery roles to invest in professional development, with the opportunities this brings for career progression and recognition of their expertise.

Changes to practice and workplace environments such as enabling nurses and midwives to work at their full scope of practice as well as workplaces that offer flexible work arrangements and are supportive of family responsibilities may assist in retaining nurses in the workplace. Positive practice environments have been shown to improve nurse retention. However, relieving the burden of performing non-nursing

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<sup>163</sup> Skills Australia, *Australian Workforce Futures: A national workforce development strategy*, Skills Australia, Canberra, 2012, p. x

tasks, such as clerical and cleaning activities, and offering professional development opportunities and career pathway options would also assist retention efforts.

In order to provide the environment for nurses and midwives to work at the top of their scope of practice, the development and employment of a trained assistant workforce that will perform more routine tasks must be considered. This may also increase the retention rates of nurses and midwives within the workforce. (This is further discussed in the nursing and midwifery workforce sustainability section, later in this chapter.)

The behaviour of an employee's manager has been identified as a highly significant factor impacting on employee turnover in the nursing profession.<sup>164</sup> Nursing and midwifery leaders confirmed that within the overall organisational culture, many of the standard practices within the work environment need to evolve further. One of the keys to improvement is the development of strong and supportive leadership to drive more supportive and collaborative action. This can lead to enhanced contemporary clinical practice and improved staff work experiences.

Effective leadership can significantly affect employee satisfaction, trust in management, commitment, individual and team effectiveness and, collectively, the culture of the organisation. While other factors are influential, leadership plays a central role in mobilising people towards a common goal, achieving outstanding health outcomes and creating a positive practice environment that attracts and retains nursing staff.

Many developed countries around the world have grappled with nursing shortages for many years and have applied nurse retention strategies to varying degrees of success. The “Magnet hospital” principles have been employed in the US since 1990 and have been affiliated with success in this area internationally.

#### Box 7.2: Magnet hospital status

Magnet status is an award given by the American Nurses' Credentialing Center, an affiliate of the American Nurses Association, to hospitals that satisfy a set of criteria designed to measure the strength and quality of their nursing. A Magnet hospital is stated to be one where nursing delivers excellent patient outcomes, where nurses have a high level of job satisfaction, and where there is a low staff nurse turnover rate and appropriate grievance resolution. Magnet status also indicates nursing involvement in data collection and decision-making in patient care delivery. The Magnet nursing leaders value staff nurses, involve them in shaping research-based nursing practice, and encourage and reward them for advancing in nursing practice. Magnet hospitals are supposed to have open communication between nurses and other members of the health care team, and an appropriate personnel mix to attain the best patient outcomes and staff work environment.<sup>165</sup>

Three hospitals in Australia have achieved Magnet hospital status: the Princess Alexandra Hospital (Brisbane), Sir Charles Gairdner Hospital (Perth) and

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<sup>164</sup> L Aiken, A Kelly, and D McHugh, “Nurse outcomes in Magnet and non-Magnet hospitals” *Journal of Nursing Administration*, October 2011

<sup>165</sup> Reproduced from: American Nurses' Credentialing Center, “[Magnet status: What it is, what it is not, and what it could be](http://www.truthaboutnursing.org/faq/magnet.html#ixzz248TURa22)”, accessed at <http://www.truthaboutnursing.org/faq/magnet.html#ixzz248TURa22>



St Vincent's Private Hospital (Sydney). The Princess Alexandra Hospital reduced nursing staff turnover from 25% in 1999 to just over 10% two years later.

Another nursing and midwifery leadership initiative that has significant traction in Australia is known as the *Essentials of Care*. New South Wales Health introduced this program in February 2008 and all Local Health Districts are now at various stages of implementation. The implementation of this initiative is enabling nurses and midwives to focus on the development of clinical environments that enhance patient care, teamwork and individual work satisfaction.

### Box 7.3: Essentials of Care initiative

*Essentials of Care* is a framework to support the development and ongoing evaluation of nursing and midwifery practice and patient care. It is underpinned by the principles of transformational practice development. This approach to practice requires that all stakeholders – patients, carers, staff and families – have opportunities to participate and are included in decisions about effective care using approaches that respect individual and collective values. Nurses and midwives have been enthused by this opportunity to refocus on the basic values of caring and the reason why many came into the profession.<sup>166</sup>

Given the importance of nursing and midwifery workforce retention, the Commonwealth should consider active involvement in the implementation of national nurse leadership programs, based on the successful *Essentials of Care* and Magnet Hospital initiatives, as there is evidence that these initiatives positively impact on workforce retention rates.

In implementing this recommendation, DoHA and the nursing and midwifery professions should be cognisant of the work currently being undertaken by HWA on this topic. This will ensure that any health leadership networks, educational courses or other activity aimed at developing mid-level health professional managers will be complementary. Additionally, the implementation of this recommendation must have strong input from the nursing and midwifery professions. This may be achieved by consultation with key stakeholder groups and could be overseen by the proposed National Nursing and Midwifery Education Advisory Network (NNMEAN), once established.

During review consultations with private sector health providers, as indicated earlier, it was acknowledged that private sector employers in Australia target specific university programs to recruit nursing and midwifery graduates. Stakeholders stated that they have some concerns about the quality of graduates from some educational institutions, and therefore preferred to develop links to specific educational institutions.

Retention rates amongst these private sector employers are believed to be higher than the public sector. While there is only anecdotal evidence to support this claim, there are a number of factors amongst the private sector workforce that may serve to enhance their retention rates. These include: the specific traits and skills of graduates from particular courses/institutions that are affiliated with successful

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<sup>166</sup> Directly quoted from: NSW Government's [Essentials of Care Program](http://www0.health.nsw.gov.au/nursing/projects/eoc.asp) website, accessed at <http://www0.health.nsw.gov.au/nursing/projects/eoc.asp>



recruitment and retention, a structured graduate program and support, workplace culture and mentoring programs along with well-resourced recruitment principles and policies, and adequate remuneration policies.

*The Nursing Futures Project*, undertaken by the University of Adelaide on behalf of DoHA, is about to provide its final report. This study undertook a systematic review of the evidence of factors that impact on quality nursing care. Specifically, it focused on the importance of maximising nurse retention and employee satisfaction to deliver high quality direct patient care. This report will also identify where further research is required to build an evidence base. Importantly, this will include the nursing skill mix and the best use of the enrolled nurse and assistant in nursing roles.

### **7.3 Nursing and midwifery workforce sustainability**

As indicated above, a general concern persists that with the current increase in the number of nursing graduates, there are not sufficient opportunities to provide employment for new graduates up until 2016, when the modelling suggests that the balance of those entering and leaving the workforce is likely to be in equilibrium. Vacancies are currently lower than normal as retention rates have increased for nurses (and anecdotally midwives). It is currently unclear whether this is a short-term phenomenon or an indication of a longer term trend. As noted earlier, the assumptions used in HWA's modelling of the nursing and midwifery workforce need to be revalidated in the future.

A number of jurisdictions have recently reported significant difficulties with the placement of nursing graduates. In Tasmania, it has been asserted that many new registered nurses may be forced to move to mainland Australia to seek employment, as a result of the Tasmanian Government's budget situation. Queensland and Victoria have also noted concerns that they will not be able to find positions for all new nursing graduates, while SA has considered an option to offer older nurses a retirement package to open up positions for nurse graduates.

HWA has undertaken a short-term project to address recruitment issues for graduate nurses and midwives. Subsequently a web-based information portal has been established which provides links to existing graduate programs in the public, private and NGO sectors. The portal is designed to complement employers' usual recruitment processes by offering a site to post information about recruitment processes and vacancies.

During the course of this review, there was some discussion regarding mature age entrants to nursing education programs. These new entrants to the nursing and midwifery workforce are more mature, have qualifications and careers in other sectors, and have chosen a career change to the health professions. This group are different from those choosing nursing and midwifery as school leavers and by making this active choice at an older age, are more likely to remain within the profession until retirement. The educational pathways that facilitate this activity should be further investigated, as this may enable older applicants in regional and rural areas to consider nursing as a career option.

#### **Overseas nurses and migration issues**

There has been an increasing trend internationally to employ overseas qualified nurses to fill nursing shortages. This has become a practice of countries such as

Canada, the UK, the US and Australia. Approximately 15% of all nurses and midwives currently practising in Australia were either born overseas or obtained their initial nursing qualification overseas. Australia is a signatory to a number of global and regional codes of practice relating to the recruitment of internationally trained health professionals. Under the codes, Australia must refrain from actively recruiting nurses and midwives in those countries that are experiencing a lack of trained health professionals.

A number of countries, including Malaysia and the Philippines, have developed university courses which have direct application and skills matched to those required in developed countries, such as Australia.

Conversely, it needs to be pointed out that the globalisation of the nursing profession has also facilitated a large number of Australian nurses moving overseas to work. It is likely that this helps balance the impact of migration flows. For example, the Nursing and Midwifery labour force survey, published by the Australian Institute of Health and Welfare (AIHW), provides data on the nursing labour force (those employed, on extended leave or looking for work). In 2009 there were estimated to be 3,233 nurses who were overseas and not in the nursing labour force. In 2011, this number was 10,166, an increase of 214% in two years.<sup>167</sup>

This data may be indicative of a trend emerging in Australia whereby Australian educated registered nurses are choosing to migrate overseas to find work. It is also possible that the apparent trend is an artefact of improved data collection, given the response rate for the 2011 survey was over 86% compared to around 44.4% for the 2009 labour force survey.<sup>168</sup> While this is unlikely to become a large scale trend (given recent downturns in nurse employment in countries like the UK) this issue has some potential to add an additional element of complexity to workforce planning.

### Re-entry arrangements

Nurses who have had significant years out of the nursing workforce are required to undertake refresher or re-entry programs to gain registration. After ten years, this may require nurses to enrol in a new entry qualification at university. Many of these nurses will be given some credit for previous studies, but nevertheless, those who have been out of the workforce for a long period may have to undertake a full three year program. This has caused particular concern for nurses in New South Wales where previously jurisdictional registration did not specify or mandate continuous professional development or recency of practice.

Guidelines for accreditation of these programs are being reviewed and updated by the Australian Nursing and Midwifery Accreditation Council. At this stage there is clearly an issue for rural nurses who are unable to access requirements locally. Costs of re-entry courses are also reported to be prohibitive for some nurses, with costs reputedly as high as \$16,000. Those rural and remote students, who are unable to access courses locally, also incur additional living away from home expenses.

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<sup>167</sup> Australian Institute of Health and Welfare 2012 *Nursing and midwifery workforce 2011*. National health workforce series no. 2. Cat. No. HWL 48, Canberra: AIHW.

<sup>168</sup> *ibid.*

One proposal which seems to have merit would be that the Commonwealth should provide flexible financial support (covering, for example, tuition fees, travel, accommodation and living expenses) of up to \$10,000 per recipient under the NAHSSS initiative for supervised re-entry courses for those registered nurses in regional, rural and remote locations, seeking to return to the workforce after extended periods away, until satisfactory flexible delivery or e-learning options are available in all states and territories.

As there is some limited scholarship assistance provided by some jurisdictions for this activity, care must be taken to ensure equity and fairness and systems put in place to avoid multiple scholarships being provided to an individual to undertake the same activity. Any such scheme would also need to be carefully designed and monitored, as there is some history of well-meaning schemes failing to achieve significant outcomes. Financial assistance to undertake re-entry and refresher courses is also discussed in the scholarship section of Chapter 3.

### Further credentialing issues

Under NRAS, there are only two categories of nurse, *enrolled* nurse and *registered* nurse. There are several endorsement processes available for both registered nurses and midwives, such as nurse practitioners and eligible midwives, which allows these clinicians to work in situations of increased autonomy and at higher levels of scope of practice and may provide access to prescribing rights. Part of the requirement is to have collaborative arrangements in place with medical practitioners. For those working in private practice, clients of nurse practitioners and eligible midwives can access MBS and PBS benefits for services provided.

In clinical practice, many senior clinical nurses hold postgraduate qualifications in areas of specialty such as acute care, intensive care and emergency nursing, rehabilitation and cancer care. Although jurisdictional industrial awards vary, some jurisdictions require formal qualifications to hold positions at senior clinical levels. These roles can provide advice and leadership for generalist nurses working in specialty areas, and may provide consultancy services for clients with complex needs. These additional skills can also provide opportunities for vertical career pathways as a clinician.

There is growing interest in increasing formal nurse credentialing. The Australian College of Mental Health Nurses has led this move and has a well-developed process requiring a certain level of qualification, years of current experience, professional development requirements and referee support. In 2011, under the auspices of the Coalition of National Nursing Organisations (CoNNO), a project was completed that provides guidance for other nursing organisations to develop credentialing processes.

In some situations this process has some merit, where a nurse may be working in relatively autonomous areas of practice, for example, a private mental health nurse working in a community setting who sees clients on a one-to-one basis. However, there is increasing concern that this amount of 'specialisation' is not essential for most clinical positions and may become an unnecessary formal requirement. This poses the risk of limiting horizontal career pathways, reducing recruitment pools and developing a requirement for formal education and training that is not necessary to perform the duties of a position competently and safely.

The issue of sub- or super-specialisation is most often raised in the medical workforce context, but the core issue potentially applies to the nursing workforce as well. If specialisation becomes an issue, there is a real possibility that some flexibility in the workforce, particularly in rural and remote areas will be reduced. There is a need in both the medical and the nursing and midwifery professions to encourage generalist roles, while still ensuring there is an appropriate balance of specialist and generalist skills.

It is important that the concept of on-the-job informal training and mentoring is not lost to formal processes which may limit access to service for clients and limit employment opportunities and choice for nurses and midwives. In the same vein, assessment of use of VET-trained assistants (enrolled nurses and assistants in nursing) to provide support to registered nurses with routine tasks within the clinical setting must be a consideration.

### Assistants in nursing workforce

The introduction and usage of an assistant workforce to support registered nurses and midwives to work to the top of their scope of practice has been identified by some stakeholders as a priority activity to address the predicted nursing and midwifery shortage. This needs careful consideration in consultation with the professions and will need to be done in conjunction with the VET sector and a variety of health service delivery providers to ensure adequate numbers of participants are employed to ensure this training and employment option is viable into the future. In parallel, investigation of new and innovative models of care designed to increase productivity of the health workforce should be developed and piloted before consideration of a wider rollout of these activities is considered.

There are a number of terms used to describe individuals performing duties to assist nurses and midwives in delivering patient care, for example Nursing Assistants, Assistants in Nursing, Health Assistants in Nursing, Personal Care Workers and Personal Care Assistants. For convenience for the purposes of this paper, the term 'Assistants in Nursing' (AINs) is used.

During the course of the review, nursing stakeholders and private health care providers noted that a significant percentage of the private aged care sector workforce is made up of enrolled nurses and assistant level staff. There are a number of programs and activities managed by DoHA and by HWA that are aimed directly at new models of care and service delivery for all levels of staff in the aged care sector. This includes nurse practitioners, registered and enrolled nurses and the assistant workforce.

The lessons learned and outcomes of these activities should be analysed with a view to transferring relevant learning or models of care to other health service delivery settings. This must be done in consultation with the nursing and midwifery profession leaders.

The call for innovation and reform of the nursing and midwifery professions in Australia has led a number of jurisdictions to commission work to investigate the role of assistants in nursing in the health workforce. It appears clear that such a role is not embraced by parts of the nursing profession. Others hold the view that assistants can potentially be a productive, efficient, innovative and viable workforce model. This is supported by the recent findings of a number of pilot projects in Victoria and NSW.

From 2005 to 2011, Victoria's Better Skills Better Care (BSBC)<sup>169</sup> strategy explored and trialled innovations that sought to improve workforce capacity, utilisation and the sustainability of service delivery, while maintaining and improving quality of outcomes, efficiency and worker satisfaction. The objective of the strategy was to ensure "that the right people with the right skills were in the right place at the right time to deliver quality care to patients". The strategy sought to extend the skills in nursing and allied health together with building an assistant workforce.

**Box 7.4: Better Skills, Better Care strategy**

Through the BSBC strategy, Austin Health ran a pilot project to introduce six Health Assistants in Nursing (HANs) across three wards. The evaluation of the strategy found that the model would be replicable and scalable in other health services with similar demographic and regional characteristics. Some of the findings from the pilot included a reduction in overtime hours worked and satisfaction by registered nurses who, through the use of HANs, were able to work on more clinically orientated tasks. Patient complaints decreased by 50% and overall, patients felt they benefited from the one-on-one contact provided by HANs. Perhaps most notable to the success of the trials was that, in all three pilot sites, there was strong executive and managerial support for the implementation of HANs.<sup>170</sup>

Similarly in NSW, the Healthcare Assistant Initiative entitled *Assistants in Nursing working in the acute care environment*<sup>171</sup> supported the employment and clinical allocation of AINs. AINs are defined in the document as "a health care provider who assists health care professionals in the provision of nursing care to patients in acute care settings".

**Box 7.5: NSW Assistants in Nursing working in the acute care environment initiative**

The resource provides a series of guidelines through which AINs may most successfully be utilised in the care environment. It consists of processes to assess and evaluate AINs in clinical environments, the education and development needs of AINs, components of establishing the scope of practice of AINs, and delegation and supervision guidelines. The initiative is a model of innovative service delivery through the refinement of policies, protocols and guidelines to suit individual health services.

The potential inclusion of AINs within NRAS was one of the major topics of discussion amongst nursing stakeholder groups during this review. The Australian Nursing Federation (ANF), for example, expressed a firm view that AINs should become registered in order to enhance the quality of services for patients and to ensure their scope of practice is clearly defined.<sup>172</sup> The ANF appears to be resistant to any increased use of AINs within the workforce until they become a registered

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<sup>169</sup> Price Waterhouse Coopers, *Evaluation of three Better Skills Better Care (BSBC) pilot projects*, Department of Health, Victoria 2011.

<sup>170</sup> *ibid.*

<sup>171</sup> NSW Department of Health, [Assistants in nursing working in the acute care environment – Health Service Implementation Package](http://www0.health.nsw.gov.au/pubs/2010/pdf/ain_acute_care.pdf), NSW Department of Health, 2009, accessed at [http://www0.health.nsw.gov.au/pubs/2010/pdf/ain\\_acute\\_care.pdf](http://www0.health.nsw.gov.au/pubs/2010/pdf/ain_acute_care.pdf)

<sup>172</sup> ANF Position Statement: [Assistants in Nursing \(however titled\) Providing Aspects of Nursing Care](http://www.anf.org.au), June 2011, accessed at [www.anf.org.au](http://www.anf.org.au).



professional group, with clear lines of responsibility between registered nurses and assistants.

The potential for greater acceptance of an expanded role for AINs by other health professionals, along with the development of more consistent educational standards and subsequent improvements in patient safety, appear to be the main arguments in favour of adopting registration requirements. In addition, registering this group would enable better monitoring of workforce data through linkages with AHPRA systems.

However, other review consultations have provided a note of caution in terms of this proposal. AINs are a major part of the private sector health workforce, particularly in aged care settings, and private sector stakeholders expressed reservations about the imposition of greater regulation upon this workforce. This was primarily on the basis of concerns about reduced flexibility, with AINs often performing different roles in a variety of settings. Potential cost implications, both for employers and individual health workers, were also expressed as key concerns.

While making recommendations for the inclusion of new professional groups within NRAS is outside the scope of this review, this issue clearly needs further informed debate amongst stakeholders that is focused on reaching agreement about what are the appropriate costs and benefits of AIN registration from the perspective of professional groups, employers (public and private) and individual health workers. Given the challenges of ensuring the community has access to sustainable nursing and midwifery services in the future, it is important that the efficient use of this workforce group is not restrained by a continuing unresolved professional debate around registration and accreditation issues.

### Summary

Nurse and midwives are the largest professional group in the health workforce. There are a variety of both public and private employers of nurses and midwives in Australia, each offering different industrial arrangements and employment conditions, which further varies between states and territories. There are a range of embedded cultural issues within the profession that differ between settings and nursing teams.

While the notion of nursing retention as a lever for reducing the predicted nursing workforce shortfall is not new, the enormity of the challenge appears to have hampered momentum in this area. Nursing workforce retention is recognised internationally as the key to addressing the nursing workforce shortage and HWA has been contracted to conduct a series of projects in this area.

The predicted nursing workforce shortage crisis is well recognised, both within health and the broader labour market and there is an agreed need for change. All Australian Governments have agreed on the need for coordinated, long-term reforms by Governments, professions and the higher education and training sector to ensure Australia has an affordable and sustainable health workforce to meet the future health needs of the community.

The challenge is made even more difficult by the variability of current forecasts for future workforce need. The key to driving change in this area will not only be in ensuring engagement and collaboration of all necessary stakeholders, but in all parties agreeing to a course of action for the future and taking ownership of the issues and solutions.



## Recommendations

Recommendation	Affected programs	Timeframe
<p><b>Recommendation 7.1:</b> The Commonwealth should work with the profession and across jurisdictions to establish a National Nursing and Midwifery Education Advisory Network (NNMEAN) that would develop five year rolling nursing education plans across the whole training pipeline from enrolled and undergraduate nurse training to advanced scopes of practice and nurse practitioner candidates.</p> <p>These plans will be based on the best possible nursing workforce data and take into account health service delivery requirements (both in the public and private sectors) and consider both the supply and demand issues.</p>	HWA, support through the Health Workforce Fund	Medium term – formation of the network and the development of consensus on its role would take some time.
<p><b>Recommendation 7.2:</b> As part of the wider NNMEAN work, an appropriate organisation should be tasked with identifying and analysing the issues related to a perceived reluctance by employers to employ newly graduated nurses.</p> <p>Further, they should identify actions that could be taken in the undergraduate program to allay these issues and provide advice and options on how professional groups and employers could best support nurses to ensure they are retained within the profession upon graduation.</p>	HWA, support through the Health Workforce Fund	Medium term – linked to the establishment of NNMEAN.
<p><b>Recommendation 7.3:</b> The Commonwealth should consider providing seed funding for a feasibility study of a national rollout of leadership courses to mid-level nurse and midwife managers, based on the New South Wales Government sponsored Essentials of Care program.</p> <p>This would build on work that Health Workforce Australia (HWA) is doing in its <i>Health LEADS Australia</i> health leadership framework. The Australian College of Nursing should lead this work and the resulting education activities should be</p>	New funding – Health Workforce Fund	Short term – work on this project could commence immediately post-Review, subject to available funding.

Recommendation	Affected programs	Timeframe
considered eligible for support under various scholarship schemes until these courses are well established and sustainable under a user pays system.		
<p><b>Recommendation 7.4:</b> The Commonwealth should consider providing flexible financial support under the Nursing and Allied Health Scholarship and Support Scheme (NAHSSS) of up to \$10,000 (per recipient) for supervised re-entry courses for those registered nurses in regional, rural and remote locations, seeking to return to the workforce after extended periods away, until satisfactory flexible delivery or e-learning options are available in all states and territories.</p> <p>The University Departments of Rural Health (UDRH) program could potentially provide a platform for delivering this education in some rural and remote areas.</p>	NAHSSS	Short term – redirection of NAHSSS priorities, existing funding.
<p><b>Recommendation 7.5:</b> The Commonwealth should continue its investment in the Practice Nurse Incentive Program (PNIP) but the Nursing in General Practice Program (NiGP) should be integrated with the activities of Medicare Locals.</p>	PNIP, NiGP	Short term – NiGP activities to be integrated with Medicare Locals from 2013-14.
<p><b>Recommendation 7.6:</b> The Commonwealth should develop a model based on the Remote Vocational Training Scheme (RVTS) model to allow distance education and supervision. This will allow highly qualified nurses working in rural and remote areas to access clinical experience and supervision while still delivering services in those areas.</p> <p>Additionally, the scheme could be modified to include education and supervision requirements associated with nurses undertaking extended scope of practice, such as advanced practice nurses or nurse endoscopists. These activities could support increased access to services for rural and remote communities.</p>	RVTS	Medium term – subject to available funding and engagement with the profession.

Recommendation	Affected programs	Timeframe
<p><b>Recommendation 7.7:</b> The Commonwealth agencies involved in nursing education need to investigate the availability and cost of VET sector training as it relates to enrolled nurses. There are a declining number of enrolled nurse places/courses being offered and a reason raised within consultations was cost (approximately \$16,000 for an enrolled nursing course). Enrolled nursing students/courses should be eligible for scholarship support.</p>	<p>Research and policy development across DoHA, DEEWR and DIICCSRTE, scholarships.</p>	<p>Longer term</p>
<p><b>Recommendation 7.8:</b> The Commonwealth should undertake an analysis of activity in other similar countries, such as the United Kingdom, New Zealand and Canada where enrolled nurse positions (and therefore training) have been reduced or removed entirely. This work would inform policy development in this area. Recently these countries have revised the enrolled nurse role in response to community needs and workforce pressures.</p>	<p>Nil – research and policy development</p>	<p>Longer term</p>



## Chapter 8: Developing the dental and allied health workforce

This chapter provides an outline of the current dental and allied health workforces, including the current and emerging issues affecting these disciplines. It also highlights Commonwealth initiatives and jurisdictional approaches aimed at increasing the supply and distribution of both the dental and allied health workforce, and identifies key areas for consideration by the Commonwealth for future policy and program development.

The chapter has been informed by the stakeholder roundtables with representation of the dental and allied health workforces conducted as part of this review, as well as a number of written submissions.

### 8.1 Dental and oral health workforce

This section has been informed by constructive discussions at the Dental Workforce Roundtable as part of this review, as well as an analysis of the *Final Report of the National Advisory Council on Dental Health, 2012* (NACDH Report).

#### Dental and oral health workforce programs

It is difficult to overstate the importance of dental and oral health services, and the risks posed to remote, rural and disadvantaged populations by the scarcity of affordable dental health services.

The Department of Health and Ageing (DoHA) allocates funding for a number of initiatives to improve the adequacy, quality and distribution of Australia's dental workforce. These programs provide training opportunities and support for dentists and other oral health disciplines. The dental workforce is comprised of dental practitioners who are categorised by registration into dentists, dental hygienists, dental therapists, oral health therapists and dental prosthetists.<sup>173</sup> In addition to these registered practitioners, this workforce also includes dental assistants.

Health Workforce Division (HWD) is responsible for a number of dental workforce initiatives which include:

- Dental Training Expanding Rural Placements (DTERP);
- University Departments of Rural Health (UDRH) Program;
- Voluntary Dental Graduate Year Program (VDGYP);
- Oral Health Therapist Graduate Year Program (OHTGYP);
- Dental Relocation and Infrastructure Support Scheme (DRISS); and
- Education and training support schemes, including the Nursing and Allied Health Scholarship and Support Scheme (NAHSSS), Nursing and Allied Health Rural Locum Scheme (NAHRLS), Rural Health Continuing Education (RHCE) Stream Two, Puggy Hunter Memorial Scholarship Scheme (PHMSS)

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<sup>173</sup> Dental Board of Australia webpage on [registration](http://www.dentalboard.gov.au/Registration), accessed at [www.dentalboard.gov.au/Registration](http://www.dentalboard.gov.au/Registration)

and the Australian Rotary Health Indigenous Health Scholarships (Rotary scholarships) program.

In addition, a number of dental projects are managed in other divisions of DoHA which complement the HWD dental workforce initiatives as well as various dental workforce infrastructure projects.

DTERP, the UDRH program and the relevant scholarship programs have been in place for a number of years. The first cohort of participating dental graduates under the VDGYP commenced in January 2013, while the OHTGYP and DRISS are still in the development phase and will commence in 2013-14. Of these initiatives DTERP, the UDRH program and the scholarship programs are funded through the Health Workforce Fund (HWF), with the VDGYP, OHTGYP and DRISS funded under separate allocations within HWD.

There are also other Commonwealth initiatives that have assisted in supporting and developing the dental workforce such as the National Oral Health Plan and the National Advisory Council on Dental Health (NACDH). These initiatives support a high level collaborative approach and have informed HWD on current and future oral health issues, including issues related to the dental workforce. Most recently the OHTGYP and DRISS (as well as an expansion of the VDGYP) were developed, informed by the NACDH report.

### *Dental Training Expanding Rural Placements*

As part of the broader Rural Health Multidisciplinary Training (RHMT) program, the Commonwealth funds the DTERP program, which has a current allocation of \$8.3 million from 2012-13 to 2015-16 through the HWF. DTERP commenced operation in 2007-08 and is designed to help address the shortage and maldistribution of dentists, especially in rural and remote areas. DTERP provides longer-term rural clinical placements for dental students studying at six universities throughout Australia. Capital funding to establish training sites has been provided to participating universities.

The universities participating in DTERP are: University of Sydney, University of Adelaide, University of Melbourne, University of Western Australia, University of Queensland and Griffith University. The rationale for this program is based on evidence showing that, as with other health professionals discussed elsewhere in this report, graduates are more likely to consider rural careers if they have had an opportunity to undertake clinical training in a regional or rural community setting.

The universities funded under DTERP are required to develop and support extended rural training placements (in nominated ASGC-RA 2–5 areas) for at least five Australian dental students (full-time equivalent) for each full academic year of participation. Individual placements must be for a minimum of one month to a maximum of 12 months. Placements are designed to provide students with a positive experience of rural dentistry with a view to encouraging future rural service provision.

To date, dental clinics have been established in rural New South Wales (Brewarrina, Ballina and Dubbo), Victoria (Morwell), Whyalla (South Australia) and Western Australia (Bunbury). There are also other clinics due for completion in rural Queensland (Warwick, Dalby and St George). Most universities are exceeding their placement targets and it is believed that this will continue as more rural dental teaching clinics are established.



The University of Sydney has undertaken two reviews of its dental rural placement program (funded by DTERP). The review of the initial pilot program of 2008-09 indicated that 96% of the students who volunteered to participate had been encouraged to consider working in a rural setting after graduation.<sup>174</sup> The follow-up report in 2012 indicated that of the University of Sydney dental graduates in 2009, a significantly greater number of students who had participated in the University's Rural Placement Program (45% of participants) went on to work in a rural location (RRMA 3+) compared to those graduates who had not participated in the Rural Placement Program (of whom 17% were working rurally).<sup>175</sup>

On review of forward budgets provided by universities participating in the DTERP program, it is apparent that operational costs (of supporting five full-time equivalent (FTE) student rural placements per year) outweigh the recurrent funding provided through the program. Operational costs to meet the program targets appear to be in the vicinity of \$419,000 to \$780,000 per dental school, while universities only receive \$331,000 per year plus indexation under the scheme.

The Australasian Council of Dental Schools (ACODS) has provided advice that economies of scale would allow them to increase their FTE from five to ten with additional funding, creating greater opportunities for increased student numbers and longer rotations. Longer term placements in rural areas have been shown to support retention in the medical study programs and an increase to eight weeks under DTERP may have similar beneficial effects. As such, it is suggested that a modest expansion in support for DTERP, funded either through HWA's clinical training funding or through a re-profiling of the RHMT program, could significantly increase the level of rural training delivered through this initiative.

#### *The University Departments of Rural Health program*

The Commonwealth funds 11 UDRHs, as part of the RHMT program. The UDRH program provides rural and remote communities with improved access to appropriate health services, by promoting professional support, education and training of the rural health workforce. Recruiting urban professionals to the country is also a focus, as is encouraging students to undertake supported clinical placements in rural and remote areas (this is further discussed in Chapter 4). Dental placements are supported as part of this program, although the level of activity varies between UDRHs. A number of UDRHs are keen to expand their activities in supporting dental training.

A submission provided by the Australian Rural Health Education Network (ARHEN) as part of this review outlines a proposal to expand the UDRH service learning model into dental training. This proposal outlines the benefits that the service learning model will have on dental training and education in rural locations. This proposal is further discussed under the Education and Training section of this chapter.

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<sup>174</sup> G. Johnson and A. Blinkhorn, *Report of the evaluation of the rural placement program*, University of Sydney, 2010

<sup>175</sup> G. Johnson and A. Blinkhorn, *An Evaluation of a Clinical Rural Placement Scheme for Universities of Sydney Dental Students - Evaluation Report 2: A look at the Second Year of the Scheme's Implementation*, University of Sydney, 2012

### ***Voluntary Dental Graduate Year Program***

The VDGYP was announced as part of the 2011-12 Commonwealth Budget with funding of \$52.6 million over four years. The purpose of this Budget measure is to provide dental graduates with a structured program for enhanced practice experience and professional development opportunities, whilst increasing the dental workforce capacity in the public dental system and other areas of need. The first cohort of graduates commenced their placements in January 2013.

The VDGYP was developed in recognition of workforce limitations in the public dental sector, partly due to the maldistribution of the workforce. Supporting dental graduates during the first year of their career is an effective way to increase recruitment into the public sector, increase workforce capacity and reduce waiting times and potentially help improve health outcomes and reduce the burden and costs to the broader health system.

The original budget measure incorporated placements for up to 50 graduates each year from 2013. However, as part of the 2012-13 Commonwealth Budget, the program was expanded providing additional funding of \$35.7 million over three years from 2013-14. The expanded program will accommodate up to 100 dental graduate placements from 2016 (with 25 additional placements in 2015 and 50 additional placements from 2016).

The VDGYP curriculum was developed by ACODS and is currently being administered by AITEC Pty Ltd. Although it is too early to establish the program's level of success, as of January 2013 there has been 100% uptake of placements in the first cohort.

### ***Oral Health Therapist Graduate Year Program (OHTGYP)***

The OHTGYP was announced in the 2012-13 Commonwealth Budget, providing funding of \$45.2 million over four years from 2012-13 to 2015-16. Similar to the VDGYP, the OHTGYP will provide participating oral health therapist graduates with a structured one year program for enhanced practice experience and professional development opportunities, whilst increasing the oral health therapist workforce capacity. The first cohort of participating oral health therapist graduates will commence their placements from early 2014.

The program will encourage graduates to work in the public sector and will provide opportunities to utilise their full range of skills in multidisciplinary teams, ongoing professional development and support, and access to mentors.

Program design is currently being undertaken by HWD with advice sought from a reference group of key dental stakeholders including state and territory dental services, the Dental Board of Australia (DBA), the Australian Dental Council (ADC), the Australian Dental Association (ADA), the Australian Dental and Oral Health Therapist Association and ACODS. The program will seek proposals from experienced organisations to develop the OHTGYP curriculum, conduct an evaluation of the program and administer the program on DoHA's behalf.

### ***Dental Relocation Infrastructure Support Scheme***

The DRISS was announced as part of the 2012-13 Commonwealth Budget and provides \$77.7 million over four years. The scheme will offer infrastructure and relocation grants for dentists to relocate to more remote areas, and assist them to establish new practices or expand existing practices. Relocation grants, ranging

from \$15,000 to \$120,000 (depending on the location) and infrastructure grants of up to \$250,000 to help with the purchase and fit-out of dental facilities, will be available from July 2013. This is likely to be welcomed by the profession, given the capital intensive nature of dental practice.

Eligibility and selection criteria are yet to be finalised within DoHA. However, it is expected that applicants will need to be registered as a dentist with the DBA and be applying to relocate to an area in an ASGC-RA location that is more remote than their practice location in the previous 12 month period. Support for rural health academics within DRISS may need to be further explored, particularly to encourage development of the service learning model discussed elsewhere in this report.

### *Education and training support*

The HWF allocates funding for a variety of allied health education and training support schemes which are inclusive of dentistry and oral health disciplines. The schemes include the NAHSSS, NAHRLS, RHCE Stream Two, PHMSS and the Rotary scholarships program (for further detail refer to Chapter 3).

### *Acute Care Division oral health programs*

ACD is supporting a number of initiatives that will affect the demand for the dental workforce and assist to improve the supply of dental services. These include:

- \$2.7 billion for around 3.4 million Australian children who will be eligible for subsidised dental care under Medicare;
- \$1.3 billion for around 1.4 million additional services for adults on low incomes, including pensioners and concession card holders, and those with special needs, who will have better access to dental care in the public system;
- \$225 million for dental capital and workforce will be provided to support expanded services for people living in outer metropolitan, regional, rural and remote areas;
- \$11 million for the establishment of mobile dental infrastructure projects to service priority Indigenous communities in rural and regional areas;
- \$8.2 million in dental infrastructure projects that will boost dental services in regional Australia as part of the regional priority round of the Health and Hospital Fund;
- \$10.5 million in funding for national oral health promotion activities; and
- \$450,000 over three years to help organise professional *pro bono* dental health services, to assist those in greatest need.

In addition to these initiatives the Health and Hospital Fund, which is managed by ACD, has provided capital funding for 11 dental infrastructure projects with funding of more than \$132.6 million since the 2009-10 Commonwealth Budget.

## **Key Issues**

### *Workforce distribution*

There is currently a significant maldistribution of the dental workforce in sectors (private and public) and geographically. In relation to sector distribution, the vast majority of the dental workforce is employed in the private sector (84.2% of dentists, 92.7% of dental hygienists, around 62% of oral health therapists and 90.5% of dental prosthetists). Similar figures are evident in relation to the geographic spread of the

dental workforce with 81% of dentists, 87.4% of hygienists and 62.2% of dental therapists practising in metropolitan areas.<sup>176</sup>

The ADA has voiced some concerns that there is now a potential oversupply of dentists in Australia due to the introduction of new dental schools, growth of the number of students graduating from dental programs, increases in the number of overseas trained dentists passing the ADC exam and the ease of migration through the Trans-Tasman Mutual Recognition Arrangement.<sup>177</sup> Growth in dental graduates will increase from 228 in 2006 to an anticipated 581 graduates in 2013.<sup>178</sup> This apparent oversupply, however, has not corrected dental workforce maldistribution – that is, shortages in rural and remote areas continue.

Interestingly, stakeholder consultations at James Cook University indicated that because of a supply of new graduates in dentistry from that university, dental locums were now available in the region at an affordable price for the first time in recent memory.

The NACDH report highlighted the need to focus on providing an appropriate distribution of the dental workforce across sectors and geographical locations. The current state of the workforce can impede timely and affordable access to services for certain groups including rural and remote communities, Aboriginal and Torres Strait Islander Peoples, low socio-economic groups and those with special needs due to the predominance of metro-centric private practice models of service provision. Increased support and incentives for the public sector and additional support for academic and clinical staff was identified as key factors in addressing this maldistribution.<sup>179</sup>

All of the HWD dental workforce initiatives currently in place, as well as those under development, have a central objective of addressing the maldistribution of the dental workforce both in terms of sectors and geographic spread. The OHTGYP, DRISS and the expansion of the VDGYP were developed and informed by the NACDH report to specifically address the maldistribution of the dental workforce issues. Appropriate data capture prior to and during the program implementation stage will be pivotal in determining the success of these measures over time.

### *Collaborative approach*

Collaboration across the key dental stakeholders is vital if dental workforce reforms are to be successful. At the government level, collaboration between the Commonwealth and jurisdictions on current health workforce programs and future initiatives is also of critical importance. This includes being clear about funding responsibilities and distribution in relation to the oral health workforce.

A collaborative approach across dental education and training providers also has potential to increase the dental workforce in areas of need such as the public sector, rural and remote areas and services for people with special needs.

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<sup>176</sup> Final Report of the National Advisory Council on Dental Health, 2012

<sup>177</sup> *ibid.*

<sup>178</sup> Figures provided by ACODS at the Dental Workforce Roundtable of the Review of Commonwealth Health Workforce Programs, 2012

<sup>179</sup> *ibid.*

At the operational level, it is also important for oral health practitioners to have a team approach to oral health care (prevention and treatment), particularly in relation to the referral pathways. Participants at the Dental Workforce Roundtable had the view that the use of a team is better entrenched within the culture of dental practice than in many other health workforces. However, improvements could be made within the public sector by further embracing the flexibility of the dental, oral health therapist and hygienist workforce and ensuring that their skills are utilised to their potential. There is scope to improve the utilisation of oral health therapists in the general public sector which will improve service delivery capacity, promote prevention and early intervention, encourage multidisciplinary approaches to care and enable dentists to focus on more complex dental service needs of the community.<sup>180</sup>

Two Commonwealth initiatives which have improved collaboration regarding dental workforce issues are the National Oral Health Plan and the NACDH.

### *National Oral Health Plan*

The *National Oral Health Plan 2004–2013* was developed in 2004 as a high level national framework aimed at integrating oral health into the health agenda and setting an overall direction for oral health, with measurable process and outcome indicators. The plan was developed in a coordinated approach with representation from the Commonwealth, state and territory governments, the oral health care professions and consumer groups. The Oral Health Monitoring Group provides regular progress reports to AHMAC on the progression of the Plan's eight key action areas.

Workforce development is one of the key action areas in the plan. The plan has provided valuable insight into the oral health workforce and its development at a national level and has been a valuable resource in policy and program development and monitoring. A coordinated approach to developing and monitoring the oral health workforce is vital, particularly in regard to the maldistribution of the oral health workforce.

The Oral Health Monitoring Group is in the early stages of developing the new National Oral Health Plan 2014–2023.

### *National Advisory Council on Dental Health*

The NACDH was established as part of the 2011-12 Commonwealth Budget, as a time-limited group to provide strategic, independent advice to the Government on dental health issues.<sup>181</sup> The NACDH report was provided to the Minister for Health outlining dental policy options and priorities for consideration including in relation to the dental workforce. *Aspiration Seven – Building workforce capacity for better service delivery and improved access* outlined the importance of dental workforce supply and distribution.<sup>182</sup>

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<sup>180</sup> National Advisory Council on Dental Health, *Report of the National Advisory Council on Dental Health*, 23 February 2012, p. 63

<sup>181</sup> Commonwealth of Australia, *Budget Paper No. 2, 2011-12*, Commonwealth of Australia, 2011, p. 216

<sup>182</sup> National Advisory Council on Dental Health, pp. 62–63



### *Data and research*

Consultations as part of this review highlighted the importance of reliable data and research in developing and maintaining an efficient and effective oral health workforce. One of the main topics of the discussion at the Dental Workforce Roundtable was the need for increased funding for oral health data and research collection.

The data collection and research done by the Australian Research Centre for Population Oral Health (ARCPHO) and the Australian Institute of Health and Welfare (AIHW) Dental Statistics and Research Unit (DSRU) has proven to be a valuable resource in HWD's policy formulation and program development and implementation.

An issue raised in the course of consultations related to the collection of accurate dental workforce figures is that overseas trained dentists are not at present included in national workforce figures. Historically, international student numbers were not significant in data collection. However, with the increase of International Dental Graduates (IDGs) in recent years, it is believed that up to 15 to 20% of dentists in the Australian workforce are overseas trained.<sup>183</sup> Continuing to exclude these graduates will have a significant impact on the reliability of workforce data.

HWA also provides valuable insight into the dental workforce through their research and data analysis. For example, dental practitioners (dentists, dental hygienists and oral health therapists) have been included in the next release of HW2025 for workforce planning purposes, more specifically examining the training implications of the dental workforce under a range of workforce scenarios (this is further discussed in the summary of the HW2025 findings at appendix ii).<sup>184</sup>

Aspiration Eight – *Enhancing data collection, research and analysis* of the NACDH report outlines the importance of reliable data and research to inform on policy decision-making and program development. The report states that additional resources are required in this area, in particular there needs to be a focus on consistent data collection amongst dental stakeholders.<sup>185</sup>

### *Inquiry into Adult Dental Services in Australia*

The House of Representatives Standing Committee on Health and Ageing is currently undertaking an inquiry into the provision of adult dental services. Part of this inquiry will focus on workforce issues relevant to the provision of dental services in jurisdictions. This inquiry will directly inform the National Partnership Agreement for adult public dental services which is a significant component of the Commonwealth's Dental Care Reform Package.<sup>186</sup>

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<sup>183</sup> Review of Commonwealth Health Workforce Programs - Dental Workforce Roundtable, 2012

<sup>184</sup> Health Workforce Australia, *2011-12 Work Plan Progress Report, Summary of Progress from 1 July 2011 to June 2012*

<sup>185</sup> National Advisory Council on Dental Health, pp. 63–64

<sup>186</sup> House of Representatives Standing Committee on Health and Ageing, [Terms of reference of the Inquiry into Adult Dental Services in Australia, 2013](http://www.aph.gov.au/Parliamentary_Business/Committees/House_of_Representatives_Committees?url=haa/dental/tor.htm), accessed at [http://www.aph.gov.au/Parliamentary\\_Business/Committees/House\\_of\\_Representatives\\_Committees?url=haa/dental/tor.htm](http://www.aph.gov.au/Parliamentary_Business/Committees/House_of_Representatives_Committees?url=haa/dental/tor.htm)



### *Education and training*

Scholarship support available for dental and oral health students is limited to generalist allied health schemes. Dental stakeholders have advocated for the Commonwealth to introduce a specific dental scholarship scheme. The NACDH report supports a specified scholarship scheme for dentistry and other oral health fields and further suggests that dental scholarship schemes could be refined to target groups with special oral health care needs. For example, scholarships for dental therapists and oral health therapists to work in aged care facilities, with a particular emphasis on working in rural and remote facilities.<sup>187</sup>

### *Supporting the academic dental workforce*

Dental schools in Australia are currently experiencing a shortage of academic dental personnel. A key reason for this shortage is the current disparity between the salaries received by academics and those received by dentists working in the private sector. This shortage will become even more evident, given the predicted increase in students undertaking dentistry courses over the coming years. In addition, the academic dental workforce is ageing. Incentives for experienced dentists to join academia and strategies to retain current academics (for example, ensuring flexible employment conditions) are vital considerations in the recruitment and retention of high-quality academics.<sup>188</sup> This is especially acute in rural and remote areas.

In relation to education and training, it is important to note that upon graduation dental students are fully qualified health practitioners and are eligible for registration with the ability to practise independently. This is an advantage in terms of the immediate boost to health care services newly graduated dentists can provide. However, it is obviously important that dental graduates acquire the full complement of skills and competencies during their studies and are fully prepared to practise at the time of graduation.

One of the innovations within dental education is the use of simulation training. In particular, dentistry university courses within Australia have successfully implemented a simulated learning environment into training and this plays an important role in a student's education. HWA has acknowledged the usefulness a simulated learning environment can have in providing enhanced knowledge, skills and performance of dental students.<sup>189</sup> The Dental Workforce Roundtable also noted that simulation training leads to better outcomes for students and therefore decreases patient risk.<sup>190</sup>

### *Enhancing rural dental training*

Final year dental placements in rural and remote locations have shown to significantly increase the oral health outcomes for people in these communities. This was evident in the recent study of the School of Dentistry and Oral Health, Griffith

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<sup>187</sup> Final Report of the National Advisory Council on Dental Health, 2012

<sup>188</sup> *ibid.*

<sup>189</sup> Health Workforce Australia, *Use of Simulated Learning Environments (SLE) in Professional Entry Level Curricula of selected professions in Australia*, Health Workforce Australia, Adelaide, 2010

<sup>190</sup> Review of Commonwealth Health Workforce Programs - Dental Workforce Roundtable, 2012

University, Clinical Placement Program, which provides placements in rural, remote and Aboriginal and Torres Strait Islander communities.<sup>191</sup>

The study highlighted that dental placements in rural and remote areas not only better the oral health outcomes of the community directly but the experience may also lead to more dental graduates choosing to take up positions as fully qualified dentists in these locations. However, appropriate clinical supervision is required for students to complete a successful placement in these areas. Supervision is a key contributing factor affecting the lack of clinical training placements in rural and remote locations, particularly in very remote and Aboriginal and Torres Strait Islander communities.<sup>192</sup>

### Box 8.1: Building the Rural and Remote Workforce through a Rural Oral Health Academic Program - submission<sup>193</sup>

A submission by the Australian Rural Health Education Network (ARHEN) seeking funding for a Rural Oral Health Academic Program to strengthen the oral health workforce in rural and remote areas has been considered as part of this review.

ARHEN's submission proposes a new program which would provide supervised clinical training for final year dental students on placement with a UDRH for 12 or more weeks throughout the academic year. Clinical training would occur in the public dentistry service and students would deliver services supervised by a qualified dentist. The program model is based on principles of community-engaged learning and teaching and service learning.

The program would be delivered in partnership with the regional public dentistry services, participating Faculties of Dentistry and UDRHs. It is envisaged that funding would be provided to each participating UDRH to employ a rural Oral Health Academic (Dentist) to develop the service learning program, supervise students as well as contribute to service delivery in their own right. Access to infrastructure funding to expand public dentistry facilities for the program and to meet the relocation costs for the Oral Health Academic would also form part of the program package. The proposal further outlines that the program could be extended to other registered oral health fields.

A key objective of this proposal is increasing access to public dental services in rural and remote areas. The submission points out that final year dental students are major contributors to public dental services in metropolitan areas. However, there are questions over the capacity for final year dental students to have a positive impact on public dental services in rural and remote areas due to a lack available, appropriately qualified supervision. This issue was also identified in consultations as part of this review.

ARHEN's submission is supported by HWA and ACODS. The submission also directly supports aspiration seven, *Building workforce capacity for better service delivery and improved access*, of the NACDH report, by delivering increased support for rural clinical placements and support for dental academics within UDRH and rural clinical schools.

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<sup>191</sup> R. Lalloo, J.L. Evans and N.W. Johnson "Dental care provision by students on a remote rural clinical placement", *Australian and New Zealand Journal of Public Health*, Vol 37(1), 2013

<sup>192</sup> *ibid.*

<sup>193</sup> Australian Rural Health Education Network, "Building the Rural and Remote Workforce through a Rural Oral Health Academic Program", submission to the Independent Review of Australian Government Health Workforce Programs, 2012

As mentioned in the dental workforce program section of this chapter, both DTERP and the UDRHs are providing education and training opportunities for dental students in rural areas. It is therefore important to take into account the current program activities and the relationships of the applicable universities in regard to the two programs.

In consideration of any expansion of DTERP and/or the development of the *Building the Rural and Remote Workforce through a Rural Oral Health Academic Program* proposal, the Commonwealth should explore how they can further complement each other, as well as any potential duplication. As DTERP and the UDRH programs are part of the broader RHMT program there may be opportunities to better align the two through a re-profiling of the broader RHMT program to significantly increase the level of rural training delivered through this initiative.

DoHA has indicated that university dental schools support the current activities undertaken by the UDRHs to increase dental education and training in rural locations. This may allow for greater crossover between dental schools and UDRHs, with an increased number of dental students taking up rural training placements. These partnerships are effective ways of meeting the needs of a broad range of dental students, but can be complex to manage and bring associated costs.

Any increase or allocation of funding should be based on capacity of the dental schools and UDRHs. The relative capacity of each UDRH to implement the program is not discussed in this submission and would need to be considered. Detailed arrangements with dental schools for facilitating student placements, as well as issues around curriculum design, require further exploration. Collaboration with key stakeholders involved in the two programs is also vital if an expansion and/or additional monies for DTERP and the *Building the Rural and Remote Workforce through a Rural Oral Health Academic Program* proposal are considered by the Commonwealth.

The Commonwealth should also take into account other funding allocations that are aimed at enhancing rural dental training. For example, DoHA has funded the Charles Sturt University School of Dentistry, at a capital cost of over \$50 million, which commenced student intakes from 2009. A key element of the Charles Sturt model is that dental clinics at five key sites throughout rural NSW provide core training, delivering activities through an innovative public/private mix and providing high quality training and much needed dental services to these rural communities. The James Cook University dental school, which was funded through the Education portfolio, is performing a similar role in northern Queensland.

### ***Regulatory requirements***

Since July 2010, the dental workforce has been regulated by the National Registration and Accreditation Scheme (NRAS). DBA is the national board for dental professions under the NRAS.

There are a number of issues for the dental workforce in relation to the current regulatory environment. For instance, at the Dental Workforce Roundtable there was discussion that some oral health therapists and hygienists have experienced restrictions working in public and private sectors due to varying jurisdictional and

service provider interpretations of the national oral health practitioner registration requirements.<sup>194</sup>

Participants at the roundtable also raised concerns in relation to restrictions placed on the dental workforce by other pieces of legislation such as state and territory drugs and poisons legislation. HWA is close to completing a *Health Professionals Prescribing Pathway* (HPPP) project with the goal of harnessing the expertise of the non-medical workforce in a manner that will promote productivity and flexibility, whilst ensuring consumer safety. Integral to this project is the promotion of quality use of medicines in the context of the National Medicines Policy (addressing regulatory issues and potential barriers is also discussed in Chapter 3 of this Review).

The Australian Health Workforce Ministerial Council (AHWMC) tasked HWA to review the roles and scope of practice of dental therapists and dental hygienists. The HWA report was provided to AHWMC in April 2012. The AHWMC requested the DBA to provide advice on the scope of practice and new models of care and training as part of the impending review by the DBA of the Scope of Practice Registration Standard.

In addition to the review of the Scope of Practice Registration Standard, the DBA will review all registration standards, codes, guidelines and policies that were developed prior to the establishment of the NRAS. The DBA has commenced the consultation process with key stakeholders in relation to these reviews.

The NACDH report supported the review of the scope of practice of dental practitioners, arguing that the scope of practice of oral health therapists, dental therapists and dental hygienists should be expanded to allow for treatment and services to broader population groups. The report notes that extending the scope of practice of oral health therapists, dental therapists and dental hygienists may relieve the time and cost pressures associated with dentists.

## Recommendations

Recommendation	Affected programs	Timeframe
<b>Recommendation 8.1:</b> The Commonwealth should closely monitor the current work being undertaken by Health Workforce Australia (HWA) and the Dental Board of Australia (DBA) in relation to the scope of practice for oral health therapists, dental therapists and dental hygienists to inform the design of future health workforce programs.	Nil	Medium term
<b>Recommendation 8.2:</b> The Commonwealth should continue with the implementation of the Oral Health Therapist Graduate Year Program (OHTGYP), the Voluntary Dental	OHTGYP, VDGYP, DRISS	Ongoing

<sup>194</sup> *ibid.*

Recommendation	Affected programs	Timeframe
Graduate Year Program (VDGYP) and the Dental Relocation and Infrastructure Support Scheme (DRISS). While implementation for these relatively new programs appears to be on track, it will be important to monitor outcomes.		
<b>Recommendation 8.3:</b> The Dental Training Expanding Rural Placements (DTERP) program has potential to provide increased numbers of student placements for a modest additional investment. Funding could be identified from within the existing Rural Health Multidisciplinary Training (RHMT) program, or through HWA. This program is strongly supported by the dental schools and appears to be delivering useful outcomes for the distribution of the dental workforce and to expand the service learning model.	DTERP, RHMT	Short term – dental schools have advised that this program is ready to be expanded almost immediately, subject to receiving extra funding.
<b>Recommendation 8.4:</b> The Australian Rural Health Education Network (ARHEN) proposal for a rural oral health academic program has merit and should be explored further in close consultation with dental schools, as a way of supporting the dental workforce in rural locations. The alignment of this potential new investment with the existing DTERP program needs to be carefully considered to avoid potential overlap, noting that some University Departments of Rural Health (UDRH) have the potential to act as new training sites for dental and oral health students.	UDRH program	Medium term – subject to available funding.
<b>Recommendation 8.5:</b> The Commonwealth should encourage key agencies (e.g. HWA and the Australian Institute of Health and Welfare) to improve data collection to inform policy development of the dental and oral health workforce. This should include better data on workforce distribution and the academic dental workforce.	Nil	Longer term

## 8.2 *Allied health workforce*

Utilising the umbrella term ‘allied health’ to represent the various health disciplines, excluding doctors and nurses, is a relatively new concept. The use of the term allied health was coined in the 1990s and has been increasingly used at service delivery and policy levels. The impetus to utilise the term and to be viewed as a ‘collective profession’ was seen as important in the drive to gain greater autonomy and influence for allied health disciplines in strategic leadership, and by symbolising integration within the health system.

There is no one definition which prescribes the disciplines considered as allied health. At the meeting of the Council of Australian Governments (COAG) in July 2006, agreement was reached to establish NRAS for health professionals, beginning with the ten professional groups registered in all jurisdictions, of which seven fall under the allied health banner: chiropractic care, optometry, osteopathy, pharmacy, physiotherapy, podiatry, and psychology (refer to Chapter 3).

A further four allied health professions joined NRAS on 1 July 2012: Aboriginal and Torres Strait Islander health practitioners, Chinese medicine practitioners, medical radiation practitioners and occupational therapists. A description of the above disciplines included under NRAS is outlined in Chapter 2.

In some cases oral health practitioners are considered to be part of the allied health workforce, however in this chapter the oral health workforce has been discussed earlier.

Other allied health professions that are not included under NRAS, but are considered in the Commonwealth’s health workforce policy planning, include:

- Audiologists
- Counsellors
- Dietitians
- Exercise physiologists
- Music therapists
- Nutritionists
- Pathologists
- Social workers
- Sonographers
- Speech pathologists

In very broad terms, allied health professionals provide services to enhance and maintain function of their patients (clients) within a range of settings including hospitals, private practice, community health and in-home care. There is an emphasis on healthy lifestyle and on independence; whether that is physically, psychologically, cognitively or socially. The allied health workforce works across the spectrum from acute to primary care and aged care. Allied health professions also have a large role in the management of people with disabilities from childhood to adult.

At a time when health economics is driving the need to look for increased productivity in the health system, the effectiveness of allied health interventions needs to be evaluated in terms of client health outcomes. There is a paucity of evidence for the effectiveness of some particular allied health interventions; both as a collective and within single discipline interventions. With allied health being a part



of the primary health care team with a focus on prevention and maintenance of function in the community, it is important that health outcomes from allied health management are better understood.

### Allied health organisations

For the most part, each allied health discipline has its own professional organisation which provides advocacy and policy development. They also provide a platform for professional development opportunities, with some organisations providing accreditation/credentialing of their professionals. However, there are also a number of overarching professional bodies that represent the allied health workforce generally.

Four key professional bodies representing allied health disciplines are outlined briefly below. Of these bodies, DoHA provides funding support to the Services for Rural and Remote Allied Health (SARRAH), CRANApplus and Indigenous Allied Health Australia (IAHA) (Refer to Chapter 5 and Chapter 9).

#### **Allied Health Professionals Australia**

Allied Health Professionals Australia (AHPA), formally called Health Professions Council of Australia, is a professional stakeholder based organisation which represents allied health professions and their representative bodies. Collectively, organisations within AHPA represent about 50,000 health professionals. AHPA's membership comprises a number of allied health professional associations including audiologists, chiropractors, dietitians, exercise physiologists, occupational therapists, orthoptists, orthotists and prosthetists, osteopaths, hospital pharmacists, podiatrists, psychologists, sonographers, social workers and speech pathologists. The Diabetes Educators and Practice Managers associations are associate members.

One of AHPA's key priorities is to ensure that allied health professionals are heard on issues affecting health care in Australia.

The main objectives of AHPA are to:

- provide national leadership on shaping and supporting the contribution made by allied health to health and wellbeing;
- provide effective representation, promotion and communication of allied health interests in the development and implementation of government policies;
- encourage and promote innovation and best practice in allied health service delivery;
- enhance cooperation between the tertiary education and service providers in allied health; and
- promote and support allied health workforce development.

#### **Services for Rural and Remote Allied Health**

SARRAH describes itself as a grass roots organisation and undertakes a significant amount of lobbying nationally for issues facing rural delivery of services but also has a strong focus on network support for rural and remote allied health. SARRAH is not a member organisation of the AHPA as it is not regarded as an allied health professional organisation.

SARRAH was established as part of the 1997-98 Budget process with the amalgamation of several discrete rural programs into one larger program with the aim of providing a more flexible and streamlined approach. The original objectives of the program include:

- supporting rural and remote allied health professionals;
- providing information and assistance to Government and interested parties;
- advancing rural and remote allied health through policy advice and identification of priority issues; and
- supporting the administration of Government-funded scholarship programs.

SARRAH also administers the allied health element of NAHSSS on behalf of DoHA.

### *Indigenous Allied Health Australia*

Indigenous Allied Health Australia (IAHA) is the peak body in Australia representing Aboriginal and Torres Strait Islander allied health professionals and students. IAHA receives funding through the Aboriginal and Torres Strait Islander Health Workforce Training Package.

As a peak body IAHA:

- provides support and advocacy on behalf of Indigenous allied health professionals and students at the local, regional and national level;
- builds strong leadership capacity across the allied health and Indigenous health sectors;
- works closely with organisations, universities and other related sectors to improve health curricula, address allied health workforce issues, and promote allied health careers to Aboriginal and Torres Strait Islander people;
- provides expert advice to governments, allied health professional bodies, educational institutions and the health sector in relation to health policy and issues;
- develops and maintains strong networks and connections to Indigenous communities to ensure IAHA core objectives are meeting their needs and aspirations; and
- works closely with the health sector and communities to improve access to allied health services.

### *Australian Allied Health Alliance*

Four allied health organisations announced the formation of the Australian Allied Health Alliance (AAHA) at the SARRAH conference in September 2012. The organisations involved are IAHA, SARRAH, AHPA and the National Rural Health Students' Network. The aim of the alliance is to form a cohesive group for championing and lobbying allied health to Government.

### *CRANApplus*

Initially an organisation for remote area nurses, CRANApplus has now expanded to include allied health and medicine. Funding is provided to CRANApplus to address:

- the lack of support experienced by remote health professionals;
- the psychological impact of working as an isolated health professional; and
- the poor access to relevant educational courses.

In 2010, the core funding for CRANaplus was included in the National Rural and Remote Health Stakeholder Support Scheme, managed by the Primary and Ambulatory Care Division of DoHA.

### Commonwealth initiatives

In the last ten years, a number of specific initiatives have been implemented by the Commonwealth targeted at allied health professionals. These initiatives have primarily been directed at improving access to allied health services for the management of chronic disease and improving the health status of Australians in rural and remote areas.

#### *Consumer access to allied health items in the Medicare Benefits Schedule*

Medicare provides public health insurance for the cost of medical and hospital treatment, which is clearly demarcated from non-medical, allied health services. Exceptions exist however, in relation to dentists and optometrists. For instance, optometrists have provided services under the Medicare Benefits Scheme (MBS) since 1975 and, in accordance with their training, are able to perform the same refractive tests and bill for items as well as ophthalmologists.

Another precedent in current Medicare arrangements is the provision allowing oral surgeons to undertake similar (prescribed) procedures to those undertaken by medical practitioners; and for the same rebate. Without this proviso, a potential anomaly in the system would otherwise be that particular procedures performed by a physician would be covered by Medicare but the same procedures would not be covered when performed by a dentist.

The Enhanced Primary Care (EPC) MBS items were introduced in 1999-2000 to improve the health and quality of life of older Australians, people with chronic conditions and those with multidisciplinary care needs. The EPC items provided a Medicare rebate for GPs to undertake or participate in health assessments for older people, and care planning and case-conferencing services for patients with chronic conditions and complex needs.

Chronic Disease Management (CDM) items were introduced in 2005 to replace the existing EPC care planning items. The Medicare allied health initiative allows chronically ill people who are being managed by their GP under a CDM plan to access Medicare rebates for allied health services.

In 2006 MBS items for GP mental health plans and associated psychological therapy items were introduced as part of the Better Access to Psychiatrists, Psychologists and GPs program to improve consumers' access to high quality primary mental health care.

#### *Better Outcomes in Mental Health Care*

The Better Outcomes in Mental Health Care program improves community access to quality primary mental health care. The program was introduced in July 2001 in recognition of the important role of general practitioners in managing mental health problems and to enable team arrangements for referral of patients to allied health services. The program has two components:

1. Access to Allied Psychological Services (ATAPS) - enables GPs to refer consumers to allied health professionals who deliver focused psychological strategies.

2. GP Psych Support - provides GPs with access to patient management advice from psychiatrists.

#### *More Allied Health Services*

More Allied Health Services (MAHS) was funded through the (then) Divisions of General Practice (now generally subsumed as Medicare Locals). The objectives of the program were to provide allied health services to rural populations and to improve local linkages between allied health care and general practice.

Divisions were able to fund a range of suitably qualified allied health professionals to increase the number and range of services available. The program was reviewed in 2007 and it was found there was overwhelming evidence that MAHS was meeting a rural workforce need and was increasing team work, communication and shared knowledge amongst Divisions. In 2004-05, there were 169 allied health professionals funded under the program. MAHS was consolidated into the Rural Primary Health Services (RPHS) program in 2008.

The RPHS program's aim was to improve access to a range of primary and allied health care services and activities for rural and remote communities. The RPHS program gives community-based primary health care services greater flexibility in the range of services they can offer, including health promotion and preventative health activities.

#### *Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS (Better Access) initiative*

The Better Access initiative provides better access to mental health practitioners through Medicare. The initiative was introduced in November 2006 in response to low treatment rates for common mental disorders (e.g. anxiety, depression and substance use disorders).

The Better Access initiative increases community access to mental health professionals and team-based mental health care, with general practitioners encouraged to work more closely and collaboratively with psychiatrists, clinical psychologists, registered psychologists and appropriately trained social workers and occupational therapists.

Part of the Better Access funding has been allocated to education and training for health professionals. Understanding the requirements relating to Medicare Benefits Schedule item numbers, referrals and patient health care planning, as well as how mental health professionals can work together in a multidisciplinary treatment team, is fundamental to treating people effectively under the Better Access initiative.

The Better Access initiative is part of the Commonwealth component of the COAG National Action Plan on Mental Health 2006–2011.

#### *Nursing and Allied Health Rural Locum Scheme*

This program is a component of the Australian Government's health reform initiatives funded in the 2010-11 Budget: *National Health and Hospitals Network – Workforce – rural locum scheme for allied health professionals*; *National Health and Hospitals Network – Workforce – rural locum scheme for nurses*. These were subsequently combined to create the Nursing and Allied Health Rural Locum Scheme (NAHRLS).

The aims and objectives of the NAHRLS are to:

- Enhance the ability of eligible nurses, midwives and allied health professionals to take leave;
- Improve the retention and distribution of nurses, midwives and allied health professionals across Australia;
- Attract nurses, midwives and allied health professionals who may otherwise leave, travel or retire, to stay in the health workforce as locums;
- Improve the attractiveness of rural and remote practice for nurses, midwives and allied health professionals; and
- Improve access of rural and remote communities to nurses, midwives and allied health professionals.

### *Education and training support*

The Commonwealth allocates funding for a variety of allied health education and training support schemes to assist allied health students and practitioners with their studies and continuing professional development (CPD). As mentioned above in 8.1, the education and training support schemes include the NAHSSS, NAHRLS, RHCE Stream Two, Rotary scholarships and PHMSS. In addition to these schemes, pharmacy has two scholarship schemes dedicated to its discipline, the Rural Pharmacy Scholarship Scheme (RPSS) and the Aboriginal and Torres Strait Islander Pharmacy Scholarship Scheme (ATSIPSS).

Eligibility varies for each of the schemes (above) and may be restricted to a selected group of allied health disciplines or in the case of the pharmacy scholarships restricted to one allied health discipline. Some scholarships and support programs are only available to Aboriginal and Torres Strait Islander people studying in health disciplines, such as the Rotary scholarships program, PHMSS and ATSIPSS. Eligibility may also be prioritised according to location, and in some cases focus on providing support to a wide variety of allied health disciplines in rural and remote areas. The scholarship and other education and training support programs are dealt with in more detail in Chapter 3.

### *Key issues*

#### *Public and private sector collaboration*

Allied health practitioners work in various settings in both the public and/or private sectors. The majority of allied health practitioners employed in the public sector work in acute care, the community care sector, and in community services. Within the public sector, particularly in the acute setting, allied health practitioners tend to work in discipline departments with a senior of their discipline. However, there has been a move towards a more multidisciplinary approach to health service delivery in the public sector, with allied health disciplines taking on a more prominent role.

There has been a significant increase in private allied health practitioners over the last ten to twenty years. Optometrists, physiotherapists, podiatrists, chiropractors, osteopaths, pharmacists and psychologists are the disciplines with significant private practice opportunities.

Within the private sector, the most common service delivery model for allied health services is a small (or solo) practice of the same discipline. Larger allied practices which may be co-located with medical practices and other health disciplines are becoming more common. However, for the most part, allied health disciplines continue to operate in a siloed manner.



Allied health practitioners working in a private capacity do not require a referral from a medical practitioner and many allied health services are funded by private health insurance 'general treatment' policies. However, allied health disciplines do form collaborative relationships and develop referral pathways to and from medical practitioners as well as other allied health disciplines. Various submissions indicated the potential for better collaboration and referral processes between allied health and other health disciplines, particularly between private providers and the public sector.

As mentioned above, collaboration and communication in patient care between allied health disciplines is crucial, particularly given the increased focus in recent years on a more multidisciplinary approach to patient/client health care. The move toward co-located health disciplines is one way to encourage and increase partnerships and collaboration activities of health practitioners.

A lack of private practitioner services in rural areas means that rural communities tend to have limited ability to access Commonwealth MBS items or any value in purchasing private health insurance for allied health services. Models need to be explored which strengthen collaboration between all services (health and disability sectors), including private and public and in smaller communities.

Medicare Locals and local health networks (LHN) could play an important role in attracting more allied health to rural locations by having an integrated approach to employment of allied health practitioners. Rights of private practice and/or collaboration between Medicare Locals and LHN could see more attractive positions developed for allied health in a possible shared public and private service.

### *Collaboration - between the health workforce*

In the current service delivery model (within the acute sector) patients/clients are often assessed and managed by a number of different allied health practitioners. For example, a patient who has suffered a stroke is likely to receive care from a number of allied health professionals including physiotherapists, occupational therapists, speech pathologists, dietitians and social workers. It is therefore important to continuously review models of care to ensure maximum coordination of client care (including with nursing) and to reduce any unnecessary overlap.

There have been some models developed in the acute sector where health professionals (including doctors, nurses and allied health) are managed at a service level rather than by discipline. This model has been used in orthopaedic services and neurological services, with a professional supervision matrix structure for supervision and support through a discipline senior. This shift is driving enhanced interdisciplinary practice and client-based care. Models of multidisciplinary care involving allied health professionals have been utilised successfully in the community health and disability sector, where allied health practitioners are more likely to be employed in multidisciplinary roles.

Further investigation into the overlap of roles/skills between allied health disciplines, and indeed with nursing, should be explored when developing new models of care. The use of allied health in specific areas of extended scope of practice in interdisciplinary teams also merits further work.

### *Leadership*

Since the acceptance of allied health as a professional grouping, some jurisdictions have established senior allied health positions in the public sector. There has been a



trend in recent years for health services (local health networks) to create allied health leadership positions in some major hospitals. The roles of these types of positions can vary depending on the service delivery structure of the particular health service. However, the main purpose is to provide better direction and coordination of the allied health workforce in health service delivery.

A significant number of leadership positions have been established by state and territory governments to support allied health policy development at a jurisdictional level. Allied health leadership and management positions within service delivery and government are important as they provide allied health disciplines with a “voice” in policy decision making as well as impetus to continue to work towards integrating allied health services into core health service delivery.

#### *Commonwealth Chief Allied Health Officer*

Allied health organisations have been advocating for a Chief Allied Health Officer in DoHA for some years. Additionally, in the recent *Senate Inquiry into factors affecting the supply of health services and medical professionals in rural areas*, one recommendation included the development of a rural allied health officer role in DoHA.

On 13 March 2013, the Minister for Health announced that the Government would establish the Commonwealth’s first Chief Allied Health Officer to further support allied health professionals and provide advice on how best to strengthen their role in the Australian health system.

The role of the Chief Allied Health Officer is envisaged to be the provision of enhanced liaison and consultation with the allied health workforce, thus enabling better informed health workforce and service delivery policy making. While the predominant focus of this position will be on improvement in the delivery of allied health services in rural and remote areas, it should also assist in providing a more integrated health workforce.

The Commonwealth has a more limited and less direct role in funding and employment of allied health professionals than the state and territory jurisdictions and the role of a Chief Allied Health Officer will therefore carry a different emphasis than is the case in those jurisdictions. The function of a Chief Allied Health Officer at a Commonwealth level should be to elevate (to a senior executive level within DoHA) the possible role of allied health professionals in relevant health workforce and service delivery policy, data and planning processes at a national level.

On the basis of submissions made to this review, the establishment of a Commonwealth Chief Allied Health Officer position within DoHA is supported. It will be important for DoHA to consider and liaise with relevant areas to determine the scope of this role and the type of representation that is necessary across disciplines.

#### *National allied health organisation*

Consideration should also be given to a Coalition of National Nursing Organisations (CoNNO) type model where allied health stakeholder representatives would meet on, for example a quarterly basis. It is possible that the new Australian Allied Health Alliance (discussed earlier) could play a role in this regard.

Regular consultation would enhance the Commonwealth’s ability to liaise and consult with the allied health disciplines. This type of approach would allow DoHA to present new or emerging policy/program implementation plans and where indicated,

ask for relevant committee representation. This would also allow allied health stakeholders to present issues and proposals for discussion with relevant areas of DoHA (including the Chief Allied Health Officer) and other Commonwealth agencies where necessary.

Both the Chief Allied Health Officer and the proposed CoNNO-type model provide the opportunity for allied health stakeholders to be more involved in DoHA discussion relevant to allied health and would assist in building allied health stakeholders' understanding and involvement in Commonwealth policy development.

### *Recruitment and retention*

Recruitment of allied health practitioners is generally not problematic in metropolitan areas but in rural and especially in inland areas, there can be recruitment difficulties to long-term vacancies. While reliable data is not available at the national level, there is a well-recognised mal-distribution of allied health professionals in rural and remote areas, in both the private and public sectors.

There can often be long-term vacancies and often positions in public health will 'disappear' with the fiscal restraints of the public health system. This means that some rural and remote communities can have limited or no services for specific disciplines. Smaller rural and remote communities also often rely on outreach service provision from larger centres, however these services are often irregular and dependent on staffing levels at the larger centres.

### *Distribution*

Certain health areas are likely to experience higher demand for allied health services over the coming years. For example, a significant number of allied health professionals work in the area of disability, managing clients from childhood through to adult. The recently announced National Disability Insurance Scheme (NDIS) is likely to increase demand for allied health services in this sector and this may have an impact on health services staffing.

There is a limited number of allied health practitioners employed in aged care services. The disciplines that are employed in this sector are mainly diversion therapists and physiotherapists. The latest aged care workforce census and survey 2012 has for the first time included a category for both allied health assistants and professionals. With both of these together, data indicates that both the head count and FTE for allied health has reduced over the past three years.

### *Support for health professionals practising in rural areas*

Professionals and their families who relocate to rural areas will often be challenged with living in a small and sometimes isolated community. However health practitioners also deal with professional isolation, increased workloads and more complex work. Many small communities are unlikely to provide sufficient business to sustain a private health practice.

Allied health practitioners in private practice are generally only funded through private health insurance where that is available, or by direct patient payments. Allied health practitioners in rural areas are not always financially viable for funding by state and territory jurisdictions as there is not always enough patient throughput to justify the costs of these positions. The argument has been made that funding for

certain allied health professions will be critical to the future better management of chronic disease in the community.<sup>195</sup> This argument has merit, but the provision of core allied health services to patients living with chronic disease is unlikely to be affordable in rural and remote locations without exploration of alternate service delivery models for allied health disciplines.

### *Allied health assistant roles*

With the recognised shortage of allied health services, many rural areas have been developing processes and frameworks to support the development of trained allied health assistant roles to assist service delivery. In 2007, a Certificate IV in allied health assistance was included in the new nationally recognised Community Services and Health Training Package. This qualification allows trained assistants to work with allied health professionals, allowing the professional to work to the full scope of their licence and have an allied health assistant to complete more routine tasks, under supervision.

There is increasing recognition that this type of role can enhance and expand allied health services and they are increasingly being developed and trialled in smaller rural communities which previously had limited allied health services. The role of the allied health assistants is also becoming more common in larger towns with assistants being supervised day to day by local health managers. Pilots are currently underway in both Victoria<sup>196</sup> and NSW.<sup>197</sup>

Rural allied health professionals and local managers appear to be supportive of allied health assistant roles. However, advocacy and peak groups for the sector appear to be far less supportive. At the consultative Allied Health Roundtable for this review there were in fact strongly expressed views in favour of increased specialisation in some allied health disciplines and opposition to any erosion of professional boundaries, including the use of allied health assistants.

The allied health assistant role is one possible solution to increase access to services in rural and remote communities. Research into the clinical effectiveness and safety of allied health assistants needs to be conducted, to see efficiencies and productivity gains as well as increased access to services. If an allied health assistant model works in rural areas and is shown to be safe and cost-effective, this could also be considered in metropolitan locations, although this will not occur without the support of the relevant professional associations.

### **Box 8.2: The Rural Allied Health Assistants Project**

In several jurisdictions, allied health professionals have led local innovation with the introduction of trained allied health assistants working with them to deliver enhanced services. An interim report from

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<sup>195</sup> Senate Community Affairs References Committee, *The factors affecting the supply of health services and medical professionals in rural areas*, Parliament of Australia, Canberra, 2012, p 19–22.

<sup>196</sup> Department of Health Victoria, “[Allied Health Assistant \(AHA\) Implementation Program – Information Sheet](http://docs.health.vic.gov.au/docs/doc/Allied-Health-Assistant-Implementation-Program-Information-Sheet)”, April 2013, accessed at <http://docs.health.vic.gov.au/docs/doc/Allied-Health-Assistant-Implementation-Program-Information-Sheet>

<sup>197</sup> NSW Health, “[Healthcare Assistant Initiative Newsletter](http://www0.health.nsw.gov.au/resources/training/ain/Healthcare_Assistant_Initiative_v1i1_pdf.asp)”, Vol 1, Issue 1, 28 October 2009, accessed at [http://www0.health.nsw.gov.au/resources/training/ain/Healthcare\\_Assistant\\_Initiative\\_v1i1\\_pdf.asp](http://www0.health.nsw.gov.au/resources/training/ain/Healthcare_Assistant_Initiative_v1i1_pdf.asp)

the NSW Health and Education Institute has shown important outcomes from the NSW program, the Rural Allied Health Assistants (RAHA) Project including:

- Enhanced service delivery to areas previously underserved or receiving no services i.e. improved access.
- Increased job satisfaction of professional staff.
- While long standing vacancies exist for professional staff, allied health assistant positions are keenly sought after positions by the local community who are keen to stay in the area and who know their community.
- Decreased waiting lists.<sup>198</sup>

### *Training and education*

Allied health professionals are generally educated in the university sector with bachelor degrees, usually three to four years duration. However, in a development common to other health professions, there is an increasing move to postgraduate degrees, for example an initial generic undergraduate science degree followed by a Masters in an individual discipline. The postgraduate stream lengthens training to a minimum of five years. Opinions are divided as to whether this is a positive development.

Of note, psychology and pharmacy are the only allied health disciplines that have a compulsory postgraduate training requirement. Issues have been raised about the barriers this further training places to rural and remote practice, particularly psychology. Dentistry, conversely, takes pride in the fact that its graduates are “work ready” and registrable upon graduation.

### *Training and supervision*

At the practitioner level, ongoing professional development can pose particular challenges for those working in rural and remote communities. The isolation experienced by these practitioners can often include a lack of supervision and support and limited opportunities to access CPD training. This creates difficulty where clinicians do not have the contemporary skill sets, limiting their capability and capacity to work in new models of care, but may also prevent them meeting mandatory registration requirements where their profession is included in NRAS.

A continued focus on allied health networking, adequate supervision and access to CPD for allied health practitioners is vital in providing quality health service delivery based on contemporary practice in rural and remote areas. Professional supervision is particularly difficult in the more rural and remote areas. Private practitioners in these areas are even more isolated than their counterparts in the same locations but in the public sector. As an example, in the consultations for this review, rural and regional stakeholders expressed strong concerns about the rigidities of the compulsory psychology postgraduate training and its impact particularly upon women in rural areas seeking qualification.

Members of some particular professions urged that their respective boards should keep this in mind so as to ensure that training requirements are as flexible as

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<sup>198</sup> Rural Division, Clinical Education and Training Institute, *Evaluation – Rural Allied Health Assistants (RAHA) Project: Interim report No. 2*, Rural Division, Clinical Education and Training Institute, 2011

possible to meet the needs of rural and remote practitioners. All standards should be reassessed from this perspective.

### *Alternative service models*

Alternative service models may be of benefit to communities where they build on health delivery structures which are already in place. MBS rebates for Telehealth consultations have been available since July 2011, with payments applicable for both a remote specialist medical practitioner and the GP, nurse, midwife or Aboriginal and Torres Strait Islander health practitioners with the patient during the real-time consultation.

Expanding the list of eligible Telehealth support practitioners to include health practitioners like optometrists is an option that should be explored. In this example, expanding the current consultation rebates would assist rural communities to access ophthalmological consultations more rapidly, with the support of a practitioner specialised in eye health.

Innovation in Telehealth and online training as well as development of professional networks for support is required. Inspirational leadership in allied health is required to move services from traditional service delivery to innovative interdisciplinary approaches.

### *Data*

The consultations as part of this review highlighted the frustration of allied health peak bodies at the lack of allied health workforce data and priority of data analysis. There is limited data available on the allied health disciplines, especially those who fall out of the registration scheme of NRAS.

Currently, there are no reliable data sources that indicate the level of employment of the allied health workforce across the different sectors and settings. Better data collection across settings should provide useful information for policy development. This is particularly important in regard to the disability sector, with the establishment of the NDIS, as well as in aged care.

Arguably, service sector workforce planning – looking at community needs for care and utilisation of allied health disciplines rather than a population-based planning approach – would provide more meaningful information to assist not only with supply and demand for the different allied health professional groups but this approach would also assist in looking at best practice models for service delivery including interdisciplinary care and the use of allied health assistants.

To combat the lack of data on the allied health workforce, HWA is to commence workforce modelling of 'selected allied health disciplines' in the near future. HWA's 2012-13 work plan indicates that it will be commencing workforce modelling by service sector. Noting the complexity and diversity of functions of the allied health disciplines across sectors (including disability), this type of approach may provide more meaningful data to assist in workforce planning rather than looking at a population-based approach for allied health as has been utilised in *Health Workforce 2025 – Doctors, Nurses and Midwives*.

*Recommendations*

Recommendation	Affected programs	Timeframe
<b>Recommendation 8.6:</b> The Government's recent announcement of the establishment of a Commonwealth Chief Allied Health Officer is supported. This new position should play an important role in providing advice on policy and allied health workforce reform.	Nil	Short term – this appointment is likely to commence in 2013.
<b>Recommendation 8.7:</b> The Commonwealth should consider options aimed at enhancing its ability to liaise and consult with the allied health disciplines. This could be pursued through supporting the development of a Coalition of National Nursing Organisations type-model, where allied health stakeholder representatives would meet regularly with senior representatives of the Department, including the Chief Allied Health Officer.	Nil – new secretariat funding, potentially through the Health Workforce Fund.	Short term – linked to the appointment of the Chief Allied Health Officer.
<b>Recommendation 8.8:</b> The Commonwealth should consider providing seed funding to establish allied health networks and professional hubs in rural areas. This would assist in peer support, ensuring adequate supervision of students and new practitioners, and access to continuing professional development. This is essential to ensure service delivery is based on contemporary practice and is more sustainable (particularly in the private sector).  Innovative methods of communication and activities such as telehealth, online training and assistance to develop new professional support networks could be funded through this approach.	Nil – new funding required.	Medium term-  Subject to available funding.
<b>Recommendation 8.9:</b> The Commonwealth should explore the possibility of expanding the list of eligible Telehealth specialist support items to include specific allied health services, including optometry. Close consultation with the Medicare Benefits Division in regard to the feasibility of the recommendation is essential.	MBS	Medium term – subject to discussions with MBD and available funding.



Recommendation	Affected programs	Timeframe
<p><b>Recommendation 8.10:</b> The Commonwealth, in conjunction with HWA, should continue to research and pilot projects to test and implement new roles and responsibilities for allied health assistants, initially in rural areas. Ongoing research into the clinical effectiveness and safety of allied health assistants needs to be undertaken examining the productivity gains and benefits to community services of developing this workforce.</p>	HWA, with potential future support through the Health Workforce Fund, if required.	Longer term
<p><b>Recommendation 8.11:</b> Regionally based agencies such as Medicare Locals and local health networks (LHN) could play an important role in the development of an integrated approach to the employment of allied health professionals. Options for the Medicare Locals and LHN networks to address the lack of allied health private practitioner services in rural areas (with the resultant current limited ability to access private health and Commonwealth MBS items) should be explored further. Although comprehensive HWA data is not yet available, it seems clear that rural communities have significantly less access to private allied health services when compared to metropolitan areas. The Commonwealth may need to address market failure through exploring models of collaboration between health services (health and disability sectors) as well as private/public partnerships in smaller communities.</p>	Medicare Locals, MBS.	Longer term
<p><b>Recommendation 8.12:</b> The concerns and representations of allied health workforce stakeholders raised in the course of this review should be forwarded to Health Workforce Australia (where relevant) for its information and appropriate action. This may improve engagement with the professions and individual practitioners, particularly those employed outside of hospitals.</p>	HWA	Short term



## Chapter 9: Opportunities for reform in program delivery and policy development

The analysis of programs and the stakeholder consultation undertaken as part of this review have highlighted a number of potential areas for reform in the administration of Commonwealth health workforce programs. This chapter will discuss recent reforms pursued by the Department of Health and Ageing (DoHA) to streamline its grants management processes, along with other areas for improvement, including ways of better integrating health workforce issues into broader health policy development.

This chapter also examines the roles, responsibilities and relationship between DoHA's Health Workforce Division (HWD) and Health Workforce Australia (HWA), and the potential for better alignment.

Finally, this chapter examines the current arrangements for providing funding support for the operation of organisations representing health professionals. It summarises the activities undertaken by each of these stakeholder organisations, as identified in their funding agreements, and discusses a number of reforms that could be pursued to streamline the administration of this support.

### 9.1 *Grants management reform*

One of the key means of producing efficiencies is to reduce unnecessary red tape and compliance costs for funded agencies in program delivery and to streamline program administration.

In early 2010 the Australian Government commenced a process of strategic reviews of a number of Commonwealth agencies and departments including DoHA. As a result of the strategic review, a process was developed to ensure the alignment of resources within the portfolio was best placed to implement and manage the government's key health and ageing priorities and programs, including the National Health Reform agenda.

Many of these initiatives are delivered through various forms of contract, service level agreement or other funding arrangement, often with agencies within the not-for-profit sector. It is therefore important to note that contemporaneously, as part of the Social Inclusion agenda, consultations with the non-government or "Third Sector" resulted in commitment to a National Compact which among other important initiatives commits to a whole-of-government process, led by FaHCSIA, to improve information sharing, reduce red tape, streamline reporting and improve funding and procurement processes. DoHA is a key party to this process. The extent to which the purported benefits of the Compact are in fact being experienced by funded non-government agencies is a matter of debate.

The Departmental view is that the reforms to the grant funding processes within the portfolio's programs and activities have commenced. This reform, including the establishment of a series of flexible funds including the Health Workforce Fund (HWF), and the introduction of updated IT systems to streamline fund management, should allow multi-year, multi-schedule funding agreements to be established with more targeted reporting requirements. This process, if properly implemented, has the potential to deliver significant benefits for funding recipients. Short-term funding

agreement periods and multiple contracts with the same organisation across different areas of the department, were among strong concerns raised by stakeholders during this review.

The HWF is intended to provide increased flexibility for both the Government and fund recipients to undertake activities that meet the aims, objectives and priorities of the Government in meeting future health workforce needs. A key outcome from the establishment or expansion of the fund should be the increased flexibility to respond to emerging health and ageing priorities.

### Establishment of the flexible funds

The new grant-related flexible funds have been envisaged to provide the following benefits:

#### *Reduced red tape*

Under the new grant management arrangements, it is envisaged that funding recipients will benefit from a significantly streamlined set of management processes. The Department has suggested that its recently introduced Enterprise Standard Funding Agreement provides a single set of terms and conditions for grant recipients. This means providers that agree to the new terms and conditions will have a more consistent approach across the whole Department.

This standard set of terms and conditions, along with the introduction of smart form technology and a single point of contact/relationship manager, should mean that most funding recipients only need to agree once on the terms and conditions to do business with the Department, no matter how many activities they deliver. The aim of these changes, the review was advised, is to achieve reduced administration and a lessening of the reporting burden, for both funding recipients and the Department.

Under the current reform agenda a number of changes are being introduced that should directly benefit those organisations submitting applications for funding as well as successful funding recipients and key stakeholder groups. It is probably important to note at the outset that many of the DoHA reforms described below have yet to be fully rolled out and the experience of many funded agencies remains frustrating.

When implemented, the advantages of reform should include:

### Simplified and automated application and funding agreement establishment processes

- A new funding and financial management IT system (FoFMs) is being implemented, with HWD already using this system for the bulk of its programs.
- Once fully implemented these new IT and financial management systems should streamline the application and funding process, the standard funding agreement management and the financial payment processes, by the use of tools such as smart forms.
- Smart forms involve a public-facing web interface that will be a feature of the new FoFMs system. This use of online forms should assist stakeholders and:
  - ensure that information provided once is automatically uploaded into multiple documents when required, such as funding agreement schedules, cover letters, and notice of successful and unsuccessful applications.
  - reduce costs and workloads for funding recipients (and the Department) in both inbound and outbound information flows.

- will help to ensure funding applications are complete, as the system uses a series of prompts to ensure appropriate information is provided before documents are submitted.
- reduce applicant workloads and increase the likelihood of the application meeting all minimum criteria for further consideration.
- Applicants will no longer have to provide multiple hard copies of documents, reducing costs of paper, printing, postage and couriers in delivering documents to Departmental tender boxes.
- Additionally applicants will know their applications have been received by the Department via an automated e-mail.

The use of Smart forms is now commencing, with the Specialist Training Program (STP) the first health workforce program to test the use of this technology. Applications for the 2014 STP selection round will be made online, avoiding the need for applicants to submit hard copies and potentially reducing the error rate in the application process by ensuring only complete funding submissions can be lodged. This application process commenced in late March 2013, and will provide an important test case for other programs.

Careful attention will have to be paid during the implementation phase of this reform process to ensure that the added use of technology is accompanied by reduction and streamlining of the compliance-based reports agencies are required to lodge.

The Department should develop a formal feedback mechanism with its major program stakeholders to enable evaluation of the benefits of these reforms from their perspective. This should commence from 2014-15. In some cases these feedback systems will already be in place as part of regular program communication systems. For other programs, discussions should be initiated by the Department to determine the best mechanism for ensuring funded agencies are able to provide feedback on the new grants management and applications processes.

#### [Simplified funding agreement management processes](#)

In considering its administrative arrangements during this review, the Department has advised that changes introduced as part of the broader DoHA National Alignment process will bring the following benefits for health workforce program activities:

- There will be consistent guidelines across all HWF activities.
- There will be increased flexibility of funding management across activity areas improving the ability to manage surplus funds more proactively.
- There will be a Department-wide use of standard, consistent funding agreements, with simplified terms and conditions, which will:
  - form the basis of all reporting requirements. Multiple activity schedules are able to be appended. Organisations will no longer need to re-negotiate agreement conditions for each project; and
  - improve financial management for both the funding recipients and the Department.
- Some payments to fund-holders will be automatically released using recipient created tax invoices (RCTI) through the FoFMs system (subject to risk assessment) while others will be subject to milestone confirmation.

- The creation and use of RCTIs mean funding recipients will often no longer need to provide invoices to the Department, saving time and money and allowing service providers to concentrate on core business.
- There will be less onerous audit conditions for most funding agreements, subject to a risk assessment process, while retaining the ability to target activities more specifically in agreement schedules.
- Once fully implemented, funding recipients will have one agreement with the Department and one point of contact for all funding agreement activities. This departmental relationship manager will seek advice from and coordinate information flow between any areas of the Department that provide funding to that recipient. The relationship manager will be located in either a state or territory office or Central office, as required.
- New agreements will move towards multi-year funding to provide funding certainty for stakeholders and funding recipients. This aspect will commence once the current review recommendations have been considered.

The Department states that all facets of its National Alignment program are being closely monitored and external reporting mechanisms are in place to ensure that the benefits to stakeholders, in terms of reduced red tape, streamlined reporting and appropriate risk management strategies are implemented. The anticipated outcomes of this process in relation to grants management reform currently underway are closely aligned with the eight priority action areas identified in the National Compact described in the background section above. The Department's view is that there are ongoing monitoring and reporting mechanisms to ensure the expected benefits of both the DoHA National Alignment and the National Compact flow to all stakeholders.

Advice from stakeholders in the course of the review was mixed as to whether the benefits of contract reform were yet seen to be occurring; and this is understandable given that key initiatives will only roll out in the next calendar year as explained above. It is true that some very experienced and senior stakeholders commented favourably on the efficiency and responsiveness of DoHA funding arrangements (sometimes in the context of highly unfavourable comments about funding practices within other related agencies, including state and territory health departments). However, other stakeholders continue to encounter unnecessary levels of compliance-based reporting, a lack of communication between different divisions of DoHA and what they experience as the imposition of unreasonable contractual conditions under tight deadlines.

Understandably, funded agencies frequently feel reluctant to raise such criticisms openly. The current reform process needs to be monitored and reported to senior management so that views can be sought from relevant peak bodies about the experience "on the ground" for funded agencies. Ideally, funding moves away from multiple process-oriented reports, gathering information which in the experience of funded agencies does not seem to be used or collated to inform policy development. In the same way, the Department itself needs outcome-based performance measures so that it is held to account for delivering measurable reductions in reporting and administrative costs.



### Health workforce programs - Health Workforce Fund and the future

In the course of this review, the need for some specific actions in managing health workforce programs in addition to the broader departmental agenda have been identified, as there are a number of instances where inconsistencies and/or duplication of effort have been identified. These include a range of short and long-term funding periods, often based on historical arrangements, rather than current requirements, and that workforce activities are dispersed over a number of divisions within the Department as well as in other portfolio agencies.

There is strong evidence of siloed behaviour, with particular policy areas appearing to act in isolation from each other, perhaps inevitable in such a large and complex department.

An approach to health workforce that is concentrated in a limited number of areas within the portfolio makes sense, as despite the need for profession relevant involvement all health service provision requires an appropriately trained and distributed workforce.

This is more effectively and efficiently managed in areas that are able to take a whole-of-sector or global approach to identifying issues, trends and opportunities in developing policy related to workforce programs and in guiding the implementation of these programs.

Scholarship schemes, rural and remote practice, peer support or continuing education issues, to name a few, are not profession-specific activities, yet current program and funding levels indicate that divisions and agencies within the health portfolio run separate activities to manage these same issues. Additionally, many of these areas then run similar activities for different sectors of the workforce, such as aged care, acute care, or primary care. (Note that scholarship programs, and their administrative arrangements, have been discussed in detail in Chapter 3 of this review.)

While the separation of similar activities may or may not be appropriate, it makes sense to consider a range of options for amalgamating, streamlining, redirecting, or ceasing activities across the portfolio. This will assist in ensuring that limited financial and human resources within the health sector are effectively utilised.

Any program consolidation will need to be implemented in collaboration with other divisions. It will be important to ensure that workforce outcomes in particular areas such as aged care and Aboriginal and Torres Strait Islander workforces are enhanced rather than impeded by any changes in these areas. Portfolio Ministers in these areas will need to be closely involved in any changes to approach.

### More effectively integrated policy development

The issue of new policy proposals related to specific activities that target a particular behaviour or disease group, such as drug and alcohol officers or healthy lifestyle and anti-smoking officers, was raised by a number of stakeholders during the consultation process. Funding for new workforce roles may conflict with existing arrangements and policy settings and can have unintended outcomes. They may fragment both holistic patient-centred care provision and limit the generalist workforce available to provide services to these targeted groups, due to outcome funding arrangements related to the specific disease group.

There is merit in developing a formal method to ensure that for new policy proposals or any activity streamlining and amalgamating programs, that an internal health workforce impact statement/check sheet be developed and implemented through collaboration between HWD and any affected divisions. This would ensure that appropriate areas within the Department have considered/noted potential workforce impacts and provided advice on options that would ensure an adequate workforce is available to implement the service delivery aspects of any new policy proposals, and that broader workforce impacts of new policy are considered.

In addition to internal departmental processes, health workforce activities are undertaken by a number of portfolio agencies, including HWA, and other Commonwealth agencies such as the Department of Human Services. Specific issues concerning the need for coordination between HWA and DoHA are discussed elsewhere.

A number of other Commonwealth Government Departments have a role in health workforce related activities including information collection and providing input into Australian Government policy positions. These include the Department of Immigration and Citizenship, the Australian Bureau of Statistics, the Australian Institute of Health and Welfare, the Department of Industry, Innovation, Climate Change, Science, Research and Tertiary Education (DIICCSRTE), the Department of Education, Employment and Workplace Relations, as well as the Department of Regional Australia, Local Government and Sport.

There are many very complex issues to be considered in planning for a future health workforce to ensure that the workforce is capable, well qualified and well distributed. These issues include the complexity and diversity within the health and education sectors that must combine to provide the necessary education and training of our health professionals. The geographic disbursement of the Australian population also impacts the various locations and specialty areas in which health professionals provide services and may inhibit equity of access to service by some more remote communities. Careful consideration of how the limited Commonwealth financial resources are allocated is required.

### Program evaluation and risk assessment

During the course of this review, a large number of programs were identified which are more than a decade old and had been established without any evaluation framework or meaningful performance measures. Some of these programs have never been evaluated in a meaningful sense. Others have been established relatively recently.

As part of the implementation of all flexible funds and grant reform processes, central agencies (Department of the Prime Minister and Cabinet and the Department of Finance and Deregulation) have required DoHA to develop and seek approval for strategic management plans and risk assessment plans for all 18 flexible funds, including the HWF.

The HWF strategic plan incorporates an evaluation strategy and is required to be updated and approved by the Minister annually. The HWF risk assessment documents are also required to be reviewed and updated annually in conjunction with the strategic plan.

While the HWF as a whole has evaluation and risk assessment process and procedures in place, the review team has identified that not all individual activities under the fund are in a similar position. There is no overarching evaluation strategy for evaluating the individual health workforce programs. The review has identified and considered a number of internal reviews and external evaluations that have been conducted for various programs, program components and broader initiatives within HWD. Often evaluation has been hampered by the lack of clear measures or objectives put in place when the program was established. It is imperative that all programs and funding activity areas are able to demonstrate measurable outcomes that are achieving the policy intent of the funding supplied.

In some cases, individual programs which have been evaluated have later been consolidated into a single, more streamlined platform, particularly for those consolidated programs that were established following the Department's broad rural program review prior to the 2009-10 Budget. For the most part, these are relatively recent consolidations and the new larger programs have not yet been subject to review or evaluation. Some program reviews have been conducted by the external administrators of the program as part of the conditions of their funding agreement while others have been commissioned directly by the Department.

The review has identified that approximately 50% of the overall number of programs and initiatives managed by HWD have benefited from a formal evaluation process (either internal or external) in the period since 2005. This excludes at least four major "lapsing program" reviews that were undertaken in the 2003 to 2005 period, which are subject to "Budget-in-confidence" rules and were subsequently not released to stakeholder groups and could not be considered in this review process.<sup>199</sup> Programs that are still in their implementation phase also tend to distort the evaluation compliance figure to some extent and mention has been made earlier of some of the medical workforce programs in particular, which require a decade or more of operation before meaningful data is likely to be available. Nevertheless, it is safe to say that at least a third of established health workforce program activity areas have not been evaluated, which is of some concern.

Given this situation, it is recommended that a comprehensive evaluation strategy should be developed for the different health workforce program activity areas to complement the broader evaluation strategy that now applies to the HWF. In addition to developing a strategy and clear timeline for the evaluation of component initiatives, there should be considerable effort put into developing key performance indicators and evaluation reporting requirements as part of any funding arrangements, so governments can make informed decisions based on quantifiable data when allocating scarce resources, to achieved improved health workforce outcomes. These evaluation and risk assessment activities need to be compliant with the broader reform agenda within DoHA and the Australian Government.

The situation with risk management compliance is more positive. As mentioned above, a broad risk management plan is in place for the HWF and there are processes to ensure this is updated regularly. Internal risk management processes have been complemented by Australian National Audit Office scrutiny of major

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<sup>199</sup> Lapsing program reviews involved considering a program in a Budget context at the end of a four year funding cycle, prior to the government of the day making a decision on renewing funding.

programs (such as the AGPT) as well as internal audits carried out by the Department's Audit and Fraud Control Branch at regular intervals.

The review has identified some program and activity areas where risk management practices could be improved. While at least 70% of HWD program areas have detailed risk management plans in place, which are updated regularly for each program funding agreement, compliance with best practice needs to be improved at the detailed program level. There are instances where older program agreements do not appear to comply with standard risk management practices.

It is suggested that a comprehensive assessment of risk management compliance (at the program and funding agreement level) across health workforce programs should be undertaken following this review. However, any such review needs to be aimed primarily at driving out internal DoHA inefficiencies, and undertaken within the context of the broader reforms to contracting practices within the Department to ensure that there is no increase in onerous and unnecessary compliance and regulatory costs, particularly for contracted agencies.

### *Recommendations*

<b>Recommendation</b>	<b>Affected programs</b>	<b>Timeframe</b>
<p><b>Recommendation 9.1:</b> The Health Workforce Division (HWD) should continue to implement the whole-of-department reforms to grants management, with a view to improving consistency of funding arrangements and achieving measurable reductions in compliance-based reporting and unnecessary focus on process rather than results. Regular feedback should be sought from peak groups as to whether the reform process is in fact achieving a reduction in red tape and administrative cost for funded agencies.</p> <p>As part of this process, it will be important to:</p> <ul style="list-style-type: none"> <li>• Establish a consistent approach to developing funding agreements, particularly in terms of detailing the key activities for each project/program. This process needs to focus on clearly defining activities while reducing the reporting burden for stakeholders.</li> <li>• Ensure outcomes measures and reporting requirements are based on a set of easily identifiable and measureable key performance indicators.</li> </ul>	All Health Workforce Fund Programs	Short term – ongoing grants management reform.

Recommendation	Affected programs	Timeframe
<ul style="list-style-type: none"> <li>• Wherever possible, align funding agreement periods within the Health Workforce Fund (HWF) to reduce the need for organisations to continually engage in multiple funding processes with different program areas;</li> <li>• Attempt to integrate the current multiple funding streams across HWD and other Divisions. This may need to involve further consolidation of funding appropriations within the most appropriate flexible fund.</li> </ul>		
<p><b>Recommendation 9.2:</b> Divisions within the Department should closely examine linkages in their health workforce programs and implement measures to reduce or remove duplication or overlap within their current programs.</p> <p>To help ensure this occurs effectively, consideration should be given to establishing a formal and regular communication system between key divisions involved in health workforce programs.</p>	All	Short term and ongoing
<p><b>Recommendation 9.3:</b> In the development of new policy proposals, the department should give specific consideration to health workforce impacts, potentially through the preparation of new internal health workforce impact statements.</p>	Policy development	Medium term – ideally to commence for the 2014 Budget process and beyond.
<p><b>Recommendation 9.4:</b> A comprehensive evaluation strategy should be developed for the various health workforce programs and activity areas. This should be designed to ensure consistency with the broader evaluation framework of the HWF and be applied consistently across all funding activities. In particular, new programs should not be rolled out without an outcome-based evaluation framework.</p>	HWF and health workforce programs outside the fund	Short/medium term – post-review work to commence in 2013-14.
<p><b>Recommendation 9.5:</b> A comprehensive assessment of internal DoHA risk management compliance across all health workforce program activity areas should be undertaken following this review. In</p>	HWF	Short/medium term – post-review work to commence in

Recommendation	Affected programs	Timeframe
addition to the broader risk management plan for the HWF, component initiatives should have risk management plans in place and update them consistently. Any such review needs to be undertaken within the context of the broader reforms to contracting practices within the department.		2013-14.

## ***9.2 Health Workforce Australia and Health Workforce Division: roles, responsibilities and options for reform***

The system and interrelationships between the broad range of stakeholders involved in health workforce training, policy development and health service delivery is notoriously complex. When, as the result of a tranche of health reform, new authorities, agencies and administrative units are created, it can be important over time to take the opportunity to clarify or rationalise relationships with existing agencies.

For this reason, it is timely for this review to attempt to make some contribution toward mapping out the existing roles and responsibilities in the arena of health workforce between DoHA – in particular, HWD – and HWA, bearing in mind, as outlined below, that further broad reviews of activity in this issue may occur in the future.

### **Health Workforce Division, Department of Health and Ageing**

The Department provides the Australian Government, through the Minister, with policy advice and implements programs to address workforce capacity, supply and training needs in the medical, nursing, dental, allied and Indigenous workforce sectors. DoHA also supports the implementation of Council of Australian Government (COAG) projects including a nationally consistent assessment process for international medical graduates, health workforce reforms under the National Health and Hospital Reform Partnership Agreement and the National Registration and Accreditation Scheme.

HWD, as is detailed in earlier chapters, administers a range of programs specifically targeting workforce in medicine, nursing, dental, allied health and Aboriginal and Torres Strait Islander health. These activities include, but are not limited to, scholarship programs, training programs targeting distribution in rural areas or specific health professions, rural incentive programs, and the development of new workforce groups such as Aboriginal and Torres Strait Islander outreach workers.

While HWD has responsibility for the majority of workforce programs, other areas of DoHA, such as mental health and aged care, also have workforce programs. This presents some challenges, both within the Department and externally, in obtaining a coherent workforce response.

In addition, the Department has had oversight of implementation of key commitments under the 29 November 2008 COAG agreement on Hospital and Health Workforce Reform, for example, increasing the number of vocational training places under the



AGPT and STP programs, establishing HWA and managing the transition of funding and functions and associated investment in infrastructure to expand the capacity to train more entry-level health students.

### *Recent changes*

In 2011, HWD acquired many of the workforce distribution arrangements, particularly those focused on rural general practice services including the Overseas Trained Doctor (s. 19AB and s. 3GA) programs, General Practice Rural Incentives Program (GPRIP), and GP procedural grant initiatives. This was to enhance the Division's capacity to provide more complete advice on distributional pressures in workforce.

The Division also established a policy branch that provides a strategic overview of 'workforce' rather than the current split by professional fields. The policy branch is also the main point of liaison with HWA.

### Health Workforce Australia

On 29 November 2008, COAG announced its \$1.6 billion health workforce reform package.<sup>200</sup> At that time, the Commonwealth committed \$1.1 billion, with the states and territories committing to \$540 million in funding. A component of the reform package was the establishment of HWA.

The Australian Government, through the Department, provides funding for HWA through a funding agreement totalling \$781 million over four years. The National Partnership Agreement (NPA) which governs the allocation of funding to HWA is scheduled to expire at the end of June 2013. HWA activities are outlined at Schedule B of the NPA. A broad review of the overarching NPA is planned and would include some consideration of the delivery of HWA's key activities specified in Schedule B, as described further below.

States and territories have not provided funding directly to HWA.<sup>201</sup> The Department has advised that these jurisdictions indicated subsequent to the 2008 COAG agreement that they would provide their \$540 million contribution to HWA's broad objectives through in-kind arrangements related to historical clinical training provided to undergraduate students through the public hospital system.

HWA was established to manage the majority of initiatives announced as part of the 2008 COAG commitment to health workforce. HWA's explicit charter is to operate across educational and health sectors and jurisdictional responsibilities to develop national, integrated solutions to workforce planning and policy in support of health reform. Seventy per cent of HWA's total allocation (\$547 million over four years) is to deliver a range of programs that aim to expand capacity in undergraduate clinical training and supervision across all health sectors, including simulated learning environments. Box 9.1 describes the key programs delivered by HWA.

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<sup>200</sup> COAG, [The National Partnership Agreement on Hospital and Health Workforce Reform](http://www.coag.gov.au/node/337), 2009 accessed at <http://www.coag.gov.au/node/337>

<sup>201</sup> The HWA Annual report 2011-12 does not show any income from outside the Australian Government, see Page 69.

### Box 9.1: Health Workforce Australia key programs

#### *Clinical Training Subsidy – Undergraduate*

Increased funding for undergraduate clinical training in medicine, nursing, allied health and dental training. The new funding to complement existing funding provided by states and territories for clinical training and, for some professions, Commonwealth HECS funding.

#### *Clinical Training Supervision*

HWA provides funding for clinical supervision capacity and competence assessment for undergraduate health training. This is critical to clinical training models and the safety and quality of competent supervisors within the health system.

#### *Clinical Training Simulated Learning Environments*

Optimising clinical training through the use of technology to develop clinical skills and competencies required by health professionals, increase the capacity of the health system to provide clinical training. This will include building or improving simulated learning environments, with a focus being on accessibility to regional and rural centres.

#### *International Recruitment Program (responsibility transferred from HWD May 2010)*

Consolidating jurisdictional international recruitment programs into a single program covering all professions to improve the capacity of Australia's health workforce. This will reduce infrastructure and operational costs and allow more resources to be spent on recruitment strategies. Elements of the program include facilitating employment and training opportunities, assistance to meet registration requirements and overseas recruitment campaigns.

#### *Workforce Redesign Funding*

Developing workforce redesign and reform strategies to improve the efficiency and effectiveness of the health workforce. This involves designing and implementing a range of strategies with and across all jurisdictions including 12 to 24 month pilot projects; evaluation of workforce models to ensure quality, safety, efficiency and effectiveness; training of health workers to support new projects and enhance practice capabilities; examination of existing barriers with the focus on advising Health Ministers on recommended changes; and promoting and facilitating rollout of successful workforce projects nationally.

#### *National workforce planning statistical database*

Effective planning of health workforce requirements through a National Health Workforce Statistical Resource (based on data from the National Registration and Accreditation Scheme).

The establishment of HWA provides the ability to significantly expand complementary activity in workforce that draws on the best available evidence, state and territory arrangements and improved workforce planning. Much of this reform activity is likely to take place in areas likely to be highly contested, either between states and territories (due to their differing service platforms – for example the rural generalist model which exists in QLD but not in all other states at this time) or by professional and industrial organisations where new professions or scopes of practice are proposed (such as nurse endoscopists).

### *Governance*

HWA has a complex governance structure requiring it to report to all Health Ministers. The CEO of HWA reports to the board consisting of a chair, three independent members and nominees from all jurisdictions. Following approval of the board, HWA then seeks approval from all Health Ministers through the Standing Council on Health for major pieces of work, resulting in a cumbersome and slow process.

Arguably, there has been an element of drift from the original concept of HWA as a joint Commonwealth/state (national) agency where jurisdictions partner to lead reform, improve national workforce planning, facilitate innovation and increase clinical training capacity. This concept was enshrined in legislation and forms the basis of the COAG fund allocation. Some possible options for future governance arrangements are outlined below.

Stakeholder feedback in the course of this review was not specifically sought on the role and function of the HWA, or on the outcomes generated by its specific funding activities. However, where stakeholders have commented on the impact of HWA involvement in particular programs or policy areas, this has been appropriately reflected in the body of the report.

Following the expiry of the NPA at the end of June 2013 it will be timely to reassess both the governance structure of HWA and the broad achievements of HWA's programs in addressing Australia's emerging health workforce issues.

If changes are contemplated possible options would be to amend the board membership so that it is comprised of skills-based representatives, removing the jurisdictional nominees, or making HWA a portfolio agency of the Commonwealth Health Minister. Removal of jurisdictional representatives from the board, however, may affect the ability to influence national, long-term health workforce reform, making HWA effectively a Commonwealth agency.

### **Relationship of HWD and HWA**

During 2009 and 2010, advice is that the relationship was in transition as HWA was being established. HWD was responsible for ensuring HWA was established including funding arrangements and in some circumstances functions, such as the International Recruitment Program, where the Commonwealth had started activities under the NPA.

From 2010, once HWA's work plan was well developed and in the implementation phase, and in particular with the commencement of rollout of funding, there has clearly been increased potential for demarcation issues to arise between the agency and the department.

HWA is an independent agency responsible for the delivery of a number of projects under the NPA, on behalf of COAG, and other items as directed by Health Ministers. HWA is limited to this function by its legislation.

The Department's role is to provide advice to the Australian Government and the Minister for Health and Ageing. The Department also directly funds a number of specific workforce programs (as above). Given that jurisdictions do not provide funding directly to HWA (despite what was originally envisaged in the model) there is an understandable imperative for the Commonwealth to seek greater involvement in HWA activities. The expenditure of Commonwealth funds is involved, and the

delivery of Commonwealth policy outcomes is to an extent contingent upon appropriate targeting of these funds.

There is no legislative or other basis for the Minister or her Department to seek to direct HWA in its operations. Its operational accountability is to its board.

It is clear that this issue has resulted at times in some tensions between relevant sections of DoHA and HWA. This, in itself, although no doubt at times irritating for those involved in both organisations, would be insufficient grounds to consider large scale structural or governance reform. The real question for future consideration will be whether the current structural arrangements facilitate or impede the delivery of good policy and operational outcomes in ensuring that Australia has a health workforce which is well qualified, capable and flexible to meet the needs of Australian communities.

### Future directions

A number of factors will assist Government in making decisions around the function of HWA and that of HWD.

### Reviews

- The outputs and outcomes of the NPA through which HWA was established will be reviewed in coming months. This broad-based review will include some consideration of Schedule B (Workforce Enablers), which includes the establishment of a National Workforce Agency (now HWA), increased funding for clinical training across the health disciplines, funding to develop supervision capacity, consolidated international recruitment, workforce redesign strategies and support for the development of simulated learning environments. In addition to these HWA functions, the NPA review will entail consideration of Commonwealth investments in postgraduate medical training linked to increasing medical school places (as discussed in earlier chapters).
- The Productivity Commission has identified its intention to undertake a follow-up inquiry to its 2006 report on Australia's Health Workforce. If this inquiry proceeds in the medium term it is likely to include the key areas of productivity improvements, geographic and professional distribution, workforce attraction and retention, and the efficiency and effectiveness of clinical training. This inquiry has the potential to highlight issues within the health workforce and provide recommendations for reform which will likely impact on the programs of the two organisations.

As already mentioned, this current review of Commonwealth health workforce programs has not been designed to include a specific analysis of each of HWA's activity areas, or duplicate the broader consideration of the overarching NPA review. However, it is inevitable that this review process has identified some factors which impinge upon HWA and its work.

Given the substantial investment by the Commonwealth in HWA's activities it would be sensible to consider a further independent evaluation process that would more closely scrutinise the delivery of key HWA functions and assess their impact in terms of efficiency, effectiveness and integration with other health workforce measures.

*Clinical training funding: the role of jurisdictions and HWA programs.*

This program has provided funding to tertiary education institutions, jurisdictions and the private sector to support the growth in clinical placements required to meet the increase in undergraduate health students. Currently, it is not clear if jurisdictions have increased or decreased funding in this area. However there is contention between the tertiary institutions and the jurisdictions about this funding. The funding provided by HWA may be used to 'top up' jurisdictional funding and therefore the Commonwealth may be funding activities that have historically been jurisdictional responsibilities. As there appear to be few clear deliverables related to this funding stream except for reporting of additional clinical placements, it is hard to track the expenditure and outputs. Possible future changes to be considered may include:

- HWA loses the function and the additional Commonwealth clinical training could be managed via the Department or could be included on base funding paid to training institutions through DIICCS RTE; or
- HWA maintains the function with possible amendments to ensure adequate Commonwealth visibility of the expenditure of Commonwealth funds; a national approach to managing funding of training in the public health sector through the Independent Hospital Pricing Authority is being developed for implementation in 2018. This option would develop a price on clinical training and identify funding sources and responsibilities.
- Modification of the HWA governance structure, noting that the NPA is scheduled to expire on 30 June 2013.

With the Commonwealth being the only direct funder there is certainly a case to argue for another structure which would allow greater Commonwealth influence of HWA/workforce initiatives and at the same time allow the agency to be in a position where it can provide more innovative and bold leadership in reform.

*Amendment to HWA's operation*

There are three broad changes that could be made to HWA's operation that could be considered by Government in the context of the NPA review.

**1. HWA operations remain the same.**

HWA's current arrangements continue with HWA having responsibility for both program and policy development. Following the expiry of the NPA Health Ministers and the board would provide strategic oversight and direction setting for HWA's work. However, the current governance arrangements have created a number of issues during HWA's operation. The requirement to report to all Health Ministers has resulted in a cumbersome process requiring HWA to report to a variety of 'masters'. This is despite HWA being fully funded from the Commonwealth.

**2. HWA becomes a 'think tank' and does not manage programs.**

HWA's programs could be managed by the Department which would enable HWA to focus on its data analysis and policy development work. This would enable HWA to be more innovative and bold in its approach to workforce reform, having more time to focus on the emerging issues. This is the aspect of HWA's work which has been most highly valued and validated by stakeholders in the course of this review, and it would justify investment of time and resources.

Under this option HWA would retain a budget for innovation and reform; to support innovative 'pilot' approaches which may be, if successful, applied more broadly



through DoHA program funding. In this option, the best approach would be to remove HWA's program delivery as there could potentially be conflicts with HWA setting the policy and then setting funding priorities without having a transparent, open process.

HWA programs could be returned and managed by the Department, for example the Clinical Training Subsidy, or (preferably, for stakeholder management reasons) be funded by the Commonwealth through other organisations, for example funding Rural Health Workforce Australia (RHWA) to manage the International Health Professionals Program or delivering other funding via the Rural Clinical Schools. This would reduce some of the overlap and confusion currently created, for example, by the fact that both HWA and RHWA undertake overseas recruitment of medical practitioners.

### 3. HWA takes over the management of selected DoHA programs

A contrasting argument would be that now HWA is more established, it could take over responsibility for the management of a number of DoHA programs to ensure synergies in program management and policy and presumably some efficiencies.

There are a number of programs (described in earlier chapters) that could be transitioned between the two organisations. For example, the HWA Clinical Training Program and HWD's Rural Clinical Training and Support (RCTS) program could be combined and refocused to rural-specific initiatives. This would ensure continuity and reduce duplication of funding to universities. It would also assist in attracting and retaining students to rural areas. It may be timely to mention here the Integrated Regional Clinical Training Networks funded by HWA which have been singled out by Medical Deans, among others, during review consultations as being particularly valuable.

The Specialist Training Program (STP) is another program that could transfer to HWA with potentially minimal impact on participants. STP is a Commonwealth-funded initiative targeted to specific priorities (agreed by the Minister for Health) which are updated annually. STP funds specialist training in areas where the states are not funding posts, mostly in the rural and private sectors.

It should be noted, however, that the RCTS program and STP are part of the HWF. The Minister, as the decision maker, currently has the flexibility to utilise funding to meet arising priorities. This capacity would be lost if programs currently managed by HWD were to transfer to HWA. Also, the transfer of programs moved from the Department to HWA would need to be subject to reform of the current HWA governance arrangements already mentioned.

### Stakeholder views

It is worthy of note at this point that in the course of this review, while many stakeholders praised the data and policy work of HWA, and particular innovative funding projects, there were critical comments about the general capacity of HWA to deliver funding. Mention was made of an extremely onerous compliance based contracting model, and in particular there was criticism of the way in which growth funding for medical places had been delivered.

No response has been sought from HWA as part of this review so it is unclear whether these issues with funding and contracts are inherent in the governance



structure of HWA or the inevitable issues encountered when establishing a new agency.

### *Recommendations*

Recommendations	Affected programs	Timeframe
<p><b>Recommendation 9.6:</b> This review has identified legitimate stakeholder concerns about the lack of clarity defining the respective roles of Health Workforce Australia and DoHA, as well as inconsistencies in the delivery of Commonwealth funding between the two agencies. It is likely that current arrangements are less than optimal.</p> <p>This issue needs to be addressed to ensure the Commonwealth gains the best value from its investment in HWA and departmental programs.</p> <p>Issues raised in the course of this review may inform the forthcoming overarching review of the National Partnership Agreement on Hospital and Health Workforce Reform (NPA), which will include consideration of Schedule B of the NPA and those items relating to HWA functions.</p> <p>There are three broad changes that should be considered by the Commonwealth in this area:</p> <p><i>Option 1 – HWA becomes a specialist data and policy agency ‘think tank’ and does not manage mature programs</i></p> <p>HWA’s programs could be managed by the Department which would enable HWA to focus on its data analysis and policy development work. HWA would retain a budget for innovation and reform; to support ‘pilot approaches’ which may be, if successful, applied more broadly through DoHA program funding.</p> <p><i>Option 2 – HWA takes over the management of selected DoHA programs</i></p> <p>HWA could take over responsibility for the management of a number of DoHA programs to ensure synergies in program</p>	Health workforce training programs and HWA funding programs.	Longer term – reform would need to be pursued on the expiry of current long-term funding agreements and be linked to the completion of structural reviews of both HWA and the larger health workforce environment.

Recommendations	Affected programs	Timeframe
<p>management and policy. Examples include the consolidation of HWA Clinical Training Program and HWA's Rural Clinical Training and Support program; and the transfer of the Specialist Training Program.</p> <p>In the event that the overarching NPA review does not provide sufficient analysis to inform these options, it may be necessary to undertake a specific independent analysis of HWA's activities and governance arrangements, building on information gathered in the course of this review and in the NPA process to inform future directions for the national health workforce agency.</p> <p><i>Option 3 – HWA operations remain the same</i></p> <p>HWA's current arrangements continue with HWA having responsibility for both program and policy development.</p> <p>However, if this 'status quo' option is pursued, at a minimum, the roles and responsibilities of both agencies will need to be clarified for the benefit of stakeholders and more effective communication channels need to be established at the program management level to enhance collaboration.</p>		

### 9.3 Health workforce data

The capacity of the Commonwealth to respond effectively to current and emerging health workforce needs is significantly enhanced by access to appropriate, reliable and up-to-date health workforce data. The national data collections available are described in Box 9.2.

DoHA has reported some concerns with the current data sharing arrangements between the agencies involved in the production and analysis of health labour force surveys, stemming from a change in the contracting arrangements.

Prior to the introduction of the National Registration and Accreditation Scheme (NRAS), DoHA funded the Australian Institute of Health and Welfare (AIHW) to compile and report on data collected through voluntary surveys of health professionals undertaken in conjunction with state/territory registration processes. Following the introduction of NRAS, HWA assumed responsibility for the funding

arrangements with AIHW, with data exchange protocols formalised under a Memorandum of Understanding between HWA, AIHW and AHPRA.

This has created some difficulty for DoHA in gaining early access to new data releases, and in undertaking the informal quality assurance and analysis function it had previously engaged in. These appear to be transitional issues that could be managed with the maintenance of communication and relationships between the Department, HWA and AIHW. Note that these issues were also raised earlier in Chapter 3.

#### Box 9.2: health workforce data collections

##### *National Health Workforce Data Set (NHWDS)*

Mandatory registration data are collected under the NRAS when health practitioners apply for initial registration and annual renewal of their registration. Data collected at initial registration includes demographic information such as age, sex, country of birth; and details of health qualification(s) and registration information such as status and type. The Australian Health Practitioner Regulation Agency (AHPRA) publishes summary registration data quarterly on their internet site as well as in its Annual Report.

When health practitioners renew their registration they are also asked to complete a voluntary Workforce Survey. The questionnaire collects information on the employment characteristics, primary work location and work activity of the practitioner. The response rate for these surveys since being undertaken by AHPRA have been high: 85% for the 2011 Medical workforce survey, 86% for the 2011 nursing and midwifery workforce survey and 73% for the 2011 dental workforce survey.

AHPRA, on behalf of the National Boards, submits the de-identified registration and workforce survey data to AIHW at designated times each year following the annual registration renewal process. The AIHW merges the two datasets into a de-identified national data set then undertakes cleansing and adjustment for non-response in preparation for submission to the NHWDS.

##### *Australian Bureau of Statistics (ABS) - Census of Population and Housing*

The ABS Census of Population and Housing (Census) data provides information which can be used to establish the size and distribution of the entire health workforce and the number of Aboriginal and Torres Strait Islander people working in the health sector, including the occupations in which they are specifically employed.

The Census is conducted by the ABS every five years in August. The Census data is available in a range of formats from free basic tables accessible online to charged products such as customised flat files and large Unit Record Files requiring organisational micro-data access. Data collected on occupation are coded using the Australian and New Zealand Standard Classification of Occupations (ANZSCO). However to get a more precise estimate of health workforce size, Census data needs to be interrogated down to the six digit ANZSCO code level. This data is not available on line and must be purchased from the ABS. Also, there may need to be consideration of exactly which occupations are categorised as health occupations, rather than for example welfare or community services occupations. This analysis was undertaken by AIHW in 2009 (and for previous Censuses) and published in the *Health and Community Services Labour Force, 2006* report. Initial discussions with HWA indicate that they will be undertaking a similar project on 2011 Census data in the future.

Geographical distribution of the health workforce can be analysed in terms of the person's place of usual residence, place of remuneration and place of work. Geographical information is available based

on ABS geographies (ASGS – Mesh block, SA1, SA2, SA3, SA4) and some non-ABS geographies (i.e. LGA, destination zone).

Additionally, information on health sector qualifications is available and may highlight where people with health sector qualifications are not employed, or employed outside of the health sector.

### *Medicare Benefits Scheme (MBS) Claims data set*

MBS data is used to calculate GP workforce statistics by counting providers who rendered services under Medicare. These figures are used in publications such as the Report on Government Services (RoGS) and are published on the DoHA internet site.

The MBS is managed and funded by DoHA and administered by the Department of Human Services (DHS). Through the process of administering the scheme, DHS captures information on Medicare benefits payable for services (items) listed in the MBS provided by practitioners with a Medicare provider number. This data is transmitted to DoHA.

### *Visa data - Department of Immigration and Citizenship (DIAC)*

Visa data is used for information about the overseas supply of health practitioners.

DIAC collects administrative data about the number of permanent and temporary visa grants and visa holders in Australia. There are a number of temporary visa options available for health practitioners.

DIAC visa information is available in the form of statistical publications and temporary entrance statistics tables (annual and quarterly stock data). The Department receives a regular medical workforce report but can also request specific information on an ad hoc basis if necessary.

### *Medical Training Review Panel Report*

Medical training information is sourced from the annual Medical Training Review Panel (MTRP) Report. It includes information on all trainees in undergraduate, postgraduate and vocational training programs compiled from various data sources including:

- Undergraduate medical students data from the Student Statistics Collection (annual) and the Medical Schools Outcomes Database (MSOD) (longitudinal) supplied by Medical Deans Australia and New Zealand Inc (MDANZ).
- First (internship) and second years of prevocational training data supplied by state and territory health departments.
- Vocational training data (doctors specialist training) provided by each of the specialist medical colleges.
- General practice training (trainee) data provided by General Practice Education and Training Limited (GPET), the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM).
- Assessment and accreditation data provided by the Australian Medical Council (AMC).

### *Higher Education Statistics Collections*

Nursing and midwifery, dental and clinical psychology training data can be sourced from the Higher Education Statistics Collection.

The Higher Education Group of DIICCSRTE, with the cooperation of the ABS, is responsible for the collection and dissemination of statistics relating to the provision of higher education in all Australian universities.

DIICCS RTE collects data from higher education providers to determine support for providers that are eligible for Australian government grants. This data is reported by all higher education providers that have been approved under the *Higher Education Support Act 2003*.

DIICCS RTE, through its Statistics Unit, disseminates data from the collections through statistical publications, datasets, tabulations, extracts and analyses prepared for clients.

### *Health Workforce 2025*

HWA has provided long-term projections for Australia's national doctor, nurse and midwife workforce to the year 2025 in the report *Health Workforce 2025 – Doctors, Nurses and Midwives*. This project included supply and demand data modelling to examine future workforce needs under a range of planning scenarios including immigration levels, productivity, workforce retention and training.

Volumes 1 and 2 of the report broadly deal with doctor and nurse/midwife numbers while Volume 3 examines 27 individual medical specialties. Results (supply, demand, excess/shortfall) are presented under different scenarios by specialty/area of practice and geography (state/territory and Remoteness Area).

In the next phase of HW2025, seven professions have been identified for inclusion in *HW2025 – Allied and Other Health Professions* (dietitians, psychologists, nursing support and personal care workers, physiotherapists, podiatrists, pharmacists, optometrists). HWA will be undertaking a similar project for Australia's oral health workforce.

The modelling and projections will be updated and refined on an ongoing basis as advancements occur. This includes inputs as better data and information about assumptions become available as well as innovative analysis techniques to improve modelling and outputs.

Other issues relating to the adequacy of data collection and analysis were raised during the course of this review. As discussed in Chapter 8, allied health professional groups expressed a sense of grievance that the need for coherent data for their sector had not yet been addressed, particularly with respect to the professions not covered by NRAS. Allied health stakeholders were keen to assert the urgency of remedying the current gap in the interests of coherent planning. The next phase of HWA's work for HW2025 may go some way towards addressing this. Data quality issues with respect to the Aboriginal and Torres Strait Islander health workforce have also been identified, as noted in Chapter 5.

The analysis of programs undertaken as part of this review has highlighted the difficulty in assessing the impact of individual initiatives towards addressing particular health workforce problems, for example, improving access in rural areas. Improvement in the collection of program-level data, along with better linkages between program-level data and broader health workforce data (for example, MBS billing data or registration data), could provide a more robust evidence base for establishing the success or otherwise of particular programs against the department's health workforce priorities.

This review has also revealed some challenges in the sharing of data between organisations, which could be impeding some program outcomes. It has been suggested that overly prescriptive interpretations of the *Privacy Act 1988* have been used by some organisations to avoid sharing even de-identified participation data that could be of great benefit to inform policy development and program delivery. Improving the understanding of privacy issues could assist the various funded groups to be more collaborative and develop better linkages within programs.

Privacy requirements need to be consistently met during program delivery, but options for obtaining informed consent for the release of participant data need to be explored where possible to help analyse the success of what are complex and inter-connected programs and initiatives.

While national health workforce planning has been a focus of cross-jurisdictional attention since 1995 through a number of advisory bodies reporting to the Australian Health Ministers' Conference (now the Standing Council on Health), the development of HW2025 as an ongoing national health workforce planning tool is a major step forward in establishing the evidence base for making policy and program-level decisions regarding the supply and distribution of the health workforce.

The past history of health workforce planning is littered with examples of expensive errors based on inadequate data or fallacious assumptions. For this reason most stakeholders have welcomed the work of the HWA and would urge continued investment in the data and high level policy aspect of its work. Clearly, however, the statistical and analytical basis of these predictive models will need to continue to be refined if major policy shifts and resource investment decisions are to be based upon them.

#### **9.4 Stakeholder support**

Health education and training organisations, along with health profession representative bodies, are the Commonwealth's key stakeholders in developing a highly qualified and appropriately skilled workforce to meet the health needs of all Australians. Each year, the Commonwealth provides funding to a number of these bodies to support their constituent members in providing the Commonwealth with advice to inform policy development and program design and implementation.

To this end, the Commonwealth provides funding to support these representative bodies to canvass their members' views and build cross-profession commitment through a variety of activities including conferences, forums, committee meetings, secretariat and professional training.

Summarised below, these arrangements provide a mechanism for the Commonwealth to gain valuable insight into current and emerging health workforce issues which impact on health care service delivery to Australian communities. The summaries are based on information gathered by the review team during the analysis of specific programs.

##### **Box 9.3: Summary of funded activities**

###### ***National Prevocational Education and Training Forum***

Amount: \$241,417 (\$60,000 pa) over 2012-13 to 2015-16

Fund holder: State and territory prevocational training councils

Fund: Health Workforce Fund

Activities: National Prevocational Education and Training Forum – annual meeting to discuss junior doctor education and training. Includes attendance of 16 junior doctors from rural areas.

This is a high profile event attracting international speakers and delegates from the fields of medical education and accreditation as well as workforce planners.



The forum provides the Commonwealth with valuable insight into new and innovative medical training models which can be used to inform the development of medical workforce policy and programs. The forum also provides opportunity for the Commonwealth to canvass views and reinforce the importance of National Health Reform.

Whilst there has been no formal evaluation of the benefits of this funding to the Commonwealth, a report is prepared describing key issues, outcomes, details of presentations and workshops, along with the results of a participant survey.

#### *The Medical Training Review Panel (MTRP)*

Amount: \$1,080,000 (\$270,000 pa) from 2012-13 to 2015-16

Fund Holder: Department of Health and Ageing

Fund: Health Workforce Fund

Activities: Two MTRP meetings each year, production of an Annual Report (as required by the *Health Insurance Act 1973*).

Under section 3GC of the *Health Insurance Act 1973*, the MTRP is required to examine the demand for and supply of medical training opportunities and to monitor the effect of the Medicare provider number arrangements. These arrangements generally require medical practitioners to complete a recognised postgraduate training program, in either general practice or another specialty, before they are eligible to provide services that attract Medicare benefits.

The MTRP comprises representatives of 35 organisations, including the Commonwealth and jurisdictions, medical education providers and medical professional associations, as well as medical student bodies. Commonwealth funding enables the MTRP to meet twice a year face-to-face.

The MTRP Annual Report provides information on university, junior doctor and medical specialist training positions, students and trainees, examinations and graduates. Information is also included on medical practitioners who have trained overseas either seeking to work in Australia or currently located in the country. This report has become a key tool in the monitoring and future planning of medical education and training and is highly regarded by governments, health care service providers and the medical education sector.

The MTRP was reviewed in 2010. The key findings were that the MTRP continue on the basis that it provides a valuable contribution to health workforce planning for the Commonwealth, jurisdictions and health care service providers as well as the education sector. It was recommended that the MTRP should be formally aligned with HWA.<sup>202</sup> This has occurred, with HWA assuming responsibility for production of the MTRP Annual Report, in consultation with the Department.

#### *Medical Deans of Australia and New Zealand (MDANZ) Standing Committee Meeting and Medical Education Conference (MedEd)*

Amount: \$27,900 pa for standing committee meetings  
\$10,000 every two years for the MedEd conference

Fund holder: Medical Deans of Australia and New Zealand

Fund: Health Workforce Fund

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<sup>202</sup> ARTD Consultants, *Report on the 2010 Review of the Medicare Provider Number Legislation*, Commonwealth of Australia, 2010.

Activities: Standing committee meetings and the MedEd conference

MDANZ comprises the 20 Australian and New Zealand university medical schools. The objective of this funding support is to enhance the Department's stakeholder relationship and provide a platform for MDANZ to inform thinking on current and emerging medical workforce education issues, including implications for National Health Reform.

Whilst there has been no formal evaluation of the impact of this funding, MDANZ provides a summary of proceedings and conference outcomes and recommendations, along with feedback from attendees.

Participant feedback indicates that the conference is important in bringing together key stakeholders and contributors to medical education and training to review and establish strategic objectives, and provide an opportunity to consider practical initiatives to address medical education and medical workforce issues.

### *Confederation of Postgraduate Medical Education Councils (CPMEC)*

Amount: \$1,138,762 from 2011-12 to 2013-14

Fund holder: Confederation of Postgraduate Medical Education Councils

Fund: Health Workforce Fund

Activities: CPMEC core operations – advice to the Commonwealth, attending conferences etc, review and dissemination of the Australian Curriculum Framework for Junior Doctors, development of national intern standards, assessment of junior doctor training positions.

CPMEC is the peak body for state and territory postgraduate medical education councils and works closely with MDANZ, medical specialist colleges and the Australian Medical Council, as well as private and public health care providers. The funding provided to CPMEC supports the Commonwealth's aim of increasing health workforce capacity and improving the quality of medical education and training through national consistency and innovation in training junior doctors.

Whilst there has been no formal evaluation or review of funding to CPMEC, regular reports are provided on the progress of funded activities. Regular liaison with CPMEC has facilitated the development of Commonwealth medical education policy and programs.

### *Coalition of National Nursing Organisations (CoNNO)*

Amount: \$49,995 from July 2012 to June 2013

Fund holder: Australian Nursing Federation

Fund: Health Workforce Fund

Activities: Meeting organisation, secretariat, travel to meetings for member organisations.

CoNNO has over 50 national nursing organisations as members. The role of CoNNO is to advance the nursing profession through key activity areas such as: being a forum for discussion and consultation on professional matters; facilitating communication between members and other stakeholders; and influencing and contributing to public discussion on health policy.

The Australian Nursing Federation is a union for registered and, enrolled nurses, midwives, and assistants in nursing doing nursing work in every state and territory throughout Australia. The ANF Federal Office also represents Australian nursing internationally through links with other national and international nursing organisations, professional associations and the International Labour Organisations.

***National Rural Health Students' Network (NRHSN)***

Amount: \$3,291,464 from 2010-11 to 2012-13  
\$260,000 in 2011-12 for the National Undergraduate Rural Health Conference

Fund holder: Rural Health Workforce Australia

Fund: Health System Capacity Development Fund  
Health Workforce Fund (conference only)

Activities: Support for Rural Health Clubs, conference attendance, "uncommitted pool of extra funding for club activities", rural high school visits, alumni database.

The NRHSN is the peak body representing 29 Rural Health Clubs at universities across the country, and their 9,000 health student members. NRHSN is supported in their activities by RHWa, with students voluntarily organising and participating in programs such as the rural high school visits, as well as providing advice to the Commonwealth on policies and programs from the perspective of health students.

The NRHSN has strong links to programs under the Rural Health Multidisciplinary Training (RHMT) program, which includes the Rural Clinical Training and Support (RCTS), University Departments of Rural Health (UDRH), Dental Training Expanding Rural Placements (DTERP), and the John Flynn Placement Program (JFPP) initiatives. A requirement of the Rural Australia Medical Undergraduate Scholarship (RAMUS) scheme is that recipients must hold Rural Health Club membership. The NRHSN promotes rural health careers through the Rural High School Visits and Indigenous Festivals, conference attendance and promotional items.

The 2005 evaluation of the National Rural Health Network (now the NRHSN) by Urbis Keys Young and the 2008 Rural Health Audit indicated the value of this funding support in promoting and supporting rural education and training.<sup>203 204</sup>

However, the review has identified a minor issue involving potential duplication with Commonwealth funding provided to GP Student Networks through General Practice Registrars Australia (GPRA) and funding support to rural health clubs through the NRHSN. There may be some potential to rationalise and streamline funding arrangements so that it is delivered by one agency, thereby reducing duplication and administration costs.

***Australian Medical Council (AMC)***

Amount: \$764,000 from Nov 2012 to June 2013

Fund holder: Australian Medical Council

Fund: Health Workforce Fund

Activities: The Department provides funding for the development and dissemination of a workplace based assessment (WBA) DVD training resource; national WBA workshop; implementation of an electronic records management system; secretariat support for the Forum of Health Professions Councils.

The AMC's purpose is to ensure that standards of education, training and assessment of the medical profession promote and protect the health of the Australian community. The AMC is the nationally recognised medical accreditation body which forms part of the National Registration and Accreditation

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<sup>203</sup> Urbis Keys Young, *National Rural Health Network Evaluation*, 2005

<sup>204</sup> Department of Health and Ageing, *Audit of Health Workforce in Rural and Regional Australia*, 2008

Scheme (NRAS) for health practitioners. It develops and implements accreditation standards as well as policies and procedures for undergraduate university medical courses, junior doctors and medical specialist training. The AMC also assesses the knowledge, skills and professional attributes of overseas medical practitioners seeking registration in Australia. It is in respect of this OTD function that the Commonwealth funding described here is provided.

The House of Representatives Standing Committee on Health and Ageing's *Lost in the Labyrinth* report noted that the AMC's WBA pathway provides an effective method of clinical assessment of overseas trained doctors (OTDs) and recommended increasing access to WBAs for OTDs.<sup>205</sup> The Commonwealth is providing funding support to the AMC for this purpose. Together, the funded projects will facilitate expansion of the WBA pathway to enable more OTDs to undertake clinical assessment in a timely fashion, thereby building the capacity of the medical workforce to provide health care to all Australians.

The Forum of Health Professions Councils, convened by the AMC, allows for the exchange of information and expertise across the health professions which are a part of NRAS. The Commonwealth is funding the AMC to provide secretariat support to the Forum in developing a quality framework to underpin accreditation arrangements across the NRAS.

### *General Practice Registrars Australia (GPRA)*

Amount: \$875,000 from Jul 2011 to Dec 2013

Fund holder: General Practice Registrars Australia

Fund: Health Workforce Fund

Activities: Administration and governance, including annual conference and online professional resources for GP registrars.

GPRA is the industrial body representing GP registrars (i.e. trainee general practitioners) and also provides professional support, promotes general practice as a career, and represents the interests of GP registrars with Government and other professional medical groups. GPRA works closely with GPET, the RACGP and ACRRM.

GPRA forms an important link between the Commonwealth and trainee general practitioners through meetings and regular reports. For example, GPRA was a key participant in the development of the GP Registrars Rural Incentive Payments Scheme, which has since been combined with GPRIP.

An evaluation of Commonwealth funding to GPRA will be undertaken in 2013. Given the mix of training, industrial and student support functions conducted by GPRA (much of which is funded through other sources), it would be timely for this review of the organisation's funding and activities to determine whether other agencies could play a greater role in delivering some of the organisation's functions, particularly in terms of possible overlaps in educational support provided by professional training organisations.

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<sup>205</sup> House of Representatives Standing Committee on Health and Ageing, *Lost in the Labyrinth: Report on the inquiry into registration processes and support for overseas trained doctors*, Commonwealth of Australia, 2012

### CRANAplus

Amount: \$12.5 million over 2010-11 to 2012-13  
\$219,333 for 2012-13 for National Standards and Credentialing program

Fund holder: CRANAplus

Fund: Health Workforce Fund and Health System Capacity Development Fund (HSCDF)

Activities: Secretariat support (HSCDF); Centre for Remote Health Academic Program (HSCDF); First Line Emergency Care (FLEC) (HWF); Bush Support Service (HSCDF and HWF), National Standards and Credentialing program (HWF).

CRANAplus' role is to educate, support and advocate for health professionals working in remote areas of Australia. Membership is open to all health professionals who work in remote areas, have a desire to do so or have a keen interest in the sector. CRANAplus aims to ensure that those who choose to work in remote areas are as prepared as they can be for the challenges they will face.

With this in mind, CRANAplus is funded by the Commonwealth to deliver a range of programs supporting all health professionals and their families in remote areas of Australia. The aim is to improve the recruitment and retention of appropriately qualified and highly skilled health practitioners in remote communities.

The quality and development of FLEC courses delivered by CRANAplus is overseen by Flinders University, which also seeks to develop greater health research capacity in remote health issues. The FLEC courses provide health professionals with additional skills specific to remote communities where other health services may not be immediately available. The Bush Support Service is a telephone counselling and workshop facility assisting health practitioners and their families who are involved in rebuilding communities following a national and/or international crisis.

There is strong stakeholder support for CRANAplus and an external evaluation of the FLEC courses found they have high participation rates and are well regarded, relevant and highly effective in upskilling the remote health workforce.<sup>206 207</sup> However, despite a requirement in the current funding agreement to seek alternate funding sources for the FLEC programs, CRANAplus has indicated that continued Commonwealth funding is their preferred model.

CRANAplus has expressed concerns about the different timing of funding payments and reporting for the HWF and HSCDF. This may represent an opportunity to rationalise the siloed approach to funding within DoHA (as discussed in the grants management reform section above).

### Services for Australian Rural and Remote Allied Health (SARRAH)

Amount: \$1,062,611 over 2010-11 to 2012-13  
\$225,500 for 2012-13 (additional communication activities)

Fund holder: Services for Australian Rural and Remote Allied Health

Fund: Health System Capacity Development Fund and Health Workforce Fund (2012-13 communication activities only)

Activities: 2010-11 to 2012-13 – secretariat.  
2012-13 – employment of a communications officer, engagement with Medicare Locals

<sup>206</sup> R. Dunn, *Evaluation of CRANAplus Remote Emergency Care Program*, CRANAplus, 2012 (unpublished)

<sup>207</sup> R. Dunn, *Evaluation of CRANAplus Maternity Emergency Care Program*, CRANAplus, 2012 (unpublished)

and HWA, SARRAH Board meeting, corporate governance training for allied health practitioners.

SARRAH advocates for, develops and provides services to allied health professionals in rural and remote areas. SARRAH assists in providing the Commonwealth with advice on workforce policies and programs, promotes rural and remote career choices and pathways and supports allied health students and practitioners outside of metropolitan areas. SARRAH administers the allied health component of the Nursing and Allied Health Scholarship and Support Scheme (NAHSSS), funded through the HWF (Refer to Chapter 3).

In consultations undertaken as part of this review, SARRAH voiced concerns about the amount of Commonwealth funding for their core business and secretariat functions. SARRAH believe that they receive less funding than other rural stakeholders and that the level is insufficient to adequately support the rural and remote allied health workforce. SARRAH states this issue is amplified by the requirement to participate in National Health Reform initiatives such as Medicare Locals and HWA. SARRAH advises that it is running at a financial deficit and requires additional funding to continue current activities.

It is difficult to test the merit of these arguments without further analysis of SARRAH's detailed financial position, which is outside the scope of this review. Given the historical nature of many of the funding allocations to organisations like SARRAH, the only way to test these funding arguments may be to move towards competitive processes.

SARRAH's outcomes and impact on the rural health workforce have not been evaluated. It is recommended that consideration be given to opportunities for savings through collaboration with other organisations, including delivery of scholarship programs by other agencies, and evaluation based on independently-gathered and assessed quantitative data rather than anecdotal material.

### *Aboriginal and Torres Strait Islander Health Workforce Training Package*

Amount: \$50.9 million from 2012-13 to 2015-16

Fund holder: Various – see Chapter 5

Fund: Health Workforce Fund

Activities: Functional and organisational activities of Indigenous Australian workforce and training organisations and networks under the Training Package. The table below outlines funded activities.

Building Aboriginal and Torres Strait Islander health workforce capacity is a key requirement to achieving *Closing the Gap*. The Training Package supports Aboriginal and Torres Strait Islander health professional bodies to support Indigenous Australian health practitioners, promote health as a career option to Aboriginal and Torres Strait Islander students, and seek to improve awareness and understanding of Indigenous health issues across the non-Indigenous health workforce.

The Aboriginal and Torres Strait Islander health workforce and the Training Package are further discussed in detail in Chapter 5 of this report.

### *Departmental funding overlaps*

The HWF is a Commonwealth initiative administered by the Department and designed to support activities that will improve the capacity, quality and mix of the health workforce to meet the requirements of health services including through training, registration, accreditation and distribution strategies.

There is a continued commitment within the HWF to key priorities such as programs that increase training opportunities, assist retention and provide support to health



practitioners. The stakeholder activities described earlier fall within the HWF's key priorities, noting the emphasis on providing support to health practitioners and the development of the Aboriginal and Torres Strait Islander health workforce.

The flexibility of the HWF allows funding priorities to reflect current and emerging health workforce priorities. Funding allocations are made on an annual basis with funded organisations having an expectation of this continuing at the same or increased levels.

The HWF is not the only source of funding for professional organisations' operating costs. As noted earlier in this chapter, the Health System Capacity Development Fund (HSCDF), managed by the Department's Population Health Division, also supports specific projects which provide support to and represent constituent workforces, in particular those in rural and remote areas.

An example of a crossover in stakeholder funding support within the Department is that provided for delivery of rural and remote health system capacity development through the HSCDF. The HSCDF supports health consumers, students and community organisations (including those in regional and remote areas) to undertake policy development and deliver safe, high quality health care systems and services. The result is that some organisations are funded through both the HSCDF and the HWF for similar activities. There is potential to streamline the funding support to health workforce bodies funded through the HWF and HSCDF. This would decrease the administrative burden in applying for funding under separate funds and would also decrease the departmental resources required to manage the agreements.

### *Recommendations*

Recommendation	Affected programs	Timeframe
<b>Recommendation 9.7:</b> To standardise funding arrangements for stakeholder support, the Department should consider future competitive targeted funding rounds. Stakeholder support should focus on the identified priorities for the Health Workforce Fund (HWF) and be based on current and emerging health workforce issues.	Organisations including (but not limited to) CoNNO, CPMC, MDANZ, AMC, SARRAH, NRHSN and CRANaplus.	Medium term – aligned with the expiry dates of current funding agreements.
<b>Recommendation 9.8:</b> To reduce the burden of multiple application processes and reduce payment timing difficulties and reporting requirements, the Commonwealth should consider co-locating all funding for a similar purpose within one flexible fund – either the HWF or the Health System Capacity Development Fund.	As above	Medium term – aligned with flexible fund management and the timing of scheduled application processes.

The Commonwealth has invested in stakeholder support funding over many years. These arrangements vary significantly between stakeholder organisations but most,

if not all, follow a historical funding pattern. This has led to significant inconsistencies in the activities funded, including the amount provided for administration, secretariat and other “core business” activities.

The complexities include multiple applications to different Flexible Funds, and variations in funding periods along with reporting and payment timing. The resulting uncertainty for stakeholders and occasional failure to communicate effectively within the Department means a reduction in effective resource utilisation for both sides and less than optimal advice to the Commonwealth on health workforce policy and program matters – the prime purpose for which this funding is provided.

This review has highlighted the reliance of some organisations on Commonwealth funding and their reluctance to explore opportunities to build financial viability. However, this too is variable with some of the larger organisations having diversified their funding base and forged a role for themselves that spans the divide to self-sustainability.

There is no doubt that the advice provided to the Commonwealth by stakeholder organisations is critical to the development of sound health workforce policy and that the successful implementation of some initiatives would be in doubt without their support. However, the current funding arrangements should be revised to optimise the opportunities for all parties.

Review recommendations<sup>208</sup>

Recommendation	Affected programs	Timeframe
<b>Ensuring a capable and qualified health workforce</b>		
<i>Quality framework for the health workforce</i>		
<b>Recommendation 3.1:</b> The Commonwealth via the Standing Council on Health (SCoH) should engage with the national health professional boards to develop sensible and more consistent requirements for continuing professional development, recency of practice and re-entry to practice. Ideally, this should be undertaken for all registered professions and focus on maximising access to health services while maintaining safety and quality for the community. Professional re-entry requirements in particular, should be subject to periodic review for unduly onerous requirements creating barriers, particularly for regional workforce.	Nil	Medium term
<b>Recommendation 3.2:</b> The Commonwealth should seek that SCoH bring forward options for a common legislative framework for prescribing of medicines by non-medical health professionals to promote workforce productivity, flexibility and mobility.	Nil	Medium term
<b>Recommendation 3.3:</b> The Commonwealth should identify and address any possible barriers to unregulated professions participating in Australian Government programs, where appropriate.	Allied health programs and scholarships.	Short term
<i>Health education and training</i>		
<b>Recommendation 3.4:</b> The Commonwealth should continue to invest in clinical training initiatives to help ensure the future health workforce has the right training to meet community needs. This should include ongoing investments in the clinical aspects of undergraduate health	HWA, AGPT, STP, PGPPP, RHMT	Short term – ongoing.

<sup>208</sup> Major recommendations are shaded.

Recommendation	Affected programs	Timeframe
education across disciplines, as well as targeted funding for vocational medical training. There are pressures on training capacity and it is critical that government investment is cost-effective and sufficiently flexible to allow resources to be directed towards identified priority areas.		
<b>Recommendation 3.5:</b> A new focus on collaboration between organisations involved in health education programs needs to be mandated as part of core program delivery. Specific requirements should be incorporated into funding arrangements, with effective collaboration included as a key performance indicator for each initiative.	AGPT, STP, RHMT (inc RCTS, JFPP, UDRH and DTERP) PGPPP, RVTS	Medium term – as agreements expire.
<b>Recommendation 3.6:</b> The Commonwealth (as well as Health Workforce Australia (HWA)) should engage more closely with the private health sector in developing and implementing health education training initiatives. This engagement should be planned and regular and occur at a senior level. This approach should help to enhance the potential for private sector training capacity to be utilised more fully and in a more structured and consistent way.	DoHA and HWA Health education programs.	Short term and ongoing – to commence post-Review.
<b>Recommendation 3.7:</b> The Commonwealth, in close consultation with General Practice Education and Training Limited (GPET) and other key stakeholders, should investigate reforms to the way in which support for intern training placements is delivered in general practice and community settings. While maintaining the focus on intern training in primary care is crucial, there may be an opportunity to work with GPET to invest a portion of the funds currently dedicated to the Prevocational General Practice Placements Program (PGPPP) in new models discussed in this review.	PGPPP	Medium term
<b>Recommendation 3.8:</b> Reforms to the Commonwealth's investment in junior	PGPPP	Medium term

Recommendation	Affected programs	Timeframe
doctor training will need to be targeted towards building a more integrated training pathway for new graduates, with a proportionate emphasis on rural training. This pathway should continue to provide structured opportunities for junior medical officers to experience general practice.		
<b>Recommendation 3.9:</b> The Specialist Training Program (STP) should provide indexed funding for its training posts.	STP, Specialist training component of the More Doctors and Nurses for Emergency Departments program.	Short term – indexation to commence as agreements with specialist colleges are extended.
<p><b>Recommendation 3.10:</b> While STP has been a well received and apparently successful program, it is important that a full evaluation of the program should be carried out to verify that settings such as the mix of positions are optimal, and to inform the future development of the scheme.</p> <p>In addition, existing STP posts should be reviewed by colleges (in discussion with the Department and other program stakeholders) to ensure they are meeting the objectives of the program. This may provide the opportunity to redirect funds to new training posts that may better meet emerging workforce priorities.</p>	STP, Specialist training component of the More Doctors and Nurses for Emergency Departments program	Short term – review to commence by the end of 2013.
<i>Health education scholarships</i>		
<b>Recommendation 3.11:</b> This review has identified inconsistencies in scholarship funding arrangements (in both administration costs and levels of support to recipients) that need to be rectified to ensure equity and value for money. To progress this issue, If the recommendations of this review are accepted, a detailed mapping of each of the health workforce scholarship schemes across the Department will have to be undertaken. This process should include an analysis of:	All scholarships including PHMSS, MRBS, NAHSS, RAMUS, SARRAH scholarships, Aged Care scholarships, Pharmacy scholarships.	Short term – review to commence from July 2013.

Recommendation	Affected programs	Timeframe
<ul style="list-style-type: none"> <li>the administrative costs of existing scholarship activities with a view towards establishing clear benchmarks for application across programs; and</li> <li>the financial and other value of various scholarships for both appropriateness and consistency across the various activities funded.</li> </ul>		
<b>Recommendation 3.12:</b> The Commonwealth should develop a health workforce scholarship internet portal. This should be the main source of information on scholarships funded by the department. It should have directions and links to other pages managed by scholarship administering agencies.	All scholarships	Short term – development to commence as soon as possible.
<b>Recommendation 3.13:</b> The Commonwealth needs to develop measurable health workforce objectives for all scholarship schemes and embed agreed outcomes in contracting, program reporting and post-project evaluation.	All scholarships	Medium term – embed outcomes reporting measures in agreements with program management agencies as they expire.
<b>Recommendation 3.14:</b> Detailed workforce data analysis needs to be undertaken to determine where scholarship funding may be most efficiently targeted to achieve workforce distribution objectives in future funding rounds. Such analysis needs to include evidence about the effectiveness of financial support for students suffering other disadvantage in choosing to enter and remain in training for particular health professions.	All scholarships	Longer term – informed by better outcomes data and analysis outlined in recommendations above.
<b>Recommendation 3.15:</b> As part of the further evaluation work recommended above, the Commonwealth should specifically consider whether continued investment in the Medical Rural Bonded Scholarship (MRBS) Scheme represents value for money in terms of the level of the scholarship in comparison to other	MRBS, RAMUS, NAHSSS	Medium to long term.  The award of new MRBS places could be ceased from 2014 and funding could begin to be



Recommendation	Affected programs	Timeframe
<p>programs, and the workforce outcomes desired.</p> <p>Subject to more detailed data becoming available, this review recommends phasing out new scholarship funding and converting MRBS medical school places to standard Commonwealth funding places.</p> <p>Scholarship commitments and return of service requirements for existing participants would be maintained under this scenario with the possible option of allowing some flexibility for students to buy their way out of the commitment.</p> <p>Any funding released from the reconfiguration of MRBS should be redirected towards the Rural Australia Medical Undergraduate Scholarship (RAMUS) Scheme and to the Nursing and Allied Health Scholarship and Support Scheme (NAHSSS) rural scholarships for allied health students.</p> <p>Given current funding levels, over time this change should substantially increase the number of scholarships that are awarded to support rural workforce outcomes. It would also allow funding to be redirected towards rural students with demonstrated financial need, and allow a greater proportion of funds to be provided to nursing and allied health than is currently the case.</p>		<p>redirected to other priorities. Existing scholarship commitments will need to be honoured for up to six years, depending on the length of degree of individual participants.</p>
<p><b>Recommendation 3.16:</b> The Commonwealth should undertake further policy analysis of possible models for consolidation of health workforce scholarship schemes within professional groups. The aim should be to reduce administrative costs and streamline reporting arrangements to maximise the number of scholarships available to each health profession.</p>	All scholarships	Longer term

Recommendation	Affected programs	Timeframe
<b>Recommendation 3.17:</b> The Commonwealth should consider changing the focus of its nursing scholarship funding towards postgraduate scholarships that are responsive to identified nursing workforce retention needs, informed through HWA workforce data and analysis. In the first instance the priorities should be mental health, aged care and palliative care. This would provide the ability to target those areas identified and would ensure that priority was given to students undertaking studies in nursing courses or specialties identified in the HWA data. Financial need should also be a relevant consideration.	NAHSS, Aged Care Nursing Scholarships.	Medium term – implementation to commence from the 2014 allocation of new scholarships.
<b>Recommendation 3.18:</b> As part of any implementation of recommendation 3.15, listed above, the Commonwealth should explicitly consider increasing the number of allied health scholarship and support places with a priority given to rural training locations.	Allied health scholarships, such as those managed by SARRAH.	Longer term – subject to available funding.
<b>Addressing health workforce shortages in regional, rural and remote Australia</b>		
<i>Health education strategies for rural distribution</i>		
<p><b>Recommendation 4.1:</b> The Commonwealth should take leadership in developing a new, more integrated rural training pathway, linking its investment in rural undergraduate medical training with new support for rural intern places and continued growth in specialist training positions.</p> <p>The model will need to build on existing programs and maintain access to primary care and private sector training through the development of a more networked approach to delivering quality education.</p> <p>This may need to involve some re-profiling of existing investments. It will need to be delivered through a highly collaborative approach involving consortia of key training/accreditation bodies and health service providers. All available policy levers, including contracting and</p>	AGPT, STP, RCTS PGPPP, HWA clinical training funding.	Medium term – timeframes will be subject to reform of funding arrangements and engagement with stakeholders around new educational models.

Recommendation	Affected programs	Timeframe
reporting mechanisms, should be directed at incentivising collaboration by local and regional agencies and supporting a local network approach.		
<b>Recommendation 4.2:</b> The Commonwealth should consider opportunities for extending the approach to building rural training pathways in the allied health, dentistry and nursing disciplines. This will need to retain the core principles of providing a more seamless transition from undergraduate training into rural practice or further professional rural training for students in these disciplines. However, it will be important to note the different structure of postgraduate training in medicine compared to other disciplines.	New funding activity	Medium term – subject to available funds.
<b>Recommendation 4.3:</b> The Commonwealth should seek that the Standing Council on Health engage with the national health professional boards and their accrediting agencies to encourage development of intra- and inter-profession courses that enable health practitioners to provide a broader range of services in rural areas.	Nil	Medium term
<b>Recommendation 4.4:</b> Commonwealth support to extend rural training at medical schools to cover full degree programs could generate positive outcomes. Current workforce projection data, including the findings of <i>Health Workforce 2025</i> , suggests that the distribution of new graduates needs to be the priority rather than increasing overall graduate numbers. Current proposals in this area should continue to be explored with careful analysis of the costs and benefits of the different models.	RCTS, NT Medical Program.	Longer term – any extension of existing rural medical programs will be subject to funding availability and the development of comprehensive costing models.
<b>Recommendation 4.5:</b> The Rural Clinical Training and Support (RCTS) program should expand its focus on supporting multidisciplinary training placements. This activity is already included within the program parameters but needs to be pursued more vigorously, where funding	RCTS	Medium term – RCTS activities could begin to expand in this area from 2014.

Recommendation	Affected programs	Timeframe
is available. Consideration should be given to RCTS infrastructure needs to support a multidisciplinary approach.		
<p><b>Recommendation 4.6:</b> The mandatory four week rural placements required for all medical students under the RCTS program should be abolished, in favour of increased support for longer-term high quality elective placements which are currently generating good outcomes.</p> <p>Funds released from supporting short-term placements should be redirected towards other priorities within the RCTS initiative. This should include enabling training sites to play an enhanced role in developing integrated vocational training pathways. This would be achieved through supporting new academic positions to play a key role in developing networked training partnerships.</p>	RCTS	Medium term – current placement arrangements could be reformed from the start of 2014, in consultation with medical schools.
<p><b>Recommendation 4.7:</b> The advantages of extending the current RCTS program rural medical student enrolment target approach to other health disciplines should be examined. The target level and the likely implementation cost across the health disciplines would need to be determined, including the resources required by universities to achieve agreed goals.</p>	RCTS	Longer term – funding implications and the ability of other health disciplines to achieve this type of target are more complex issues.
<p><b>Recommendation 4.8:</b> There is strong potential for the network of 11 University Departments of Rural Health (UDRHs) to play a greater role in supporting longer term, more structured, rural training placements for allied health, dental and nursing students. This should be supported by the Commonwealth where funding is available. The service learning model put in place by the Broken Hill UDRH should be explored further, including the cost implications of this model across the UDRH network.</p>	UDRH	Medium term – expansion of UDRH training is subject to funding availability. New activities would need to be progressed during the next funding period.
<p><b>Recommendation 4.9:</b> Any extension of a comprehensive rural training program to cover nursing, allied health and dentistry</p>	UDRH and allied health clinical training support	Longer term – reflecting long lead times for the

Recommendation	Affected programs	Timeframe
should be supported by the collection of longitudinal outcomes reporting. The value of adopting a similar approach to the Medical Schools Outcomes Database project, and linking this to national registration data, should be considered.	programs (SARRAH/ NAHSSS)	development of data systems.
<p><b>Recommendation 4.10:</b> Research activities funded under the core operational grants of the RCTS and UDRH programs need to be examined in consultation with key program stakeholders to ensure they are effective and well-targeted.</p> <p>The Commonwealth should encourage greater rural research collaboration and seek to reach agreement across the UDRH network on an appropriate maximum research proportion of the program's core operational grant. This process could build on the work of the Research Leaders Network that has been established through Australian Rural Health Education Network (ARHEN).</p>	RCTS, UDRH	Medium term – a new research strategy will require extensive development work and consultation.
<p><b>Recommendation 4.11:</b> There could be benefit for the Commonwealth and for universities in pursuing further consolidation of the RCTS and UDRH programs. This should be pursued on a case-by-case basis, taking into account the willingness of individual universities to pursue integration and administrative efficiencies. This approach will have benefits for some organisations but may not be appropriate in all cases.</p>	RCTS, UDRH	Medium term – case-by-case consolidation could begin to occur as existing funding agreements expire.
<p><b>Recommendation 4.12:</b> Rural health clubs should extend their focus to maintaining the involvement of graduates as they progress into further training beyond university. Expanded activities in this area may require additional funding support.</p>	RHMT	Medium term – subject to available funding.

Recommendation	Affected programs	Timeframe
<i>Rural recruitment and retention strategies</i>		
<p><b>Recommendation 4.13:</b> Continued support for rural doctors, including targeted financial incentives, should remain a key component of the Government's health workforce strategy to address the serious ongoing maldistribution of health professionals.</p> <p>However, there is currently insufficient emphasis on support for other health professionals. A broader approach to rural health workforce development, focussing on social and professional issues as well as financing, needs to be taken consistently to complement the Government's current investments.</p>	GPRIP, HECS Reimbursement	Ongoing, with longer term development of new approaches, as outlined below.
<p><b>Recommendation 4.14:</b> Expenditure on the General Practice Rural Incentives Program (GPRIP) needs to be better targeted for equitable workforce outcomes by:</p> <ul style="list-style-type: none"> <li>• Adopting a modified rural classification system and better targeting financial incentives towards smaller regional settings in Australian Standard Geographic Classification – Remoteness Areas (ASGC-RA) RA2 and 3, while maintaining expenditure in RA4 and 5; and</li> <li>• Designing and implementing a new capped, decentralised incentive approach delivered through regionally based workforce development agencies such as Medicare Locals and Rural Workforce Agencies.</li> </ul> <p>Movement to a regionally based approach in the medium to longer term is strongly preferable as it offers both fiscal certainty and the opportunity to enhance outcomes.</p> <p>Determining need at the local and regional level is likely to be more effective than the current centralised entitlement system. This approach also provides flexibility to direct resources to the</p>	GPRIP	Medium term – new models of financial support will require extensive consultations with stakeholders and the development of revised administrative systems.



Recommendation	Affected programs	Timeframe
recruitment and retention of other professional groups, subject to local workforce requirements and identified health needs.		
<b>Recommendation 4.15:</b> Any change to a new incentive system should feature an appropriate transition period, of at least one financial year, and further consultation with stakeholders about the detailed requirements and funding allocation systems. Arrangements for supporting rurally based GP registrars should be considered as part of this process.	GPRIP	Medium term
<b>Recommendation 4.16:</b> The HECS Reimbursement Scheme should be integrated with the similar HECS-HELP forgiveness initiative already managed by Department of Industry, Innovation, Climate Change, Science, Research and Tertiary Education (DIICCS RTE) and the Australian Taxation Office (ATO).  While the latter scheme already covers nurses, the benefits and costs of participation by rural allied health professionals should also be examined.  Integration should achieve administrative savings and an ability to target HECS forgiveness in a responsive manner to projected workforce shortages.	HECS Reimbursement	Medium term
<b>Recommendation 4.17:</b> The Rural Health Continuing Education (RHCE) program (Stream 2) provides a good basis for supporting postgraduate training in allied health and nursing, but is significantly oversubscribed. The Commonwealth should consider expanding this program and linking it to other training initiatives, subject to the availability of further funding.	RHCE	Longer term – expansion will be subject to funding availability.

Recommendation	Affected programs	Timeframe
<b>Recommendation 4.18:</b> The Commonwealth should progress the consolidation of the administration of the various discipline-based locum programs into an integrated rural multidisciplinary locum provision service.	SOLS, GPALS, Rural LEAP, NAHRLS	Medium term – consolidation should be pursued as existing funding agreements expire.
<b>Recommendation 4.19:</b> Government involvement in alternative rural health service models should continue to be explored. Investments in developing new practice models in areas of market failure may assist to ensure more remote communities can access reasonable levels of service.	Primary and Ambulatory Care Division programs, new workforce initiatives.	Longer term – new models require significant development for national implementation, subject to available funding.
<i>Reform of the ASGC-RA rural classification system</i>		
<p><b>Recommendation 4.20:</b> The ASGC-RA system should be substantially adapted to the needs of health workforce programs to more appropriately recognise differing access to health services within broad geographic regions and within communities.</p> <p>A modification to the “Monash model” is recommended as the approach most likely to provide positive enhancements to current systems. This “modified Monash model” would retain the ability to provide greater definition between locations in the same ASGC-RA bands (RA2 and 3) while recognising the need to allow for remoteness as a key factor (retaining RA4 and 5).</p> <p>The geographic classification components of the revised system should be based on the Australian Statistical Geography Standard (ASGS), as the ABS will soon replace the use of ASGC with this enhanced system.</p> <p>Further work on the implementation of this model will be required before it can be used within individual programs. The model is not appropriate for application inflexibly across programs. Each initiative may need to adjust its guidelines to use</p>	GPRIP and other incentive programs, rural training programs	<p>Short term – further development of the classification model and data systems will be required immediately following this review.</p> <p>Medium term – health workforce programs, and potentially other Commonwealth initiatives, will need to transition to the enhanced system.</p>

Recommendation	Affected programs	Timeframe
<p>the revised system in the most effective way.</p> <p>The Department should commence discussions with stakeholders on a revised model based on the core principles outlined in the Report. This should include discussions across the portfolio around the implications for other program areas and the potential for broader application of the model outside workforce initiatives. An implementation working group should be established.</p>		
Supporting the Aboriginal and Torres Strait Islander health workforce		
<p><b>Recommendation 5.1:</b> There must be better coordination of activities aimed at increasing the capacity of the Aboriginal and Torres Strait Islander health workforce, across the Department of Health and Ageing and across other Commonwealth agencies working in this area including Health Workforce Australia, the Department of Families, Housing, Community Services and Indigenous Affairs, the Department of Education, Employment and Workplace Relations and the Department of Industry, Innovation, Climate Change, Science, Research and Tertiary Education. This should include the formulation of clear implementation plans, timelines and reporting processes to avoid the current potential for policy stalemates.</p>	All Aboriginal and Torres Strait Islander health workforce programs	Short term – enhanced coordination should commence as soon as possible.
<p><b>Recommendation 5.2:</b> The Commonwealth should continue to fund peak Aboriginal and Torres Strait Islander bodies/networks (under the Training Package) to help drive progress in Aboriginal and Torres Strait Islander health education and training for both health students and the health workforce.</p>	Aboriginal and Torres Strait Islander Health Workforce Training Package	Short term – ongoing.
<p><b>Recommendation 5.3:</b> The Commonwealth should continue to consult with the National Congress of Australia's First People's National Health Leadership Forum, as the collective and</p>	Discussions between HWD and OATSIH on consultation activities.	Medium term – allowing appropriate time for consultation with key groups.

Recommendation	Affected programs	Timeframe
<p>consultative forum of peak Aboriginal and Torres Strait Islander health workforce bodies. This forum should continue to assist in collaboration and coordination within and between these organisations.</p> <p>The Commonwealth should also ensure that it continues to work closely with the National Health Leadership Forum on the ongoing implementation of strategies arising from community consultations and the recommendations of this review of health workforce programs.</p> <p>Engagement between the National Health Leadership Forum and cross-jurisdictional consultative groups such as the Health Workforce Principal Committee should also be considered in this context.</p> <p>Complementary consultative arrangements, through a regular working group similar to those of the Coalition of National Nursing Organisations, may be beneficial in achieving implementation of identified strategies.</p>		
<p><b>Recommendation 5.4:</b> The Commonwealth should build on the success of the Leaders in Indigenous Medical Education (LIME) Network by extending its reach or reconfiguring this group to include support and mentoring for all Aboriginal and Torres Strait Islander tertiary level health professional students, including nurses and midwives, dentists and allied health professions.</p> <p>Alternatively, activities of the LIME network could be adopted by other networks in their specified health discipline.</p>	Aboriginal and Torres Strait Islander Health Workforce Training Package	Short term
<p><b>Recommendation 5.5:</b> The Commonwealth should develop and implement a new national program specifically aimed at:</p> <ul style="list-style-type: none"> <li>increasing Aboriginal and Torres Strait Islander health student enrolment and graduate numbers; and</li> <li>pursuing the development and</li> </ul>	<p>Indigenous Chronic Disease Package</p> <p>RCTS program</p> <p>Funding source to be identified</p>	Medium term – this reform and extension of the current RCTS targets should be considered when existing agreements with universities

Recommendation	Affected programs	Timeframe
<p>inclusion of culturally appropriate curriculum into all health courses.</p> <p>Alternatively, there may be an opportunity to extend the existing workforce and support component of the Indigenous Chronic Disease Package to achieve the above aims.</p> <p>Possible mechanisms to achieve the program outcomes should be further explored including options for delivery such as virtual support and/or support units with physical office locations.</p> <p>Extending the Aboriginal and Torres Strait Islander support units which are currently in place in various universities should be considered rather than duplicating current efforts. Support units will need to vary from location to location, taking into account the service delivery environment and, where appropriate, encouraging collaborative regional support hubs. These regional support hubs should incorporate partnerships between universities.</p> <p>The program should extend to all tertiary health professional courses (as opposed to medicine only). Program targets should have key performance indicators, such as the percentage of students entering or graduating that are of Aboriginal and Torres Strait Islander background relative to the Aboriginal and Torres Strait Islander population at either a national or geographic regional level.</p> <p>Partial funding for this Aboriginal and Torres Strait Islander health program could be redirected from the current Rural Clinical Training and Support (RCTS) program.</p>	<p>through cross-portfolio discussions.</p>	<p>expire. Additional funding beyond the RCTS program is likely to be necessary to achieve a sustainable investment across health disciplines.</p> <p>Longer term – subject to the availability of funding and engagement with both Aboriginal and Torres Strait Islander groups and the university sector.</p>
<p><b>Recommendation 5.6:</b> Recommendation 5.5 should be complemented by the development of Aboriginal and Torres Strait Islander academic leaders/champions and Aboriginal and Torres Strait Islander student support networks that would provide culturally</p>	<p>Funding source to be identified through DoHA and cross-portfolio discussions.</p>	<p>Longer term – as above.</p>

Recommendation	Affected programs	Timeframe
<p>appropriate mentoring, counselling and, if appropriate, pastoral care type activities to all Aboriginal and Torres Strait Islander health students. This may also include providing support to students' direct family members, which may assist the student to remain in study and graduate.</p> <p>This could be achieved by further developing the "Health Heroes" (part of the Indigenous Chronic Disease Package).</p>	<p>"Health Heroes" (Indigenous Chronic Disease Package).</p>	
<p><b>Recommendation 5.7:</b> The Commonwealth should take action to implement those recommendations directed to Registered Training Organisations as outlined in the Battye Review. There does not appear to be any compelling reason to further postpone implementation of these recommendations, which were well considered.</p>	<p>Aboriginal and Torres Strait Islander Health Workforce Training Package.</p>	<p>Medium term – implementation should commence on a case-by-case basis as existing funding agreements expire.</p>
<p><b>Recommendation 5.8:</b> The Commonwealth should consider options for the establishment of an Aboriginal and Torres Strait Islander Nursing and Midwifery Policy Adviser role within one of the nursing peak bodies.</p>	<p>Aboriginal and Torres Strait Islander Health Workforce Training Package.</p>	<p>Short term</p>
<p><b>Recommendation 5.9:</b> The NT Medical Program's Indigenous Transitions Pathway program should be further evaluated to assess its outcomes before considering future options for mentoring Aboriginal and Torres Strait Islander students.</p> <p>If the evaluation demonstrates positive outcomes in terms of increased students graduating and increased retention of these students in the surrounding communities, an increase in numbers and funding should be considered.</p>	<p>Aboriginal and Torres Strait Islander Health Workforce Program, NT Medical Program</p>	<p>Medium term</p>
<p><b>Recommendation 5.10:</b> The Commonwealth should further investigate activities related to the connectivity of the education and training sectors from school, through the vocational education and training (VET) sector and on to</p>	<p>Nil</p> <p>This is in part a DEEWR program responsibility.</p>	<p>Short term – this policy work should commence following this</p>



Recommendation	Affected programs	Timeframe
undergraduate studies, with multiple entry points supported for younger and mature students. This will encourage more Aboriginal and Torres Strait Islander students studying health professions (over 7000) in the VET sector to progress to tertiary-based study programs by building on their success in prior health education and training programs.		Review.
<b>Managing the supply of health workers to meet community needs</b>		
<i>International recruitment, support and regulation</i>		
<b>Recommendation 6.1:</b> the Department should continue to work with medical professional groups, including the specialist colleges, to identify opportunities to improve professional support for overseas trained doctors (OTDs) in rural and remote areas. Support should be targeted to help doctors to meet the requirements for general and specialist medical registration, and provide ongoing peer mentoring particularly for OTDs in rural and remote areas.	Nil	Short term – ongoing.
<b>Recommendation 6.2:</b> Funding for Rural Workforce Agencies (RWAs) to deliver the International Recruitment Strategy (IRS) and recruitment and retention activity under Health Workforce Australia's (HWA's) International Health Professionals Program (IHPP) should be consolidated through one fund-holder.  The most appropriate organisation to take on the fund-holder role should be negotiated with Rural Health Workforce Australia, HWA and the RWAs. If RWAs are to have a continuing role in this program, consideration should be given to enabling them to receive recruitment payments at the end of each funding period.	IRS, HWA (IHPP)	Medium term

Recommendation	Affected programs	Timeframe
<b>Recommendation 6.3:</b> The Commonwealth should explore opportunities to provide additional information about Medicare provider number restrictions to ensure OTDs have full and accurate information before accepting job placements.	Nil	Short term
<b>Recommendation 6.4:</b> The Commonwealth should give detailed consideration to the legislative changes and practical implementation requirements that would be needed to enable OTDs and their families to access Medicare rebates for health services received as patients. If access to Medicare cannot feasibly be delivered other support mechanisms should be considered to ensure reasonable access to health care for providers supporting the community. Consideration of this issue may also need to be extended to other overseas trained health professionals.	MBS	Medium term – subject to costing analysis, consideration of implications for Medicare and other policy areas (e.g. Immigration) and available funding.
<b>Recommendation 6.5:</b> The Commonwealth should consider amending s. 19AB of the <i>Health Insurance Act 1973</i> to allow for the backdating of s. 19AB(3) exemptions, under limited circumstances.	MBS	Longer term
<b>Recommendation 6.6:</b> The Commonwealth, through its role on the Standing Council on Health, should continue to encourage efforts to deliver a shared electronic repository for documents relating to the registration and employment of new OTDs, noting HWA's current work with the Australian Health Practitioners Regulation Agency and the medical profession on this issue. The current requirements for multiple lodgement, inconsistent lodgement dates and formats are significant obstacles to effective workforce administration.	HWA	Longer term

Recommendation	Affected programs	Timeframe
<i>District of Workforce Shortage classification system</i>		
<p><b>Recommendation 6.7:</b> The Commonwealth should introduce a revised system to replace the current districts of workforce shortage (DWS) classification system. It should be introduced in 2 stages.</p> <p>Under the first stage, the geographic classification requirements of the revised system should be based on the Australian Statistical Geography Standard (ASGS), these requirements being:</p> <ul style="list-style-type: none"> <li>• Remoteness area classifications as provided under the ASGS; and</li> <li>• SA2/SA3 boundaries to be used as 'area' boundaries for workforce shortage classifications.</li> </ul> <p>2011 census data (i.e. the most up to date data) should be used as the population measure for the revised system.</p> <p>The revised system should abandon the use of the additional overlay of the "metropolitan areas classification system" for general practice.</p> <p>The revised system should use a modified general practice workforce measure within major cities (RA1) and inner regional areas (RA2) comprised of:</p> <ul style="list-style-type: none"> <li>• a comparison of the population-to-full-time equivalent (FTE) ratio of each area against the national average;</li> <li>• the application of a 10% buffer to the raw population-to-FTE ratios; and</li> <li>• a full-time workload equivalent (FWE)-to-GP ratio to areas that have better than the national average but fall within the 10% buffer zone.</li> </ul> <p>The second stage should consider the introduction of the use of the 'modified Monash model' proposed in chapter 4 to determine automatic DWS status for certain remoteness categories.</p> <p>If the 'modified Monash model' of</p>	DWS, allocation of MBS provider numbers, BMP	<p>Short term – transitional arrangements, further discussions with stakeholders and the development of communication and data system should commence immediately post-Review.</p> <p>Medium term – it is likely that the work outlined above will necessitate medium term implementation of the full DWS changes.</p>

Recommendation	Affected programs	Timeframe
<p>geographical classification is implemented and its methodology can be applied to DWS in an administratively efficient manner, the following areas should be granted automatic DWS status for both general practice and other specialties:</p> <ul style="list-style-type: none"> <li>• RA2 and RA3 areas with populations less than 15,000;</li> <li>• RA4; and</li> <li>• RA5.</li> </ul> <p>Additional discussions with stakeholders should be undertaken to assist in the implementation of the new system, including transition arrangements. This should include discussions with jurisdictions around how this new DWS system will overlap with their current Area of Need determinations.</p> <p>An implementation working group should be established.</p>		
<i>Achieving workforce distribution aims through return of service obligations</i>		
<p><b>Recommendation 6.8:</b> Major reform to the operation of the Bonded Medical Places (BMP) scheme should be considered to address stakeholder concerns and escalating administrative challenges.</p> <p>The return of service obligation (RSO) required of medical students should be substantially altered to help make the scheme fairer and more certain for students as well as more efficient to administer. This should involve:</p> <ul style="list-style-type: none"> <li>• Making designated rural areas permanently eligible for completion of the RSO period, removing the use of the districts of workforce shortage (DWS) system in these areas;</li> <li>• Aligning eligible metropolitan areas for RSO with the reforms to the DWS system outlined elsewhere in this review, as well as allowing flexibility for graduates to work in high need metropolitan areas, such as</li> </ul>	BMP	Medium term – changes to the operation of the program could commence for new entrants from 2014, subject to consultation with universities and other stakeholders.

Recommendation	Affected programs	Timeframe
<p>community health settings like Aboriginal Medical Services; and</p> <ul style="list-style-type: none"> <li>Changing the RSO period to commence from attainment of fellowship to make the scheme administratively sustainable through basing it around access to Medicare provider numbers. To offset this change the Commonwealth should halve the maximum RSO period and retain the use of 'scaling' to encourage graduates to work in more remote areas.</li> </ul>		
<p><i>Workforce distribution programs targeted at non-vocationally recognised medical practitioners</i></p>		
<p><b>Recommendation 6.9:</b> The Commonwealth should consolidate the existing Section 3GA workforce programs.</p>	All 3GA programs	Medium term
<p><b>Recommendation 6.10:</b> The Commonwealth should combine the After Hours Other Medical Practitioners program, the Medicare Plus Other Medical Practitioners program, the Rural Other Medical Practitioners program and the Outer-metropolitan Other Medical Practitioners program into a single program. In developing the program, issues to consider include:</p> <ul style="list-style-type: none"> <li>use of the revised geographical classification system proposed elsewhere in this report;</li> <li>grandfathering arrangements for pre-1996 medical practitioners;</li> <li>standardised specialist college training and continuing professional development requirements;</li> <li>expansion to include Aboriginal and Torres Strait Islander health services;</li> <li>interaction with s. 3GA workforce programs, specifically the Approved Medical Deputising Service program and Rural Locum Relief Program; and</li> <li>the potential for unintended negative outcomes for medical service provision in rural areas.</li> </ul>	All other medical practitioners programs	Medium term

Recommendation	Affected programs	Timeframe
<b>Recommendation 6.11:</b> The Department should undertake a process with individual participants on the Temporary Resident Other Medical Practitioners (TROMPs) program so that a timeline can be set for all participants to indicate a clear intention about engaging with the relevant college on a process to proceed to fellowship.	TROMPS	Short term – small number of program participants.
<b>Nursing workforce - education, retention and sustainability</b>		
<p><b>Recommendation 7.1:</b> The Commonwealth should work with the profession and across jurisdictions to establish a National Nursing and Midwifery Education Advisory Network (NNMEAN) that would develop five year rolling nursing education plans across the whole training pipeline from enrolled and undergraduate nurse training to advanced scopes of practice and nurse practitioner candidates.</p> <p>These plans will be based on the best possible nursing workforce data and take into account health service delivery requirements (both in the public and private sectors) and consider both the supply and demand issues.</p>	HWA, support through the Health Workforce Fund	Medium term – formation of the network and the development of consensus on its role would take some time.
<p><b>Recommendation 7.2:</b> As part of the wider NNMEAN work, an appropriate organisation should be tasked with identifying and analysing the issues related to a perceived reluctance by employers to employ newly graduated nurses.</p> <p>Further, they should identify actions that could be taken in the undergraduate program to allay these issues and provide advice and options on how professional groups and employers could best support nurses to ensure they are retained within the profession upon graduation.</p>	HWA, support through the Health Workforce Fund	Medium term – linked to the establishment of NNMEAN.
<b>Recommendation 7.3:</b> The Commonwealth should consider providing seed funding for a feasibility study of a national rollout of leadership courses to	New funding – Health Workforce Fund	Short term – work on this project could commence immediately post-



Recommendation	Affected programs	Timeframe
<p>mid-level nurse and midwife managers, based on the New South Wales Government sponsored Essentials of Care program.</p> <p>This would build on work that Health Workforce Australia (HWA) is doing in its <i>Health LEADS Australia</i>, health leadership framework. The Australian College of Nursing should lead this work and the resulting education activities should be considered eligible for support under various scholarship schemes until these courses are well established and sustainable under a user pays system.</p>		Review, subject to available funding.
<p><b>Recommendation 7.4:</b> The Commonwealth should consider providing flexible financial support under the Nursing and Allied Health Scholarship and Support Scheme (NAHSSS) of up to \$10,000 (per recipient) for supervised re-entry courses for those registered nurses in regional, rural and remote locations, seeking to return to the workforce after extended periods away, until satisfactory flexible delivery or e-learning options are available in all states and territories.</p> <p>The University Departments of Rural Health (UDRH) program could potentially provide a platform for delivering this education in some rural and remote areas.</p>	NAHSSS	Short term – redirection of NAHSSS priorities, existing funding.
<p><b>Recommendation 7.5:</b> The Commonwealth should continue its investment in the Practice Nurse Incentive Program (PNIP) but the Nursing in General Practice Program (NiGP) should be integrated with the activities of Medicare Locals.</p>	PNIP, NiGP	Short term – NiGP activities to be integrated with Medicare Locals from 2013-14.
<p><b>Recommendation 7.6:</b> The Commonwealth should develop a model based on the Remote Vocational Training Scheme (RVTS) model to allow distance education and supervision. This will allow highly qualified nurses working in rural and remote areas to access clinical experience and supervision while still</p>	RVTS	Medium term – subject to available funding and engagement with the profession.

Recommendation	Affected programs	Timeframe
<p>delivering services in those areas.</p> <p>Additionally, the scheme could be modified to include education and supervision requirements associated with nurses undertaking extended scope of practice, such as advanced practice nurses or nurse endoscopists. These activities could support increased access to services for rural and remote communities.</p>		
<p><b>Recommendation 7.7:</b> The Commonwealth agencies involved in nursing education need to investigate the availability and cost of VET sector training as it relates to enrolled nurses. There are a declining number of enrolled nurse places/courses being offered and a reason raised within consultations was cost (approximately \$16,000 for an enrolled nursing course). Enrolled nursing students/courses should be eligible for scholarship support.</p>	<p>Research and policy development across DoHA, DEEWR and DIICCSRTE, scholarships.</p>	<p>Longer term</p>
<p><b>Recommendation 7.8:</b> The Commonwealth should undertake an analysis of activity in other similar countries, such as the United Kingdom, New Zealand and Canada where enrolled nurse positions (and therefore training) have been reduced or removed entirely. This work would inform policy development in this area. Recently these countries have revised the enrolled nurse role in response to community needs and workforce pressures.</p>	<p>Nil – research and policy development</p>	<p>Longer term</p>

Recommendation	Affected programs	Timeframe
<b>Dental and allied health workforce development</b>		
<i>Dental and oral health workforce</i>		
<b>Recommendation 8.1:</b> The Commonwealth should closely monitor the current work being undertaken by Health Workforce Australia (HWA) and the Dental Board of Australia (DBA) in relation to the scope of practice for oral health therapists, dental therapists and dental hygienists to inform the design of future health workforce programs.	Nil	Medium term
<b>Recommendation 8.2:</b> The Commonwealth should continue with the implementation of the Oral Health Therapists Graduate Year Program (OHTGYP), the Voluntary Dental Graduate Year Program (VDGYP) and the Dental Relocation and Infrastructure Support Scheme (DRISS). While implementation for these relatively new programs appears to be on track, it will be important to monitor outcomes.	OHTGYP, VDGYP, DRISS	Ongoing
<b>Recommendation 8.3:</b> The Dental Training Expanding Rural Placements (DTERP) program has potential to provide increased numbers of student placements for a modest additional investment. Funding could be identified from within the existing Rural Health Multidisciplinary Training (RHMT) program, or through HWA. This program is strongly supported by the dental schools and appears to be delivering useful outcomes for the distribution of the dental workforce and to expand the service learning model.	DTERP, RHMT	Short term – dental schools have advised that this program is ready to be expanded almost immediately, subject to receiving extra funding.
<b>Recommendation 8.4:</b> The Australian Rural Health Education Network (ARHEN) proposal for a rural oral health academic program has merit and should be explored further in close consultation with dental schools, as a way of supporting the dental workforce in rural locations. The alignment of this potential new investment with the existing DTERP program needs to be carefully considered to avoid	UDRH program	Medium term – subject to available funding.

Recommendation	Affected programs	Timeframe
potential overlap, noting that some University Departments of Rural Health (UDRH) have the potential to act as new training sites for dental and oral health students.		
<b>Recommendation 8.5:</b> The Commonwealth should encourage key agencies (e.g. HWA and the Australian Institute of Health and Welfare) to improve data collection to inform policy development of the dental and oral health workforce. This should include better data on workforce distribution and the academic dental workforce.	Nil	Longer term
<i>Allied health workforce</i>		
<b>Recommendation 8.6:</b> The Government's recent announcement of the establishment of a Commonwealth Chief Allied Health Officer is supported. This new position should play an important role in providing advice on policy and allied health workforce reform.	Nil	Short term – this appointment is likely to commence in 2013.
<b>Recommendation 8.7:</b> The Commonwealth should consider options aimed at enhancing its ability to liaise and consult with the allied health disciplines. This could be pursued through supporting the development of a Coalition of National Nursing Organisations type-model, where allied health stakeholder representatives would meet regularly with senior representatives of the Department, including the Chief Allied Health Officer.	Nil – new secretariat funding, potentially through the Health Workforce Fund.	Short term – linked to the appointment of the Chief Allied Health Officer.
<b>Recommendation 8.8:</b> The Commonwealth should consider providing seed funding to establish allied health networks and professional hubs in rural areas. This would assist in peer support, ensuring adequate supervision of students and new practitioners, and access to continuing professional development. This is essential to ensure service delivery is based on contemporary practice and is more sustainable (particularly in the private sector).	Nil – new funding required.	Medium term- Subject to available funding.

Recommendation	Affected programs	Timeframe
Innovative methods of communication and activities such as telehealth, online training and assistance to develop new professional support networks could be funded through this approach.		
<b>Recommendation 8.9:</b> The Commonwealth should explore the possibility of expanding the list of eligible Telehealth specialist support items to include specific allied health services, including optometry. Close consultation with the Medicare Benefits Division in regard to the feasibility of the recommendation is essential.	MBS	Medium term – subject to discussions with MBD and available funding.
<b>Recommendation 8.10:</b> The Commonwealth, in conjunction with HWA, should continue to research and pilot projects to test and implement new roles and responsibilities for allied health assistants, initially in rural areas. Ongoing research into the clinical effectiveness and safety of allied health assistants needs to be undertaken examining the productivity gains and benefits to community services of developing this workforce.	HWA, with potential future support through the Health Workforce Fund, if required.	Longer term
<b>Recommendation 8.11:</b> Regionally based agencies such as Medicare Locals and local health networks (LHN) could play an important role in the development of an integrated approach to the employment of allied health professionals. Options for the Medicare Locals and LHN networks to address the lack of allied health private practitioner services in rural areas (with the resultant current limited ability to access private health and Commonwealth MBS items) should be explored further. Although comprehensive HWA data is not yet available, it seems clear that rural communities have significantly less access to private allied health services when compared to metropolitan areas. The Commonwealth may need to address market failure through exploring models of	Medicare Locals, MBS.	Longer term

Recommendation	Affected programs	Timeframe
collaboration between health services (health and disability sectors) as well as private/public partnerships in smaller communities.		
<b>Recommendation 8.12:</b> The concerns and representations of allied health workforce stakeholders raised in the course of this review should be forwarded to Health Workforce Australia (where relevant) for its information and appropriate action. This may improve engagement with the professions and individual practitioners, particularly those employed outside of hospitals.	HWA	Short term
<b>Opportunities for reform in program delivery and policy development</b>		
<i>Grants management reform</i>		
<p><b>Recommendation 9.1:</b> The Health Workforce Division (HWD) should continue to implement the whole-of-department reforms to grants management, with a view to improving consistency of funding arrangements and achieving measurable reductions in compliance-based reporting and unnecessary focus on process rather than results. Regular feedback should be sought from peak groups as to whether the reform process is in fact achieving a reduction in red tape and administrative cost for funded agencies.</p> <p>As part of this process, it will be important to:</p> <ul style="list-style-type: none"> <li>• Establish a consistent approach to developing funding agreements, particularly in terms of detailing the key activities for each project/program. This process needs to focus on clearly defining activities while reducing the reporting burden for stakeholders.</li> <li>• Ensure outcomes measures and reporting requirements are based on a set of easily identifiable and measureable key performance indicators.</li> </ul>	All Health Workforce Fund Programs	Short term – ongoing grants management reform.



Recommendation	Affected programs	Timeframe
<ul style="list-style-type: none"> <li>• Wherever possible, align funding agreement periods within the Health Workforce Fund (HWF) to reduce the need for organisations to continually engage in multiple funding processes with different program areas;</li> <li>• Attempt to integrate the current multiple funding streams across HWD and other Divisions. This may need to involve further consolidation of funding appropriations within the most appropriate flexible fund.</li> </ul>		
<p><b>Recommendation 9.2:</b> Divisions within the Department should closely examine linkages in their health workforce programs and implement measures to reduce or remove duplication or overlap within their current programs.</p> <p>To help ensure this occurs effectively, consideration should be given to establishing a formal and regular communication system between key divisions involved in health workforce programs.</p>	All	Short term and ongoing
<p><b>Recommendation 9.3:</b> In the development of new policy proposals, the department should give specific consideration to health workforce impacts, potentially through the preparation of new internal health workforce impact statements.</p>	Policy development	Medium term – ideally to commence for the 2014 Budget process and beyond.
<p><b>Recommendation 9.4:</b> A comprehensive evaluation strategy should be developed for the various health workforce programs and activity areas. This should be designed to ensure consistency with the broader evaluation framework of the HWF and be applied consistently across all funding activities. In particular, new programs should not be rolled out without an outcome-based evaluation framework.</p>	HWF and health workforce programs outside the fund	Short/medium term – post-review work to commence in 2013-14.
<p><b>Recommendation 9.5:</b> A comprehensive assessment of internal DoHA risk management compliance across all health workforce program activity areas should be undertaken following this review. In</p>	HWF	Short/medium term – post-review work to commence in

Recommendation	Affected programs	Timeframe
<p>addition to the broader risk management plan for the HWF, component initiatives should have risk management plans in place and update them consistently. Any such review needs to be undertaken within the context of the broader reforms to contracting practices within the department.</p>		2013-14.
<p><i>Health Workforce Australia and Health Workforce Division: roles, responsibilities and options for reform</i></p>		
<p><b>Recommendation 9.6:</b> This review has identified legitimate stakeholder concerns about the lack of clarity defining the respective roles of Health Workforce Australia and DoHA, as well as inconsistencies in the delivery of Commonwealth funding between the two agencies. It is likely that current arrangements are less than optimal.</p> <p>This issue needs to be addressed to ensure the Commonwealth gains the best value from its investment in HWA and departmental programs.</p> <p>Issues raised in in the course of this review may inform the forthcoming overarching review of the National Partnership Agreement on Hospital and Health Workforce Reform (NPA), which will include consideration of Schedule B of the NPA and those items relating to HWA functions.</p> <p>There are three broad changes that should be considered by the Commonwealth in this area:</p> <p><i>Option 1 – HWA becomes a specialist data and policy agency ‘think tank’ and does not manage mature programs</i></p> <p>HWA’s programs could be managed by the Department which would enable HWA to focus on its data analysis and policy development work. HWA would retain a budget for innovation and reform; to support ‘pilot approaches’ which may be, if successful, applied more broadly through DoHA program funding.</p>	<p>Health workforce training programs and HWA funding programs.</p>	<p>Longer term – reform would need to be pursued on the expiry of current long-term funding agreements and be linked to the completion of structural reviews of both HWA and the larger health workforce environment.</p>

Recommendation	Affected programs	Timeframe
<p><i>Option 2 – HWA takes over the management of selected DoHA programs</i></p> <p>HWA could take over responsibility for the management of a number of DoHA programs to ensure synergies in program management and policy. Examples include the consolidation of HWA Clinical Training Program and HWD's Rural Clinical Training and Support program; and the transfer of the Specialist Training Program.</p> <p>In the event that the overarching NPA review does not provide sufficient analysis to inform these options, it may be necessary to undertake a specific independent analysis of HWA's activities and governance arrangements, building on information gathered in the course of this review and in the NPA process to inform future directions for the national health workforce agency.</p> <p><i>Option 3 – HWA operations remain the same</i></p> <p>HWA's current arrangements continue with HWA having responsibility for both program and policy development.</p> <p>However, if this 'status quo' option is pursued, at a minimum, the roles and responsibilities of both agencies will need to be clarified for the benefit of stakeholders and more effective communication channels need to be established at the program management level to enhance collaboration.</p>		
<i>Stakeholder support</i>		
<p><b>Recommendation 9.7:</b> To standardise funding arrangements for stakeholder support, the Department should consider future competitive targeted funding rounds. Stakeholder support should focus on the identified priorities for the HWF and be based on current and emerging health workforce issues.</p>	<p>Organisations including (but not limited to) CoNNo, CPMC, MDANZ, AMC, SARRAH, NRHSN and CRANaplus.</p>	<p>Medium term – aligned with the expiry dates of current funding agreements.</p>

Recommendation	Affected programs	Timeframe
<b>Recommendation 9.8:</b> To reduce the burden of multiple application processes and reduce payment timing difficulties and reporting requirements, the Commonwealth should consider co-locating all funding for a similar purpose within one flexible fund – either the HWF or the Health System Capacity Development Fund.	As above	Medium term – aligned with flexible fund management and the timing of scheduled application processes.

## Appendix i: Health Workforce Division programs and funding<sup>209</sup>

Program/Initiative	2012-13 (\$m)	2013-14 (\$m)	2014-15 (\$m)	2015-16 (\$m)
Nursing & Allied Health Rural Locum Scheme	8.1	8.3	8.4	8.6
National Aboriginal and Torres Strait Islander Health Workforce Training Package	10.2	13.1	13.8	14.1
Puggy Hunter Memorial Scholarship Scheme (PHMSS)	4.5	4.6	4.7	4.8
General Practice Training Program <i>Australian General Practice Training Program</i> <i>Prevocational GP Placement Program</i> <i>Remote Vocational Training Scheme</i> <i>General Practice Registrars Australia</i> <i>GP Procedural Training Program</i>	209.2	232.7	251.6	267.1
Rural Health Continuing Education Program (RHCE) <i>Includes Rural Health Education Foundation</i>	3.2	3.3	3.4	3.4
Rural and Remote General Practice Program	18.9	19.6	19.9	20.3
Health Workforce Innovation and Reform <sup>210</sup>	14.6	18.2	14.3	11.0
Medical Rural Bonded Scholarships <i>Includes Bonded Support Scheme</i>	13.1	13.4	13.6	13.9
Specialist Training Program (STP) <i>Includes Diagnostic Imaging – Enhancing Rural and Remote Workforce Scheme</i>	96.8	129.0	140.3	145.2
Rural Health Multidisciplinary Training Program <i>Dental Training Expanding Rural Placements Program</i> <i>John Flynn Placement Program</i> <i>Rural Clinical Training and Support Program</i> <i>University Departments of Rural Health</i>	126.8	128.3	130.5	133.0
Stakeholder Support <i>Includes Bush Services Support Program and nursing stakeholder support</i>	7.1	0.7	2.9	3.0
Nursing & Allied Health Scholarship & Support Scheme	27.1	29.4	30.8	31.4
Nursing in General Practice Program	2.5	3.0	3.1	3.1
Midwife Credentialing	0.0	0.1	0.1	0.1
International Recruitment Strategy (IRS) <i>International Recruitment Strategy</i> <i>Additional Assistance Scheme</i> <i>5 Year Overseas Trained Doctor Scheme</i> <i>Rural Locum Relief Program</i>	4.5	4.8	4.9	5.0
Practice Nurse Incentive Program (PNIP)	302.6	331.2	360.0	366.9
Rural Procedural Grants Program	17.0	17.2	17.4	17.6

<sup>209</sup> Funding figures beyond 2012-13 are indicative. In most cases contractual funding commitments have not been made for these initiatives.

<sup>210</sup> Includes funding for initiatives such as 2013 Additional medical internships, stakeholder support, and evaluation projects.

## Review of Australian Government Health Workforce Programs

Program/Initiative	2012-13 (\$m)	2013-14 (\$m)	2014-15 (\$m)	2015-16 (\$m)
<i>Includes Rural Locum Education Assistance Program</i>				
Radiation Oncology Workforce Program	1.9	1.9	2.0	2.0
Rural Australia Medical Undergraduate Scholarship	10.1	3.3	6.9	7.1
HECS Reimbursement Scheme	11.3	12.0	12.6	13.2
Rural Health Workforce Strategy – Communications	0.1	0.2	0.2	0.2
National Rural Locum Program	2.0	2.1	2.1	2.2
Supporting the Emergency Medicine Workforce	16.4	28.3	27.5	28.0
Telehealth - Training of Medical Professionals <sup>211</sup>	11.6	0.0	0.0	0.0
General Practice Rural Incentives Program (GPRIP)	116.4	88.1	91.6	93.7
Exploring regulation of the personal care workforce <sup>212</sup>	0.4	0.0	0.0	0.0
Outer Metropolitan Relocation Incentive Grant program <sup>213</sup>	1.9	3.8	3.9	3.9
Oral Health Therapists Graduate Year Program	12.7	15.5	8.0	7.5
Voluntary Dental Graduate Year Program	16.8	33.7	24.5	18.1
Dental Relocation and Infrastructure Support Scheme	0.9	22.2	23.9	29.3
Academic Health Sciences Precinct Pilot Project <sup>214</sup>	0.0	0.8	0.2	0.0
Northern Territory Medical Program <sup>215</sup>	2.2	2.3	2.3	2.3
Health Workforce Australia funding	213.6	228.9	231.7	234.2
Section 3GA programs <sup>216</sup>	n/a	n/a	n/a	n/a
<i>Approved Private Emergency Department program</i>				
<i>Approved Medical Deputising Service Program</i>				
<i>Special Approved Placements Program</i>				
<i>Temporary Resident Other Medical Practitioner Program</i>				
Other Medical Practitioner programs <sup>217</sup>	n/a	n/a	n/a	n/a
<i>Rural Other Medical Practitioners Program</i>				
<i>After Hours Other Medical Practitioners Program</i>				
<i>Outer Metropolitan Other Medical Practitioners Program</i>				
<i>Medicare Plus Other medical Practitioners Program</i>				
Bonded Medical Places scheme <sup>218</sup>	n/a	n/a	n/a	n/a

<sup>211</sup> The Telehealth initiative ceases after 30 June 2013.

<sup>212</sup> This program ceases after 30 June 2013.

<sup>213</sup> As of 1 July 2013 Outer Metropolitan Relocation Incentive Grant funding will be devolved to Medicare Locals covering outer metropolitan regions.

<sup>214</sup> This program will commence in 2013-14.

<sup>215</sup> This operational funding is part of the National Partnership Agreement on Health Services between the Commonwealth and the Northern Territory Government.

<sup>216</sup> There is no program funding attached to these programs, but they have cost impacts through Medicare.

<sup>217</sup> There is no program funding attached to these programs, but they have cost impacts through Medicare.

<sup>218</sup> There is no program funding attached to this scheme.



Summary of programs delivered outside HWD

Division	Program	Description	Funding 2012-13
<b>Ageing and Aged Care</b>	Aged Care Education and Training Incentives	Aims to develop and retain a skilled and sustainable aged care workforce by providing incentives to undertake study.	\$13.7m
	Aged Care Nursing Clinical and Graduate Placements	Encourages high quality clinical placements for undergraduate nursing students and transition to practice programs.	\$2.2m
	Aged Care Nursing Scholarships	Provides scholarships for undergraduate and postgraduate study as well as continuing professional development activities.	\$18.8m
	Encouraging Better Practice in Aged Care	Encourages and supports evidence-based care through resource development and evidence translation into care.	\$3.4m
	Nurse Practitioners – Aged Care Models of Practice	Aims to promote models of care and the financial viability of nurse practitioners, thereby promoting access to and growth of this workforce.	\$6.4m
	Training and Research in Aged Care Services	Supports location-specific projects combining teaching, research, clinical care service delivery in a learning environment for nursing students and staff.	\$2.5m
	Aged Care Workforce Vocational Education and Training	Aims to improve quality of care by funding training providers to deliver courses to upskill the workforce.	\$48.7m
<b>Primary and Ambulatory Care</b>	Increased Clinical Teaching Capacity	Increased clinical training capacity for entry level health professionals prior to the establishment of HWA.	\$68.0m 2009-13
	Innovative Clinical Teaching and Training Clinical Grants	Funded infrastructure projects to increase capacity and improved distribution of clinical teaching and training prior to the establishment of HWA.	\$15.0m
	Rural Education Infrastructure Development Pool	Funded capital infrastructure for Rural Clinical Schools.	\$3.2m 2011-12
<b>Medicare Benefits</b>	Better Access to Radiation Oncology	Intends to improve access to radiotherapy services by increasing the size of the trained workforce and improving safety and quality systems.	\$6.8m
<b>Pharmaceutical Benefits</b>	Rural Pharmacy Workforce and Aboriginal and Torres Strait Islander Pharmacy Workforce	Aims to maintain and improve access to services and support the rural workforce, as well as supporting Aboriginal and Torres Strait Islander participation in the pharmacy workforce.	\$8.1m
<b>Population Health</b>	Australian National Breastfeeding Strategy	Develops training materials to assist health professionals to use the World	\$0.1m

## Review of Australian Government Health Workforce Programs

Division	Program	Description	Funding 2012-13
	2010-15: Growth Charts	Health Organisation growth charts.	2011-12
	BreastScreen Australia	Promotes enhanced workforce practices and service models for students and practicing radiographers and radiologists working in mammography.	\$0.3m
	Family Planning Grants Program – Bridging the Gap	Supports the delivery of family planning and reproductive health activities focused on community education, professional development and national leadership..	\$0.1m
	Palliative Care and Advance Care Planning Advisory Services	Fund advisory services to health professionals to assist them in providing palliative care services to older Australians.	\$1.0m
	Palliative Care Curriculum for Undergraduates	Develop and of palliative care teaching and learning resources for health undergraduate courses.	\$0.5m
	Program of Experience in the Palliative Approach	Provides workshops and clinical placements for health care professionals to build knowledge and experience in providing palliative care.	\$3.3m
	Review and Update of the Guidelines for a Palliative Approach in Residential Aged Care	The Guidelines are being reviewed in accordance with NHMRC requirements for review every five years.	\$0.2m
<b>Office of Aboriginal and Torres Strait Islander Health</b>	Remote Area Health Corps	Attracts and recruits urban-based health practitioners and places them in short-term placements in NT indigenous communities where there is demand.	\$6.5m
	Aboriginal Health Worker Ear Training	Training of Aboriginal Health Workers in ear health and hearing monitoring and screening.	\$1.0m
	Outreach worker training and orientation	Orientation and training support for Aboriginal and Torres Strait Islander Outreach Workers funded under the Indigenous Chronic Disease Package	\$0.5m

## Appendix ii: Health Workforce 2025 - summary

Health Workforce 2025 (HW2025) is a health workforce projection study undertaken by Health Workforce Australia (HWA) to assist in future workforce planning. The study aimed to model future health workforce supply and demand across a number of possible policy scenarios.

Health Workforce 2025 – Doctors, Nurses and Midwives Volumes 1 and 2, was released in April 2011 and Health Workforce 2025 – Medical Specialties Volume 3 was released in November 2012.

This appendix provides a short summary of the major findings of the HW2025 analysis. It is not intended to replace the nuance and complexity of the three volumes of the HWA report (and apologies are tendered in advance to the authors of that report if this summary does not do their work justice), but may provide a useful reference point in relation to some of the workforce planning and data issues discussed within this review.

### Conclusions drawn from the HWA findings

This appendix does not seek to summarise the HWA conclusions in their entirety. However, some relevant observations are as follows:

- Transformation of health policy settings is required for health services to be sustainable since the comparison (“do nothing”) scenario shows that there will be a continued geographic maldistribution of doctors and a very significant shortage of nurses by 2025.
- The comparison scenario modelling predicts that there will be a shortage of 109,490 nurses at 2025, which is a 28% shortfall on estimated demand, and a shortage of 2,701 doctors by 2025, a less significant shortfall of 2% below expected demand at that time. (The midwifery workforce data available at the time to HWA was regarded as insufficiently reliable to make reasonable predictions for this workforce segment.)
- Although the HWA report does not explicitly attempt to specify the projected direct and indirect costs of employing, for example, 110,000 nurses, it is clearly both unaffordable in total budget terms and unachievable in terms of recruitment and training. HWA's conclusion is that investment must be made in innovation and reform measures, leading to productivity gains.
- For nurses, HWA modelling projects that measures to improve retention could make a significant impact in reducing workforce shortages. The report notes that there has been increased workforce retention within nursing recently (2007-2008), possibly as a result of the impact of the global financial crisis upon superannuation and retirement funds. If these slowed exit rates were to continue, the expected shortage would decrease by 77%.
- For the medical workforce, HWA modelled a scenario where demand continues to increase and the working hours of doctors continue to reduce, resulting in an even greater shortage in the projected workforce.
- HWA concluded that shortfalls cannot be filled by increased training under the clinical training model as currently configured. HWA modelling indicates that this issue is even more highly problematic in the case of medical postgraduate training (specialist training) which will need to be increased in line with increasing medical graduate numbers and graduate demand.

## Volume 1

### *Policy levers*

HW2025 presents four policy levers which have the potential to address shortages around workforce reform, training, immigration and geographic distribution. The most promising area, for HWA, concerns innovation and reform measures.

The potential solutions identified in HW2025 include changing models of care, adjustments to skills mix, expanded scope of practice, use of assistants or increased use of technology (i.e. telehealth) which aims to increase the efficiency of the workforce without needing potentially significant investments in education.

HWA's workforce planning model appears to be particularly sensitive to changes in demand for health services. It is suggested that lowering demand can be achieved through better health promotion and prevention programs and new technology allowing greater numbers of conditions to be treated diagnosed. Options for improving workforce retention (nurses only) included improving the workplace environment (such as provision of adequate equipment and resources), involvement in decision making, leadership support and the ability to practice to the full scope of practice.

Enhanced targeting of international health professionals to areas of need (whether by specialty or geography) is one strategy to ensure adequate workforce numbers and distribution. The third key policy area is education and training, which is generally defined to mean the quantity and funding of education and training places to educate the undergraduate and postgraduate health workforce. Potential policy reforms outlined by HWA include shortening the length of training, improving the work readiness of graduates, streamlining courses and introducing pathways to generalism especially in rural and remote areas.

HWA notes that any reforms to policies in this area are attended by complexities given the spilt in responsibility between the Commonwealth Education and Health portfolios, state and territory governments as well as the medical colleges, the private and community sectors in funding and providing training to the health workforce. In order to address this issue, HWA has received agreement from Health Ministers to establish a National Medical Training Advisory Network to improve coordination between stakeholders.

### *Modelling*

The principal method used by HWA to develop the projections of the medical, nursing and midwifery workforce numbers is mathematical simulation utilising a "stock and flow" model, where people entering and exiting the workforce (flows) periodically adjust the initial number in the workforce (stock). The workforce is broken down into age and gender cohorts and different flow rates are applied to each cohort. Demand projections are based on service utilisation rates for each population age and sex cohort.

The principle source of HWA's workforce supply data was the 2009 AIHW labour force survey data, estimates of medical and nursing graduates entering the workforce and immigration information on international medical and nursing professionals. However, any model is necessarily only as good as the quality of the data on which it relies and the robustness of the assumptions used to build the model.

In the case of the 2009 AIHW workforce survey data, the response rates to the nursing (44.4%) and medical workforce (53.9%) surveys were low, casting some doubt on the validity of this data. The model will be updated in the future with newly obtained data from the 2011 medical and nursing workforce surveys for which the response rates have been much better; over 80% in both cases.

### *Scenarios*

For the sake of completeness, and to provide the context of current policy debates in this sector, a short summary is provided of the workforce scenarios modelled by HWA.

HWA modelled all scenarios against a “comparison” scenario which assumes that current policy settings are applied into the future and held constant. This comparison scenario results in the projected 2,701 excess demand (shortage) for doctors and a 109,490 excess demand (shortage) for nurses in 2025. These projected shortfalls have in many ways become the “headline” stories arising from the HWA report, and are frequently cited without reference to the more nuanced and complex work undertaken by HWA.

### *Innovation and reform scenario*

These are scenarios predicated upon changes resulting from various demand management initiatives. They are designed to illustrate how responsive the workforce can be to such changes.

- The “productivity gain” scenario assumes a 5% gain from various initiatives which HWA believes are possible with current reform projects. This scenario predicts a 2,811 surplus of doctors and an 89,993 shortage of nurses.
- The “low demand” scenario assumes a 2% reduction in demand due to the effects of preventative health strategies and reform in health care. This scenario envisages that it is possible to achieve an 18,690 oversupply of doctors and a 31,355 shortage of nurses.
- A scenario based on increasing retention rates for nurses applied the unexpected lower 2007-08 nursing exit rate applied across all future projections. Under such a scenario, a shortage of 24,846 was predicted.

### *Immigration scenario*

These scenarios test the impact of changing current immigration levels to move towards self-sufficiency. Under these scenarios, the demand for services is held constant as the number of entrants into the workforce from international graduates and migrants are reduced. Notably, and unsurprisingly, under “self-sufficiency” scenarios there is projected to be an acute shortage of both doctors and nurses. Key points include:

- The medium self-sufficiency scenario postulates a 50% reduction in international migration. The inflow of migration would be progressively cut to 50% of its initial level by 2025. This scenario results in a 9,300 shortage of doctors and a 129,818 shortage of nurses.
- The “high self-sufficiency” scenario would require a 95% reduction in international migration. The inflow of migration is progressively cut to 5% of its initial level by 2025. This scenario results in a 15,240 shortage of doctors and a 148,113 shortage of nurses.

### Other impact scenarios

These scenarios examine the potential impact of other shocks on the health system.

- The “high demand” scenario models the impact of an increase in demand of 2% for health services. This scenario results in a 26,124 shortage of doctors and a 193,122 shortage of nurses. Given past health and technology trends, and trends toward subspecialisation in the medical profession, it is certainly conceivable that demand could accelerate in excess of 2%.
- The “undersupply” scenario assumes that currently the health system is in a state of workforce shortage, rather than using the 2009 position as a “steady state” baseline. Since no reliable estimate of current shortage could be determined, HWA used an assumption of 5%. This scenario results in an 8,389 shortage of doctors and a 193,122 shortage of nurses.
- The “capped working hours” scenario for doctors only models the effect of reduced working hours. The total number of hours worked were capped at 50 hours per week and the equivalent FTE modelled to show a decrease in supply. This scenario results in a 5,178 shortage of doctors.

### Training scenarios

Using the projections estimated in the various scenarios outlined above, HWA calculated the number of graduates which would be required to meet/balance the gaps between supply and demand. For doctors the assumption is an increase in the 2013 intake (with a 5 year lag for course completion) to produce the extra graduates from 2018. For nurses the increase in student numbers occurs in 2013 with graduates entering the workforce in 2016. Given the larger rate of attrition for nursing, student intake figures and graduate figures were employed for each scenario. The clear conclusion is that bridging the gap through training alone will be very difficult given the number of graduates required.

#### *Vocational medical training*

HWA has also attempted to model demand for advanced vocational training positions. This modelling assumed current migration patterns and models the flow of medical graduates through three ‘pools’ of training.

- Pool 1 – PGY1, PGY2, CMOs and those in ‘basic’ specialist training
- Pool 2 – ‘advanced’ specialist training
- Pool 3 – Doctors who have obtained fellowship and are active in the labour force

The results show that if the availability of advanced training places were to be kept fixed at the number required for community needs then there will be an increased pool of pre-vocational (pool 1) doctors who are unable to move through training. If, on the other hand, the number of training places is set in accordance with trainee demand, then specialist training will expand at a much greater rate.

#### *Midwives*

As noted above, HWA encountered data limitations with midwifery and hence 2025 projections of workforce supply were modelled using three different datasets. This resulted in three different projected gap results:

- AIHW data only resulting in an anticipated excess of the midwifery workforce of 721.RI



- 2006 census “hours worked” applied to AIHW data resulting in an anticipated shortage of midwifery workforce of 346.
- 2006 census “hours worked” resulting in a shortage of midwifery workforce of 2,030.

Data limitations were also encountered in the projection of demand for services which was unable to factor in the demand for non-birth services (including early pregnancy services, miscarriages, etc). HWA also encountered difficulty in distinguishing between midwives, registered nurses practising with qualifications in midwifery and registered nurses working in midwifery without midwifery qualifications. Given these data limitations and the variance in projection, the HWA modelling was inconclusive for workforce planning purposes.

#### *Registered nurses vs enrolled nurses*

HWA undertook modelling for the above scenarios (innovation and reform, immigration, other impact and training) separating out enrolled nurses from registered nurses. Most scenarios saw similar projections for both registered and enrolled nurses with the exception of immigration. Varying the international graduates and migration rates is projected to have a greater impact on workforce gaps for registered nurses than on enrolled nurses. Enrolled nursing is not statistically sensitive to changes in immigration rates due to historically low migration rates.

#### *Geographical Location*

The report mapped the number of doctors, nurses and midwives across remoteness areas (Australian Standard Geographical Classification Remoteness Area) using AIHW data. Perhaps unsurprisingly, the results showed that while nurses and midwives were more evenly distributed across the nation, doctor ratios were markedly concentrated in major cities and inner regional areas.

Notably however, nurses in regional, rural and remote areas were older, which would lead to predictions of future geographic maldistribution without appropriate workforce strategies. Given the lack of other health professionals in these areas, HW2025 suggests that the nursing workforce in these areas may come under future pressure.

HWA undertook modelling to show the effect of improving distribution by apportioning the expected increase in doctors (the “comparison/do nothing” scenario) across inner regional, outer regional, remote and very remote areas to gain a 10%, 50% or 100% (even population density) improvement in distribution. The results show an improvement in the ratio of doctors to population in all these areas with a decreased doctor ratio in major cities. In the course of this modelling HWA did not seek to determine which policy levers would be most likely to achieve such changes in distribution.

*Table Aii. 1: Modelled effect of geographical re-distribution of medical practitioners*

Remoteness Area	2025 Headcount of medical practitioners			
	Current distribution	10% improvement in distribution	50% improvement in distribution	100% improvement in distribution
<b>Major Cities (RA1)</b>	86,153	84,933	80,055	75,974
<b>Inner Regional (RA2)</b>	13,751	14,526	17,627	21,504
<b>Outer Regional (RA3)</b>	5,760	6,132	7,622	9,484
<b>Remote (RA4)</b>	1,102	1,135	1,268	1,434
<b>Very Remote (RA5)</b>	422	461	616	810
<b>Australia</b>	109,205	109,205	109,205	109,205

## Volume 2

HW2025 Volume 2 projects both enrolled nursing and registered nursing by areas of practice as well as modelling supply and demand for each of the scenarios across individual state and territories.

HWA modelled scenarios for both enrolled and registered nursing across five areas of nursing practice (acute care, critical care and emergency, aged care, mental health and other nursing) using reported area of practice within AIHW labour force data. For demand side modelling current utilisation rates for each area of practice were applied against population growth.

This modelling may assist policy makers in understanding which areas of practice will be in shortage for both registered and enrolled nursing and therefore in formulating policy responses. State and territory estimates were projected by using the jurisdictional breakdown in AIHW workforce data. Assumptions included constant proportions over time (that is, no interstate/inter-territory movement of workforce), inclusion of all workforces (public, private and community) and the use of modelling to estimate entry and exit rates.

In many cases there were significant differences to the HWA projections and those calculated by individual states, who are the major employers of the nursing workforce. These have been identified as differences in initial staff numbers, data sources, assumptions made on retirement age, demand and exit rates, lack of re-entrants into state workforces and migration. This illustrates the real complexity in trying to bring some element of data rigour to workforce planning.

## Volume 3

HW2025 Volume 3 examines the state of the medical workforce across medical specialties. For each medical specialty the assessment includes an overview of training for Australian graduates, and assessment of the additional training required

for Specialist International Medical Graduates (SIMGs), modelling data (workforce stock, demand and inflows), scenario results and a workforce dynamic assessment.

The scenarios modelled were limited to service and workforce reform, registrar work value, medium self-sufficiency and capped working hours rather than the more elaborate modelling in Volumes 1 and 2. The “service and workforce reform” scenario examined interventions that would increase productivity and lower demand for the workforce. The “registrar work value” scenario assigned all registrars a value of 50% in the last 2-3 years of the training therefore challenging the increasingly prevalent assumption that trainees do not supply specialty medical services.

A “workforce dynamics indicator scale” was used to highlight the current status of each specialty that may be of concern in the future using the average age of the existing workforce, the percentage of new fellows versus fellows exiting the workforce, dependence on migrant inflows and length of training.

HWA calculated demand for each specialty from Medicare and hospital utilisation data. Supply data included the Medical Training Review Panel data on the number of training places and graduates. Also included is data regarding SIMGs from the Australian Medical Council and the Department of Immigration and Citizenship.

The analysis showed that while the number of medical specialists is increasing the workforce is not evenly distributed. There is a growing trend towards specialisation and sub-specialisation, and an insufficient number of generalists.

The specialties estimated to be in shortage by 2025 are obstetrics and gynaecology, ophthalmology, anatomical pathology, psychiatry, diagnostics radiology and radiation oncology. The specialties of cardiology, gastroenterology and hepatology and surgical specialties are currently meeting demand for health services however projections estimate there will be more of these specialists coming through the pipeline than needed by 2025.

The analysis also concluded that general practice, psychiatry, ophthalmology, radiology and obstetrics and gynaecology are highly reliant on international medical graduates.

One of HWA’s significant conclusions is that the medical training pathway is both poorly coordinated and lacks appropriate planning and incentives to ensure the effective distribution of numbers between generalists, specialties and sub-specialties and on a geographical basis.

Data limitations meant that scenario modelling and what HWA termed “workforce dynamics assessments” were not able to be provided for addiction medicine, medical administration, occupational and environmental medicine, pain medicine, palliative medicine, public health, rehabilitation medicine, sexual health medicine, sports and exercise medicine and some physician sub-specialties.

## Appendix iii: History of Commonwealth investment in the medical workforce

### Introduction

The Commonwealth's role in planning and investing in the medical workforce of Australia is based on the principle of ensuring whole community access to quality medical services. Trends in policy development and funding targets have been underpinned by evidence that the geographic and structural distribution of the workforce have not matched population need over time, with the result that parts of the population, notably rural and Aboriginal and Torres Strait Islander communities, and those reliant on the public hospital systems have been underserved.

In contrast, many analysts argue, oversupply of practitioners in other parts of the country, particularly inner metropolitan areas, has led to price distortions which result in inequitable access to medical services by different sectors of the community as well as unnecessary expenditure of public money. The following is a history of the various key Commonwealth investments, policies and programs which have contributed to the current supply and distribution patterns of medical practitioners in Australia in 2013.

### Supply

#### *Sourcing the workforce - domestic education*

Historically, policies surrounding medical school places in Australia have fluctuated between phases of restriction and expansion.<sup>219</sup> However, the last 10 years have been a cycle of growth with 20 medical schools operating in Australia in 2012 compared to 10 in 2003. The increase in capacity for training has naturally led to an increase of graduates with an expected 3,512 students completing their degree in 2012 up from 1,633 in 2006.<sup>220</sup>

The current efforts to increase the domestically trained medical workforce are not without precedent. There was a mini-boom in medical workforce supply during the 1970s when the number of Australian medical graduates rose from 851 in 1970 to 1278 in 1980. This may be attributed to the release of the Karmel report (1973) with its recommendation to increase undergraduate medical places to respond to a perceived future shortage of doctors. In contrast – and as a result of a shift to a policy of constraint – graduate numbers remained quite static during the 1980s and 1990s, at around 1200-1300 per year.<sup>221</sup>

As discussed in Chapter 3, controls on the allocation of Commonwealth Supported Places (CSPs) in medicine were first announced in 1995 and implemented in 1996 in response to the view that there were adequate numbers of medical practitioners to serve the population. Amongst health portfolio considerations were concerns about pressure of graduate numbers on future Medicare rebateable services. Caps on the number of medical places still remain in force however the upper limit was increased

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<sup>219</sup> Joyce et al. (2007). Riding the wave: current and emerging trends in graduates from Australian university medical schools. *Medical Journal of Australia*, 197(6):374-5

<sup>220</sup> Medical Training Review Panel, 15th Report 2012

<sup>221</sup> Joyce et al, loc cit.

in 2006, with 605 additional CSPs announced by the Council of Australian Governments (COAG). A corresponding commitment to Commonwealth investment in new medical schools was also made. To support the 605 new places the Commonwealth, jointly with Victoria, committed to provide a total of \$46 million in capital funding for medical schools at Deakin and Monash Universities. The Commonwealth also offered to provide further capital funding of about \$26 million for New England, Queensland and James Cook Universities, subject to matching funding from the states.<sup>222</sup>

Under the *Higher Education Support Act 2003* (HESA), the Minister for Tertiary Education has the authority to make changes to the controls on Commonwealth supported places in medicine courses (the only course of study exempted under HESA). Advice on the impact on the health system of additional CSPs in medicine is sought from the Minister for Health and Ageing.

From 2009 domestic undergraduate full-fee paying places (DUFFP) have been phased out and no new intake is permitted in public universities. Universities are able to determine the number of places they offer each year to international medical students. Currently there are no controls on international student numbers. This combination of policy settings produces paradoxical and controversial outcomes.

#### *Sourcing the workforce - overseas trained doctors (OTDs)*

In 2009, 25.5% (18,458) of medical practitioners in Australia obtained their first medical qualification overseas.<sup>223</sup> Although Australia's migration patterns had always included those in the medical profession, the 1990's saw the rise of OTDs entering Australia on temporary contracts. This was likely in response to the long period of stable domestic graduation described above. The Australian Institute of Health and Welfare's *Medical Labour Force 1998 report* shows that 893 OTDs entered on temporary contracts in 1993-94, increasing to 2,224 in 1998-99 and that these doctors stayed for an average of one year.

A decade later, the figures reflect that the situation is little changed; more visas were granted to medical practitioners in 2009-10 (3,190 temporary and 1,551 permanent visas) than there were doctors graduating from Australian Universities (2,380) in 2009.<sup>224</sup> The goal of achieving self-sufficiency in the medical workforce has been discussed in various policy documents concerned with domestic and international workforce planning. The 2004 National Health Workforce Strategic Framework recommended that the focus of Australian workforce planning be national self-sufficiency and acknowledged that under-investment has influenced approaches to self-sufficiency and use of OTDs to meet workforce needs particularly in areas experiencing shortage.<sup>225</sup> The 2005 Productivity Commission's Review "Australia's Health Workforce" recommended that:

COAG should consider whether the current wording of the self-sufficiency principle in the National Health Workforce Strategic Framework is unduly restrictive in the

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<sup>222</sup> COAG [Communique July 2006](http://www.health.gov.au/internet/main/publishing.nsf/Content/6F61F2FB891D83D6CA25726B0003893D/$File/mstapd.pdf), accessed at [http://www.health.gov.au/internet/main/publishing.nsf/Content/6F61F2FB891D83D6CA25726B0003893D/\\$File/mstapd.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/6F61F2FB891D83D6CA25726B0003893D/$File/mstapd.pdf)

<sup>223</sup> AIHW (2011). Medical labour force 2009. AIHW bulletin no. 89 Cat.no. AUS 138. Canberra

<sup>224</sup> Health Workforce Australia 2025: Doctors, Nurses and Midwives Vol. 1, 2012

<sup>225</sup> Australian Health Ministers' Conference, 2004

context of the international nature of the health workforce and if so, how it should be interpreted.

Currently, the formal goal of self-sufficiency is difficult to reconcile with the pragmatic challenge presented by the projected shortfalls in medical practitioners if net migration is reduced, as reflected in HWA modelling.<sup>226</sup> However, the Commonwealth commitment to increasing the domestically trained workforce indicates movement towards achieving this goal.

### *Accreditation and assessment*

Responsibility for the development of accreditation standards, policies and procedures for medical programs of study for entry level courses and vocational training based predominantly in Australia and New Zealand and for assessment of OTDs for registration in Australia lies with the Australian Medical Council (AMC).

Under Section 42 of the National Law the AMC is responsible for:

- assessing the training and assessment standards of specialist colleges (including their assessment of overseas trained specialists); and
- assessing authorities in other countries who conduct examinations for registration in a health profession, or accredit programs of study relevant to registration in a health profession, to decide whether persons who successfully complete the examinations or programs of study conducted or accredited by the authorities have the knowledge, clinical skills and professional attributes necessary to practice the profession in Australia.

There are three main pathways for assessing the suitability of OTDs for registration in Australia:

- a) the AMC examination/assessment pathway for **non-specialists**; (standard pathway)
- b) the competent authority pathway for **non-specialists** which fast tracks doctors from countries with similar training and assessment standards to Australia; and
- c) the **specialist** assessment pathway which relies heavily on the specialist medical colleges to provide advice on the suitability and comparability of the candidate to Australian trained specialists.

In the 2006-07 Budget there was a commitment to various initiatives under the Strengthening Medicare package to attract OTDs to Australia. Over 300 additional doctors were expected to be working in areas of workforce shortage as a result of these programs. In 2008, 41% of practitioners in rural and remote areas had received their training overseas.<sup>227</sup> These figures also reflect the changes to the *Health Insurance Act (1973)* which were enacted in 1996, described in more detail below.

Under the Strengthening Medicare initiatives, DoHA endorsed a number of organisations to carry out the recruitment of OTDs to Australia. The Rural Workforce Agencies (RWAs) also have broader responsibility for support services and

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<sup>226</sup> Health Workforce Australia 2025: Doctors, Nurses and Midwives Vol. 1, 2012

<sup>227</sup> Audit of Health Workforce in Rural and Regional Australia, 2008



workforce planning. Rural Health Workforce Australia is the peak body for the seven RWAs that operate in each state and the Northern Territory. RWAs are not-for-profit organisations funded by DoHA as well as their respective state Governments.

RWAs recruit and support doctors in rural and remote communities. This includes crucial assistance and case management for OTDs as well as workforce support for Aboriginal Medical Services. They are funded to deliver programs for non-GP health professionals, such as the Medical Specialist Outreach Assistance Program which enables multidisciplinary health teams to visit rural and remote communities experiencing chronic health issues.

DoHA meets the recruitment costs associated with placing an OTD in an eligible medical vacancy, provided the medical recruitment agency assisting in filling the vacancy is one contracted for this purpose. For a position to be considered eligible for filling by an OTD the position needs to meet specific criteria, such as:

- the vacancy must be in a recognised District of Workforce Shortage
- the vacancy must be available for filling for a period of at least 12 months
- the location must have a current state area of need determination
- there is a billing component through Medicare.

### Quality and distribution

Until the late 1980s, the size and structure of the medical workforce was largely unregulated by the various state and Commonwealth governments.<sup>228</sup> Although the introduction of Medicare in 1984 reduced the role of private health insurance and guaranteed Australians free access to the public health system, the retention of the fee-for-service model still blunted any market pressures which would otherwise encourage the movement of doctors to the areas of greatest need. This is because the provision of a set level of public subsidy per eligible patient service is economically attractive in population dense areas or areas in which an individual practitioner's specialty is in greatest demand due to the potential for high practice throughput.

In 1989 the Commonwealth established a vocational register for general practitioners to recognise general practice as a discipline in its own right, improve professional standards and to reward high-quality practice. Between 1989 and 1995, medical practitioners already practising in general practice who met the eligibility criteria could apply to be grandfathered on to the vocational register. The grandfathering period for the vocational register ended in November 1996 with the introduction of the Medicare Provider Number Legislation.

As a result of the 1996 Commonwealth Budget, there were major changes to the *Health Insurance Act (1973)* to include new sections 19AA, 3GA and 3GC, collectively known as the Medicare Provider Number Legislation. These amendments had their basis in concerns about the quality and safety of care being

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<sup>228</sup> Department of Health and Aged Care Occasional Paper New Series No. 12 *The Australian Medical Workforce*. August 2001

delivered to the Australian community and as a policy mechanism to enable growth of the medical workforce to be kept in line with population needs. Prior to the introduction of this legislation it was possible for interns who had not received their basic registration to enter private practice i.e. to provide services which attract Medicare rebates. It was determined that without specific postgraduate training relevant to a particular field of medicine, the possibility of providing services that were inappropriate was considerably increased.

Under s. 19AA, any doctor who was fully registered as a medical practitioner after November 1996 could not have an unrestricted Medicare provider number until he or she had completed specialist training and gained fellowship of a recognised medical college or was doing an approved placement on a s. 3GA program.<sup>229</sup> This continues to be the position. Section 19AB is a related section of legislation, which restricts OTDs' and foreign graduates of accredited medical schools' (FGAMs) access to Medicare benefits, for a period of generally 10 years, unless the doctor is working in a DWS. This is commonly known as the '10 year moratorium'. OTDs and FGAMs can access Medicare benefits for the services they provide in a DWS if they obtain an exemption under s. 19AB of the Act. OTDs and FGAMs who are Australian permanent residents or citizens and who have yet to gain Fellowship of a specialist college or vocational recognition are also subject to s. 19AA of the Act. This group of OTDs are eligible to work under s. 3GA programs.

### Rural workforce

In April 2008, the then Minister for Health and Ageing released a report on the Audit of Health Workforce in Rural and Regional Australia. The findings of the audit were that the supply of the medical workforce, when considered as the number of doctors in comparison to the population area where they practice, was low to very poor in many regional and remote areas of Australia.<sup>230</sup>

Although there is a heavy reliance on OTDs in rural and regional areas, the rise of needs based planning, focused on health service delivery by region has led to a number of programs and initiatives to encourage Australian graduates to train and remain in rural and regional areas. However, with the exception of s. 19AB restrictions on OTDs and return of service obligations for bonded places and scholarships, these measures are almost all voluntary.

### Early initiatives

The Rural Undergraduate Support and Coordination Program (RUSC) established in 1993 was one of the many initiatives developed to promote rural general practice as a career. Funding was provided to universities for rural placements for medical students, to establish rural health clubs and to increase the level of rural health teaching available through Australian medical schools. Participating universities were required to provide 4 weeks of RUSC funded rural placements to all medical students. On 1 July 2011, the RUSC and Rural Clinical Schools program merged to become the Rural Clinical Training and Support (RCTS) program.

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<sup>229</sup> Department of Health and Ageing. [Section 19AA of the Health Insurance Act 1973: Factsheet](http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/section19AA)  
<http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/section19AA>

<sup>230</sup> Australian Government Department of Health and Ageing (2008). *Report on the Audit of Health Workforce in Rural and Regional Australia, April 2008*. Commonwealth of Australia, Canberra.

Another early measure targeted at individual medical students was the (still extant) John Flynn Placement Program (JFPP), developed as part of the General Practice Strategy (1996-97 Budget) aimed at addressing the maldistribution of general practitioners between urban and rural areas.

### *A coordinated response to rural workforce development*

In March 1999, all Australian Health Ministers approved a policy framework to coordinate rural health efforts. This document: *Healthy Horizons, A Framework for Improving the Health of Rural, Regional and Remote Australians* was developed in consultation with the National Rural Health Alliance, a key peak organisation representing a broad range of interests in rural health. A \$162 million package to further doctors' and medical graduates' training and educational needs was later announced as part of the 2000-01 Budget's Regional Health Strategy - More Doctors, Better Services.

Under the package, nine new Rural Clinical Schools and three new University Departments of Rural Health (UDRHs) were established to allow a rural-focused national network of training. This built on the existing Commonwealth supported regional clinical training school at Wagga Wagga and the seven UDRHs around the country. This was a significant investment in novel models of training delivery spread over non-traditional teaching settings. It represented an investment in both traditional infrastructure and in 'human capital' - based on the premise that completing study and training in rural areas will ultimately encourage medical practitioners to settle there permanently once they obtain their specialist qualifications.

Specific measures from the Regional Health Strategy included:

- The Rural Australia Medical Undergraduate Scholarship (RAMUS) Scheme;
- The Medical Rural Bonded Scholarship (MRBS) Scheme; and
- The HECS Reimbursement Scheme.

### *Development of further initiatives*

The Regional Health Strategy was reviewed in 2003. The review found that the strategy had been effective in meeting its aims of providing more doctors and better services to people in rural and remote Australia. The review recommended that the strategy continue, with some administrative enhancements and with a greater emphasis on preventative health and providing access to health services in more remote areas. Building on the Regional Health Strategy, the Rural Health Strategy announced in the 2004-05 Budget provided \$830.2 million over four years for a flexible package of health and aged care services and workforce measures. Workforce measures included:

- The Bonded Medical Places (BMP) Scheme; and
- The Prevocational General Practice Placement Program (PGPPP).

### *Rural Health Workforce Strategy*

The Rural Health Workforce Strategy committed \$134.4 million in the 2009-10 Budget in response to the findings of the 2008 Audit of Health Workforce in Rural and Regional Australia. The major component of the Strategy is the General Practice Rural Incentives Program (GPRIP) which commenced on 1 July 2010. GPRIP is a consolidation of two previously separate retention incentive programs available to GPs and registrars and a new relocation grant.

Also announced under the Strategy was the scaling initiative. From January 2010 scaling has been applied to a range of Rural Health Workforce programs that have a return of service obligation, including the BMP Scheme. Scaling increases the attractiveness of working in rural areas by fast tracking the return of service obligation based on the ASGC-RA category which the practitioner is working in. The greatest incentives are for practitioners working in the most remote locations of Australia. Scaling discounts are applied either by the Department of Health and Ageing in the case of salaried officers or based on monthly claiming activity if Medicare is being billed.

### Health reform

In response to the Productivity Commission's 2005 Report, Australia's Health Workforce, COAG announced a package of key health workforce reforms on 8 April 2006.

#### *COAG 2006*

- To help ensure that specialist trainees have appropriate skills and experience, COAG agreed that the Commonwealth and the states and territories would establish, by January 2008, a system for these trainees to undertake rotations through an expanded range of settings beyond traditional public teaching hospitals. This would include a range of public settings (including regional, rural and ambulatory settings), the private sector (hospitals and practices), community settings and non-clinical environments such as simulated learning. This became the 'Specialist Training Program' (see below).
- COAG agreed that the Commonwealth would provide about \$120 million over four years to fund 605 new medical places. In April 2006, 400 new medical school places were announced with an additional 205 places announced in July 2006. Agreement was also given by states and territories to guarantee high quality internship places to medical graduates in a Commonwealth supported place (CSP).
- COAG also agreed to establish a taskforce on the national health workforce to undertake project-based work and advise on workforce innovation and reform. The National Health Workforce Taskforce was subsequently established, providing advice and secretariat support to the Health Workforce Principal Committee (HWPC), the Australian Health Ministers' Advisory Council (AHMAC) and the Australian Health Ministers' Conference (AHMC).
- To facilitate workforce mobility, improve safety and quality and reduce red tape, COAG agreed to establish, by July 2008, a single national registration scheme for health professionals – beginning with the nine professions currently registered in all jurisdictions. They also agreed to establish by July 2008 a single national accreditation scheme for health education and training, to simplify and improve the consistency of current arrangements.

#### *COAG 2008*

The COAG 2008 Health and Hospital Workforce reform package built on the investments made under the COAG 2006 agenda.

- A Health Reform package of \$1.1 billion of Commonwealth funding was committed, of which \$500 million was additional funding for undergraduate

clinical training, including increasing the clinical training subsidy to 30% for all health undergraduate places. The package also provided for an increase of 605 postgraduate training places, including 212 GP places, and the establishment of a national health workforce agency (Health Workforce Australia) and health workforce statistical register to drive a more strategic long-term plan for the health workforce.

- Investment of \$175.6 million over four years in capital infrastructure was committed to expand teaching and training, especially at major regional hospitals to improve clinical training in rural Australia.
- The 212 additional ongoing GP training places were intended to boost the total number of GP training places to over 800 from 2011 onwards, and 73 additional specialist training places in the private sector. Funding was also to be provided to train approximately 7,000 medical supervisors.

### Commonwealth funded vocational training programs

#### *Australian General Practice Training Program (AGPT)*

Following a ministerial review announced in January 1997 it was determined that a Commonwealth owned company delivering a regionalised approach to vocational education and training would be established. Subsequently in 2001 General Practice Education and Training Ltd (GPET) was established by the Commonwealth for this purpose. GPET is responsible for the management of the AGPT and, since 2010, PGPPP. Previously the Royal Australian College of General Practitioners was responsible for the vocational training of GPs. Unlike training leading to Fellowship of other specialist medical colleges, the cost of GP training is fully funded by the Commonwealth.

#### *Specialist Training Program*

The Commonwealth has been supporting the provision of specialist training arrangements in rural and outer metropolitan areas since 1997 with the establishment of the Advanced Specialist Training Posts in Rural Areas (ASTPRA) measure in the 1997-98 budget. This early work was complemented and significantly expanded through the 2006 COAG decision to fund training places in settings other than public teaching hospitals. This initiative became known as the Expanded Specialist Training Program (ESTP). At the same time funding was provided through the COAG National Action Plan on Mental Health (2006-2011) to fund psychiatry training, delivered through the Psychiatry Training Outside Teaching Hospitals (PTOTH) program. Further COAG investment was agreed to in 2008 through the Hospital and Health Workforce Reform - Health Workforce package.

Under the 2009-10 Budget a number of Commonwealth funded specialist training programs were brought together into a single initiative the 'Specialist Training Program' (STP). On 15 March 2010 the Government announced the National Health and Hospitals Network initiative "Expand and Enhance the Specialist Training Program". This provided resources to increase the number of specialist training places to be made available under the Program to 900 by 2014, and allowed for resources to support the private sector via a clinical supervision and infrastructure allowance. The funding associated with the medical components of the Government's "More Doctors and Nurses for Emergency Departments" election commitment that was announced in 2010 is now being administered under the STP.



Note: accredited training leading to Fellowship of specialist medical college is generically referred to as a 'specialist medical college training program'. This should not be confused with the Commonwealth Government's STP, which is a discrete funded initiative supporting training places at health care settings, as opposed to places on a training program for individual graduates.

### Workforce Programs

#### *Commonwealth section 3GA workforce programs*

All medical practitioners restricted by s. 19AA of the Act are unable to claim Medicare benefits for services unless they apply to participate on an approved training or workforce program under s. 3GA of the Act. There are placements in various approved training programs which allow doctors to access the Medicare benefits arrangements while undertaking vocational training to gain Fellowship of a recognised medical college. Alternatively, the doctor can be placed in a workforce program where workforce shortages have occurred.

The Rural Locum Relief Program (RLRP) was introduced in 1998. It enables doctors who are not otherwise eligible to access the Medicare Benefits Scheme (MBS) to have temporary access when providing services through approved placements in rural areas. RWAs in each state and the Northern Territory administer the program on behalf of the Commonwealth. Doctors without postgraduate qualifications who fall within the scope of the restrictions under s. 19AA of the Act are eligible to make an application to their respective state or territory RWA for a placement on the program. For OTDs who are subject to the restrictions under s. 19AB of the Act, practice locations must be within a DWS. Participants in the program are given clinical support and mentoring throughout the placement. Longer-term participants must undertake appropriate education and training to achieve postgraduate qualifications in general practice.

The purpose of the Approved Medical Deputising Service (AMDS) program is to expand the pool of available medical practitioners who may work for after-hours deputising services. This program allows otherwise ineligible medical practitioners to provide a range of restricted professional services, for which Medicare benefits will be payable, where the medical practitioner works for an approved medical deputising service. The AMDS program was established under s. 3GA of the Act in 1999 in response to concerns about the shortage of medical practitioners providing after-hours home visit services in metropolitan areas.

The Approved Private Emergency Department (APED) program allows advanced specialist trainees undertaking emergency medicine training to work under supervision in accredited private hospital emergency departments. The program was established to enhance public access to private emergency departments by expanding the pool of doctors able to work in these settings.

Special Approved Placements Program – established December 2003. This program allows medical practitioners to access Medicare benefits in metropolitan areas if they can demonstrate exceptional circumstances that make them unable to participate on any other workforce or training program under s. 3GA of the Act.

The Temporary Resident Other Medical Practitioners (TROMPs) Program was established in 2001. The program was introduced to overcome an unintended consequence of amendments to the 1996 Medicare provider number legislation,



which would have resulted in a number of long-term temporary resident medical practitioners losing access to Medicare benefits. This affected temporary resident medical practitioners who had entered medical practice in Australia prior to 1 January 1997 and who were not vocationally recognised. The TROMPs program provides access to Medicare benefits at the A2 rate for these eligible medical practitioners.

Medical Specialist College Training Programs – for trainees on the pathway to fellowship of a specialist medical college. Under s. 3GA of the Act, a trainee undertaking advanced training in a specialist medical college approved training placement may be listed on the Register of Approved Placements. The specialist medical college must provide written notice of the trainee and placement location and duration to the Chief Executive Medicare. The college must also confirm that the placement is advanced according to the college training program.

### Timeline of key events in the Development of the Medical workforce

Time Period	Policy Drivers	Policy and Program Activity
<b>1970s</b>		
1973	Karmel Report	Increase in undergraduate medical school places
<b>1980's</b>		
1984	Establishment of Medicare	Universal public health insurance
1985	Australian Medical Council established	Accreditation of Australian Medical Schools by a local independent body as opposed to oversight from the General Medical Council of the United Kingdom.
1988	Doherty Report	Linked medical education with health service delivery
1989	Improvement in the quality of general practice	Vocational registration for GPs commenced
<b>1990s</b>		
1996	Rural workforce shortage, concerns about quality and safety in health care delivery.	Introduction of Medicare Provider Number Legislation – s. 3GA Workforce Programs, s. 19AB exemptions etc.
1996-97	Shortage of practitioners experienced in rural practice	First 7 University Departments of Rural Health established
1997-98	Shortage of practitioners in rural areas	Rural retention program – GP retention grants for rural workforce
1999	AHMC policy framework to coordinate rural health efforts	<i>Healthy Horizons, A Framework for Improving the Health of Rural, Regional and Remote Australians</i>
<b>2000s</b>		
2000-01	Australian Health Workforce Advisory Committee established under AHMAC	Rural Health Strategy: New RCSs and UDRHs, HECS Reimbursement Scheme, MRBS, RAMUS
2001	Un-met need and under supply of doctors in rural areas	Health Insurance Act amendments (Rural and Remote Area Medical Practitioners) Bill 2000. Additional 100 places per year through MRBS.

<b>Time Period</b>	<b>Policy Drivers</b>	<b>Policy and Program Activity</b>
2002-03	Policy to encourage more doctors to relocate from metro to outer metropolitan areas	Incentives for doctors to relocate to outer metro, increased levels of GP and specialist registrars undertaking placements in outer metropolitan areas
2003-04	Future workforce shortages identified.	Additional Commonwealth supported places for medicine. Bonded Medical Places Scheme started Jan 2004.
2004	The National Health Workforce Strategic Framework (AHMC)	Endorsed by COAG 2006
2004-05	Strengthening Medicare Package.	Higher Medicare rebates to non-VR GPs if they work in a DWS/AoN.
2005	Productivity Commission Review "Australia's Health Workforce"	2006 COAG Health Reform
2005	Biennial review of Medicare provider number legislation	Updates to s. 3GA programs including PGPPP and relevant changes to Schedule 5 of the Regulations.
2006	COAG Health Workforce Reforms	Response to productivity commission report - NRAS, 605 additional medical places and guaranteed internship places for CSP students.
2006	Medical Training and Review Panel	Subcommittee formed to take on role monitoring clinical training
2006-07	COAG	2006 - Expanded specialist training program. 2007 Additional PGPPP, specialist and GP places.
2008	Report on the Audit of Health Workforce in Rural and Regional Australia	The main findings of the report were that there is a persistent workforce shortage in rural and regional areas leading to resources being allocated in the subsequent budget.
2008	National Clinical Training Review reports provided to MTRP	Reports supported COAG 2008 health workforce reforms in relation to improving clinical training capacity.
2008	Bradley review	Higher education reform, retained cap on medical places but recommended uncapping nursing and allied health.
2008-09	National Health and Hospitals Reform Commission	

<b>Time Period</b>	<b>Policy Drivers</b>	<b>Policy and Program Activity</b>
2009	Response to the Bradley review of Higher Education	Student centred funding, removal of caps, increased indexation.  A demand-driven funding system commenced in 2012, with exception of medicine.
2009-10	<i>2009-10 Rural Health Workforce Strategy Budget</i>	Adoption of ASGC-RA classification, replacing RRMA. General Practice Rural Incentive Program. New scaling initiatives for bonded medical students and retention and relocation grant programs. Pathology and diagnostic imaging workforce training places and support for rural pathologists.
2010	COAG 2008	Health Workforce Australia established
2010	Health reform	Increased specialist and GP training places
2010	COAG 2006 - NRAS	Medical Board of Australia commences
2011	Knight - Strategic Review of Student Visa Program	Temporary student visa class easier to obtain
2011	COAG	August – COAG National health reform agreement
2012	Health Workforce Australia 2025 Vol 1-3	Contains detailed supply and demand projection results for the medical and nursing and midwifery workforces.

## Appendix iv: History of Commonwealth involvement in the nursing and midwifery workforce

### Introduction

Nursing and midwifery workforce issues are matters for both Commonwealth and state governments. As the major employer of nurses and midwives, the states and territories are primarily responsible for recruitment and retention. The Australian Government is responsible for funding the delivery of health services and for university education of nursing and midwifery students.<sup>231</sup> The Commonwealth's wider function in planning and investing in the nursing and midwifery workforce of Australia has only emerged relatively recently. Initially, the majority of funding and policy initiatives were directed through the Education portfolio driven by the transition of nursing to the tertiary education sector in the early 1980s. Later, investment through the Council of Australian Governments' (COAG) 2006 Health Reform Agenda has resulted in a much broader role for the Commonwealth with the ability to impact on the workforce through education and training reform.

### Background

#### *Nursing*

Historically, nursing education in Australia was public hospital based, with an apprenticeship style system whereby the students were paid under conditions which included full board and lodging. Gradually, regulatory bodies for nursing were established in each state and territory. This resulted in the introduction of minimum standards for both the theory and clinical components of nurse training and the accreditation of schools for general nursing education. These agencies or authorities also maintained a register of those who had met the required standards and were eligible to practice as registered nurses. Admittance to the register was controlled by state-based examination near the end of the training period.<sup>232</sup>

By the 1980s, many of the schools of nursing in the smaller, regional and rural hospitals had closed as they did not have the capacity to meet the stringent educational requirements of the state-based nursing registration boards. The 1980s had seen a rapid increase of technology in the health sector and this in turn placed demands on all health professionals to expand their scope of practice with the nursing curriculum increasing from 1,000 to 1,200 hours over the three years training period. When the registration boards proposed an increase to 1,500 hours in order to include the theoretical components necessary for a nurse to be educated to meet the increasing demands of health care, it rendered this type of education no longer viable outside of the larger metropolitan centres.

Ultimately, it was agreed by the majority of stakeholders that the delivery of a contemporary curriculum reflective of the changes in the health system could only be delivered in the tertiary education sector. The legislation to enable the transfer was passed on 24 August 1984. States and territories moved at various speeds in establishing timetables to implement the transfer. NSW moved quickly and had

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<sup>231</sup> Council of Australian Governments' [Communique 14 July 2006](http://archive.coag.gov.au/coag_meeting_outcomes/2006-07-14/index.cfm) at [http://archive.coag.gov.au/coag\\_meeting\\_outcomes/2006-07-14/index.cfm](http://archive.coag.gov.au/coag_meeting_outcomes/2006-07-14/index.cfm)

<sup>232</sup> Extract (2005) from Russell, L (1990). *From Nightingale to Now: Nurse Education in Australia*

completed the transfer by 1987 while other jurisdictions embarked on programs to complete the transfer by 1991. Queensland was the last state to enact the reform finally commencing its transfer in 1991 with a three year completion date. All jurisdictions established teams to manage the process and there was an Inter-jurisdictional Committee established at the Commonwealth level.

During the period of transfer from 1985 to 1993 the funding of nursing in higher education was shared by the state and territory governments (75%) and the Commonwealth (25%).<sup>233</sup> As part of the agreement for the transfer, the Commonwealth proceeded on a program of infrastructure grants to jurisdictions to provide nursing education facilities at universities. These facilities were mostly in the form of buildings for classrooms, clinical laboratories and offices. The state and territory health departments retained the funding used for hospital based nursing training or re-directed it to clinical supervisor positions in anticipation of the changed model of education and training. From 1 January 1994, the Commonwealth assumed responsibility for full public funding for tertiary nursing education.<sup>234</sup>

As discussed in Chapter 7, at present the qualifications and skill level required for registration or enrolment as a nurse reflect the various types of work and level of responsibility in the workplace. For registered nurses, a 3-year bachelor or postgraduate degree in nursing (or the equivalent) is usually required. This degree includes both theoretical and clinical aspects. Enrolled nurses usually work with registered nurses to provide patients with basic nursing care, doing less complex procedures than registered nurses. Enrolled nurses must have completed an appropriate vocational education and training (VET) course or equivalent, lasting between 1 and 2 years, providing a theoretical base as well as supervised clinical experience. At present, 1 year courses for enrolled nurses are being phased out.

Nurse practitioners also train as registered nurses but undergo additional tertiary education at Master's degree level and training in nursing at an advanced level, in line with their additional responsibilities. Working autonomously in an advanced and extended clinical role, authorised nurse practitioners may perform some specified functions traditionally done by a medical practitioner, such as prescribing some medications, ordering diagnostic tests and making referrals when operating within approved guidelines. Nurse practitioners are currently a small group, with 731 registered in Australia in 2012, according to the Australian Health Practitioner Regulation Agency.

### *Midwifery*

The formalisation of midwifery training in Australia began with the Diploma of Midwifery issued by the Women's Hospital in Melbourne from 1893, undertaken after 'general' nursing training.<sup>235</sup> Transition to a degree based qualification began at Flinders University in Adelaide, which offered the first Bachelor of Midwifery for registered nurses in 1997.<sup>236</sup> However, the traditional model of midwives possessing nursing qualifications has been altered in the last 15 years.

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<sup>233</sup> Nursing education in Australian universities: report of the national Review of Nurse Education in the Higher Education Sector - 1994 and Beyond

<sup>234</sup> *ibid.*

<sup>235</sup> Thornton, A. (1972). The past in midwifery services. *Australian Nurses Journal* 1, March (9):19-23

<sup>236</sup> Flinders University, 2011. <http://www.flinders.edu.au/courses/undergrad/bmidu/>



Direct entry midwifery degrees at undergraduate level are now available in most Australian states, with at least four such degrees planned or in existence since 1998. These new degrees differ in that they do not require pre-registration as a nurse to be accepted into the course, although alternative more streamlined pathways have been maintained for nurses who wish to obtain midwifery qualifications. Direct entry midwives, as with other midwives, must be registered with the Nursing and Midwifery Board of Australia to practise.

### *HECS-HELP*

As of December 2010, under the Commonwealth Grants Scheme for funding of university places, nursing courses of study were listed as a national priority and specific purpose funding is available for nursing clinical placements.<sup>237</sup> For students commencing in 2008, nursing was in the lowest band of HECS-HELP 'national priority' for student contributions.

From 1 January 2010, the maximum annual student contribution amount for commencing Commonwealth supported students undertaking nursing units of study increased from the 'national priority' rate to the Band 1 rate. This was due to the Bradley Review of Australian Higher Education which found that student demand was not impacted by lower student contribution incentives and recommended increasing the maximum student contribution for nursing study from the "national priority" rate of \$4,249 to the Band 1 rate of \$5,310 from 2012 and indexed.<sup>238</sup> This has been implemented with an associated reduction in HELP debts for eligible nursing graduates who work in the nursing profession. A maximum reduction of \$1,558.50 (indexed) is available for up to 5 years of eligible employment to encourage graduates to remain in the nursing workforce.

### *The nursing and midwifery workforce*

Australian Institute of Health and Welfare reports that:

- In 2011, the total number of nurses and midwives registered in Australia was 326,669, a 6.8% increase since 2007 (305,834).
- Between 2007 and 2011, the number of nurses and midwives employed in nursing or midwifery increased by 7.7% from 263,331 (86.1% of registrations) to 283,577 (86.8% of registrations).
- Of these people employed in nursing and midwifery, 36,074 were midwives (including 1,517 people registered as midwives but not nurses), though only 15,523 reported working in midwifery as the principal area of their main job.<sup>239</sup>

Data on students completing courses leading to registration as a nurse from 2001 to 2011 have been provided by the Australian Government Department of Industry, Innovation, Climate Change, Science, Research and Tertiary Education. Figure iv.1 indicates that overseas student numbers have been increasing rapidly, doubling from 2005 to 2007 and doubling again from 2007 to 2011. Domestic graduates showed similar growth.

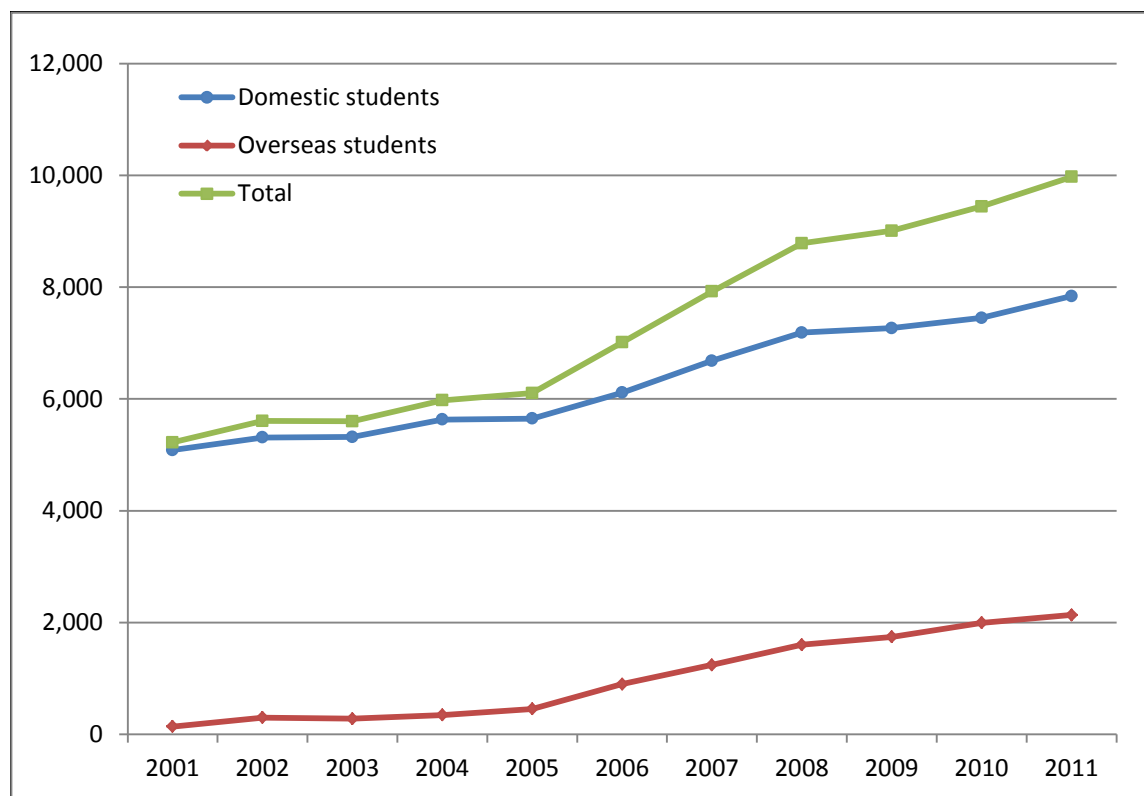
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<sup>237</sup> Department of Education, Employment and Workplace Relations. Administrative information for providers: Commonwealth Grant Scheme.

<sup>238</sup> Review of Australia Higher Education: The Bradley Review Report 2008

<sup>239</sup> Australian Institute of Health and Welfare: Nursing and Midwifery Workforce 2011

Figure iv.1: Students completing courses leading to registration as a nurse, 2001 – 2011



Source: Australian Government Department of Industry, Innovation, Climate Change, Science, Research and Tertiary Education

### Overseas trained nurses and midwives

The Nursing and Midwifery Board of Australia (NMBA) assesses internationally qualified nurses and midwives against criteria that will align them with the requirements for Australian qualified applicants for registration, as specified in the NMBA's registration standards and the board approved course accreditation standards.

Though New Zealand nurses and midwives registered with the Nursing Council of New Zealand and the Midwifery Council of New Zealand may apply for registration under the National Law, they are also eligible to apply for registration under the Trans-Tasman Mutual Recognition Arrangement.

### Registration

Registration for nurses and midwives is the responsibility of the NMBA. The NMBA replaced the previous state and territory nursing and midwifery boards on 1 July 2010 as part of the National Registration and Accreditation Scheme (NRAS) for health professions. The NMBA operates as an independent authority and its functions include:

- overseeing the registration of practitioners;
- development of professional standards, codes and guidelines;
- handling of notifications and complaints in relation to the profession;
- assessing overseas trained practitioners who wish to practice in Australia; and

- approving accreditation standards and courses of study.

Under the NRAS, nurses can be registered in two divisions: registered nurse (Division 1) or enrolled nurse (Division 2). Midwife registrations have no division, though most midwives are also registered as nurses in Division 1 (registered nurses). The term 'registered nurse' has been preserved in the NRAS and in the preceding state systems even though enrolled nurses are, in fact, 'registered' to practice as enrolled nurses.

Registered nurses (Division 1) include registered nurses, registered midwives, direct entry midwives, nurse practitioners, and midwife practitioners. Enrolled nurses (Division 2) include enrolled nurses and enrolled nurses (mothercraft). To approve registration or enrolment, registration boards must be satisfied that the applicant has completed an appropriate nursing or midwifery course, is fit and competent to practise, has a state of health such that he or she can practise safely, and has sufficient command of the English language to ensure safe practice.

A national approach to registration and resourcing has permitted collection of national data for the first time, provided a platform for quality and safety and opened up new policy avenues such as nurse practitioner and midwife prescribing. The current data set is subject to many caveats in terms of accuracy, but most stakeholders agree that it represents a considerable advance on the material previously available for workforce planning.

### Commonwealth programs and budget measures

In 1994, the *Report of the National Review of Nurse Education in the Higher Education Sector (1994 and beyond)* was released. The impetus for the review was the transfer of pre-registration nurse education to the tertiary education sector which was due for completion by the end of 1993. Recommendations of the review included: that mental health be included in the undergraduate nursing curriculum with the termination of direct entry mental health nursing programs, that AHMAC provide funding for centres for rural and remote areas nursing located in university schools of nursing or health science, and that infrastructure and support be provided for Aboriginal and Torres Strait Islander nursing students and nursing students from a rural background.

In response to ongoing concerns about national nursing shortages and the adequacy of undergraduate training places, the National Review of Nursing Education was initiated in April 2001 by the then Department of Education, Science and Training (DEST). The aim of the Review (2002) was to examine the future nursing educational needs of the health, community and aged care system in Australia and to provide advice on appropriate education policy and funding frameworks.

The terms of reference included initial registered nurse preparation, enrolled nurse education, education for specialisation, continuing education and the relationship of nursing with other groups in the health workforce. The final 'Our Duty of Care' report was released in 2002 with 36 recommendations supporting three main strategies to address the issues arising from the review:

- building a sustainable workforce,
- maximising health outcomes through quality education; and
- capacity building.

The DEST-led Review ran in conjunction with the Senate Community Affairs References Committee Inquiry into Nursing. The final Report 'The Patient Profession: Time for Action' was released in June 2002. Recommendation 12 was that the Commonwealth provide additional undergraduate nursing places to meet the workforce requirements set by the states. In the 2002-03 Budget, \$26.3 million had been provided for up to 250 aged care nursing scholarships annually at rural and regional universities. The universities were responsible for marketing the scholarships and for making additional nursing places available.

As a result of the 2002 National Review of Nursing Education, the Commonwealth increased the amount of funding per place given to institutions for nursing in the 2003-04 Budget. This increased funding was directed towards the cost of clinical practice in nursing with an additional 210 nursing places funded in regional institutions which rose to 574 places by 2007 as students progressed through their courses.

In November 2003 the National Nursing and Nursing Education Taskforce (N<sup>3</sup>ET) was appointed to implement a number of recommendations from the 'Our Duty of Care' report. In essence the role of the taskforce was to drive major nursing education and workforce reforms with responsibilities for the recommendations assigned to the groups or organisations best positioned to take on that work. Key work referred to the taskforce included increasing Commonwealth funding for additional undergraduate university places, developing a national classification of nursing and midwifery specialties, promotion of a nationally consistent scope of practice and enhancing nursing leadership and management.

### Health reform

In response to the Productivity Commission's 2005 Report, *Australia's Health Workforce*, COAG announced a package of key health workforce reforms on 8 April 2006 which included \$93 million over four years to fund 1,000 new higher education nursing places. The subsequent COAG 2008 Health and Hospital Workforce reform package built on the investments made under the COAG 2006 agenda. Also in 2008 the first Chief Commonwealth Nursing and Midwifery Officer was appointed, as a result of the commitment made by the Government in the 2007 election.

#### *Health and Hospital Workforce Reform COAG 2008*

- A Health Reform package of \$1.1 billion of Commonwealth funding was committed, of which \$500 million was for additional funding for undergraduate clinical training, including increasing the clinical training subsidy to 30% for all health undergraduate places. The package also provided for the establishment of a national health workforce agency (Health Workforce Australia) and a health workforce statistical register to drive a more strategic long-term plan for the health workforce.

As part of the National Partnership Agreement on Hospital and Health Workforce Reform, the Bringing Nurses Back into the Workforce program was announced on 15 January 2008. \$39.4 million was committed over 5 years to provide 7,750 extra nurses and midwives in public and private hospitals and 1,000 nurses in residential aged care homes with the aim of supporting the nursing workforce by increasing workforce numbers, reducing the need for excess overtime and casual replacements and, in turn, allowing nurses to undertake more professional development.

However, this program was slow to demonstrate results and in the 2009-10 Budget funding was redirected to new measures aimed at ensuring the retention of the existing nursing workforce and increasing recruitment into the aged care sector. Eligible nurses who were already participating on 11 May 2010, continued to receive incentive payments under the Bringing Nurses Back initiative. No new applications were accepted beyond 11 May 2010.

In 2008, the Chief Nurse and Midwifery Officer, Dr Rosemary Bryant led the National Review of Maternity Services. It was conducted as part of the Government's 2007 election commitment to provide a National Maternity Services Plan. The final report of the review – *Improving Maternity Services in Australia* – was released in February 2009 and provided recommendations for the future of maternity services in Australia.

The Government responded to the report through the *Improving Maternity Services Budget Package (2009-10)*, providing \$120.5 million over four years. A range of initiatives have been funded to support the maternity services workforce, and specifically to make better use of the midwifery workforce in providing safe, high quality maternity care in Australia. In the development of the National Maternity Services Plan, states and territories were asked to make complementary commitments and investments, particularly around the provision of birthing centres and rural maternity units.

The Commonwealth initiatives include:

- A Government-supported professional indemnity insurance scheme for eligible, privately practising midwives working in collaboration with doctors;
- An expansion of the Medical Specialist Outreach Assistance Program (MSOAP) to provide more services in rural and remote communities;
- Extra scholarships for GPs and midwives to expand the maternity workforce, particularly in rural and remote Australia with 20 scholarships available each year for midwives to obtain the formal qualifications needed to be able to provide Medicare-subsidised services and access to the Pharmaceutical Benefits Scheme (PBS);
- An expansion and improvement of the existing National Pregnancy Telephone Counselling Helpline to deliver a new 24 hour, seven days a week telephone helpline and information service to provide women, their partners and families with greater access to maternity information and support before and after birth;
- Funding for improvements to national maternity data collection and for a small program of research aimed at improving the safety and quality of maternity services; and
- Medicare Benefits Scheme (MBS) and PBS benefits for services provided by eligible, privately practising midwives, working in collaboration with doctors.

It is important to note that policies which increase nurses' access to the MBS have evolved over time. Initially measures supported nurses through "for and on behalf of items" for specific tasks such as immunisation. Later initiatives included incentives paid to general practice through the Practice Incentives Program to take on a practice nurse, MBS access for mental health nurses through expended primary care items, or a non-MBS incentive to take on a mental health nurse.

Most recently, the measures flowing from the 2009-10 Budget give eligible nurse practitioners and midwives direct MBS and PBS access for the first time, allowing them to deliver a range of subsidised services in non-acute settings including

primary care, aged care and rural and remote settings. This access is provided for by the *Health Legislation Amendment (Midwives and Nurse Practitioner) Act 2010* and has been available from 1 November 2010.

Prior to the passage of the legislation, nurse practitioners (NPs) were already performing in an advanced nursing role and had been able to order certain tests and prescribe certain medications under existing state and territory legislation. The 2009 Budget measure did not enable NPs to provide services beyond their scope of practice but was aimed at enabling eligible NPs to provide certain services on a subsidised basis through the MBS and PBS.

Aged care reform was a 2010 election commitment of the Government, informed by the recommendations of the Productivity Commission's Inquiry into Aged Care (2010). On 20 April 2012, a comprehensive 10 year package to reshape aged care was announced. Under the reform package, the Government will provide \$1.2 billion over five years in additional funding to aged care providers who take steps to improve the terms and conditions of their workers (the Addressing Workforce Pressures Initiative). An Aged Care Workforce Compact has been developed by the Aged Care Strategic Workforce Advisory Group chaired by Commissioner Anne Gooley from Fair Work Australia.

The Aged Care Workforce Compact will improve the capacity of the aged care sector to attract and retain staff through:

- higher wages
- improved career structures;
- enhanced training and education opportunities;
- improved career development and workforce planning; and
- better work practices.

On 19 October 2012, Commissioner Gooley presented her Final Report to the Government. The Strategic Workforce Advisory Group recognised that a clear distinction can be made between commitments for the sector as a whole that are best expressed in the Compact, and those which are more appropriately agreed by employers and employees through bargaining at the enterprise level. The report details areas of agreement and disagreement from the Advisory Group on the requirements to be met by providers in order to access the additional funding under the *Addressing-workforce-pressure* initiative.



### Timeline of key events in the Development of the Nursing and Midwifery workforce

Time period	Policy drivers	Policy and program activity
<b>1970s</b>	The establishment of three nursing education programs at diploma level in Sydney, Melbourne and Adelaide.	Campaign begins for nursing education to be transferred from the acute setting to the classroom.
1973	Aim of the nursing community to develop clear goals for nurse education in Australia.	Establishment of a working party with representatives from all major Nursing organisations across Australia.
1975	Goals in Nursing: Part 1 published	The working party led to a comprehensive strategy outlining positive actions to achieve change, with a revised policy statement being circulated to nurses, health authorities and governments.
1978	The Sax Report	Commonwealth report on nurse education, committee recommendations included transfer of nursing education into the tertiary sector.
<b>1980s</b>	Nursing registration boards	Nursing education began to be confined to major hospitals in the capital cities as smaller rural hospitals could not meet the requirements of the nursing registration boards.
1984	Interjurisdictional Committee established at the Commonwealth with jurisdictions creating teams to manage to transfer process.	Consensus reached on education of registered nurses at tertiary levels. The Legislation to enable the transfer to University based training passed on 24 August 1984
<b>1990s</b>		
1994	Australian Health Ministers' Advisory Council	Nursing education in Australian universities : report of the national Review of Nurse Education in the Higher Education Sector - 1994 and Beyond
1997	Department of Employment, Education, Training and Youth Affairs.	National Review of Specialist Nurse Education.

Time period	Policy drivers	Policy and program activity
<b>2000s</b>		
2001	Department of Health and Aged Care.	Scoping study of the Australian mental health nursing workforce; Final report.
2002	Senate Community Affairs Inquiry into Nursing. Report on the Inquiry into Nursing - The patient profession: Time for action	Identified aged care as a priority area for reform. Recommended the appointment of a Commonwealth Chief Nurse.
2002	Department of Health and Ageing	Recruitment and Retention of Nurses in Residential Aged Care; Final Report.
2002	Department of Education Science and Training	National Review of Nursing Education
2003/04	National Review of Nursing Education	Additional CSP places for nursing as a priority area.
2003	'Our Duty of care' recommendations.	National Nursing and Nursing Education Task Force (N3ET) appointed.
2006	Australian Health Ministers' Advisory Council	N3ET Final Report.
2007	Australian Nurse Practitioners Conference	Minister indicates support for nurse practitioners
2008	Strategy to build the Nurse Practitioner workforce in rural and remote areas	Minister announced \$2.1m for scholarships for Nurse Practitioners
2008	Senate Community Affairs Inquiry into Nursing.	Appointment of the Chief Commonwealth Nursing and Midwifery Officer.
2009	Maternity Services Review	
2008/09	Budget	MBS and PBS access for nurse practitioners & midwives
2010	COAG 2006	National Registration and Accreditation Scheme commences
2010/11	Budget	\$18m over 4yrs to explore appropriate models of practice for Nurse practitioners in Aged Care.
2010	Australian Health Ministers' Conference	The National Maternity Services Plan was endorsed by the Australian Health Ministers' Conference in November.
2010	Medicare access	New MBS items available for eligible Midwives and Nurse Practitioners. Health Legislation Amendment

<b>Time period</b>	<b>Policy drivers</b>	<b>Policy and program activity</b>
		(Midwives and Nurse Practitioner) Act 2010.
2010	PBS prescribing	Nurse practitioners endorsed to prescribe under state or territory legislation can apply for approval as PBS prescribers.
2011	Productivity Commission – Caring for Older Australians Report.	Living Longer Living Better aged care reform package provides \$3.7 billion over five years. Includes the Aged Care Compact announced in 2012.

## Appendix v: History of Commonwealth investment in the dental and allied health workforce

Historically, Commonwealth funding for the dental and allied health workforce has focused on expanding the eligibility of benefits (predominantly through access to Medicare) for certain health procedures and services. There has also been an emphasis on education and training support for these disciplines through various scholarship schemes. The majority of the scholarship schemes and the education and training support programs have had a combined health discipline approach rather than specifically targeting individual allied health and/or dental disciplines. As such, dental and oral health disciplines are supported through many of the schemes and programs listed in the allied health table below. Many of the scholarship schemes and education and support also have a rural and remote and/or Aboriginal and Torres Strait Islander focus (further information on education and training support is at Chapter 3).

In addition to expanding the scope of benefits and support for education and training programs, the Commonwealth has provided direct funding to jurisdictions to assist with service delivery, particularly in regards to dental services. This investment has coincided with the allocation of Commonwealth funding for infrastructure and capital works projects to assist with service delivery, as well as funding to support clinical placements. This funding has not only been in the form of direct funding to jurisdictions but also in broader DoHA infrastructure funding rounds and programs such as the University Departments of Rural Health (UDRH) program (refer to Chapter 4).

More recently the Commonwealth has allocated funding for specific dental workforce initiatives with an aim of enhancing and distributing the dental workforce, particularly in the public sector and rural/remote locations. These programs are in the early stages of implementation or are due to commence in 2013-2014.

Below is a table outlining various Commonwealth initiatives that have influenced the supply and distribution of the allied health and dental workforce. The various funding rounds that assist with service delivery and the health workforce are not included in the table below (for further details on DoHA funding rounds refer to Chapter 9).

## Dental/oral health

Time period	Policy drivers	Policy and program activity
<b>1970s</b>		
1973 - 1980s	Building dental service capacity for Australian children	Australian School Dental Program  Under the supervision of dentists, dental therapists provided dental treatment for all Australian school children up to the age of 15 years.
<b>1980s</b>		
From 1981	Benefits for dental services	The Commonwealth provided benefits for orthodontic services for young patients with cleft lip or cleft palate conditions since 1981.
From 1984	Medicare benefits for dental services	Since the introduction of Medicare in 1984 the Commonwealth has provided benefits for various surgical procedures (performed by dental surgeons) to treat diseases of the oral cavity and jaw.
<b>2000s</b>		
2004 – 2007	Medicare benefits for patients with chronic conditions.	Strengthening Medicare package  Allied Health and Dental Care Initiative (AHDCI)  Medicare benefits for particular dental services to treat patients with chronic conditions were introduced. A referral from a General Practitioner and an Enhanced Primary Care plan was required to claim rebates.
2007 - 2012 -	2007-08 Budget  Dental benefits for people with a chronic condition and complex care needs.	The Medicare Chronic Disease Dental Scheme (CDDS)  The CDDS provided up to \$4,250 in Medicare benefits over two years to patients with a chronic disease and complex care needs. The CDDS covered a comprehensive range of preventative and treatment items. Residents of aged care facilities (that were managed by a general practitioner) were eligible for benefits.
2007	Enhance dental clinical training in rural areas	Dental Training Expanding Rural Placements (DTERP) is now a component of the RHMT program.  DTERP provides longer-term rural clinical placements for dental students studying at six universities throughout Australia. Capital funding to establish training sites has been provided to participating universities.
2008	Preventative dental care for teenagers aged between 12 and 17 years.	Medicare Teen Dental Plan  Eligible families have access to vouchers (up to \$150 each year) to assist with dental check-ups for teenagers aged between 12 and 17 years.  A new standalone Dental Benefits Schedule that includes means-tested, age restricted Medicare benefits for the preventative dental check for teenagers was also developed as part of this initiative
2010	COAG 2006  Ensuring safe practice standards for the public.	National Registration and Accreditation Scheme  Dentists, dental hygienists, dental therapists, dental prosthetists and oral health therapists are all included under the scheme

Time period	Policy drivers	Policy and program activity
2012	2011-12 Budget	National Advisory Council on Dental Health Time-limited group to provide strategic, independent advice to the Government on dental health issues. A report was provided to the Minister for Health and Ageing in 2012.
2012	2012-13 Budget Reducing the public dental waiting list	National Partnership Agreement on Treating More Public Dental Patients Funding to be provided to jurisdictions to treat patients on public dental waiting lists
2012	2012-13 Budget	Funding for the National Oral Health Promotion activities
2012	2012-13 Budget	Support for private dentists' pro bono work
2013	2011-12 Budget	Voluntary Dental Graduate Year Program (VDGYP) The VDGYP provide up to 50 dental graduates each year, with a structured program for enhanced practice experience and professional development opportunities, whilst increasing the dental workforce capacity in the public dental system and other areas of need. The first cohort of graduates commenced their placements in January 2013.
2014	2012-13 Budget Building the dental workforce capacity	Expansion of the VDGYP from 50 to up to 100 placements each year. Additional placements are due to commence in 2015.
2014	2012-13 Budget Building the oral health workforce capacity	Oral Health Therapist Graduate Year Program (OHTGYP) Similar to the VDGYP, the OHTGYP provides participating oral health therapist graduates with a structured program for enhanced practice experience and professional development opportunities, whilst increasing the oral health therapist workforce capacity. The first cohort of placements commence from early 2014.
2014	2012 Dental Health Reform Commitment	<i>Grow Up Smiling</i> Grow Up Smiling will replace and expand the former Medicare Teen Dental Plan. Under Grow Up Smiling eligible children aged between 2-17 years will have access to dental benefits of up to \$1,000 over two calendar years for basic prevention and treatment services. Grow Up Smiling will commence on 1 January 2014.
2014	2012 Dental Health Reform Commitment	National Partnership Agreement on Adult Public Dental Services Additional funding to be provided to the states and territories from 1 July 2014 to expand dental services for adults in the public system.
2014	2012 Dental Health Reform Commitment	The Flexible Grants Program Under the Flexible Grants Program a total of \$225 million will be provided from 2014 for dental infrastructure (both capital and workforce) in outer metropolitan, rural and regional areas to assist in reducing access barriers for people living in these areas. The grants may also be used for targeted programs to address other gaps in service delivery.



## Allied Health

Time Period	Policy Drivers	Policy and Program Activity
<b>1970s</b>		
1975	MBS access	Optometrist access to the MBS, limited to a range of restricted items.
<b>1990s</b>		
1997	1997-98 Budget	Services for Australian Rural and Remote Allied Health (SARRAH) established through consolidation of various rural programs.
1999	MBS access and chronic disease management.	Enhanced Primary Care package Included new items for medical practitioner involvement in multidisciplinary case conferencing and care planning for people with chronic and complex needs.
<b>2000s</b>		
2000	Third Community Pharmacy Agreement	The Rural Pharmacy Workforce Programs and the Aboriginal and Torres Strait Islander Pharmacy Workforce Program were introduced under the Third Community Pharmacy Agreement, commencing 1 July 2000. The programs comprises a range of elements which aim to maintain and improve access to quality private sector community pharmacy services in rural communities, and strengthen and support the rural pharmacy workforce in Australia.
2001	Promotion of team care arrangements.	The Better Outcomes in Mental Health Care program was introduced.
2001	Rural health disparities.	More Allied Health Service program established to help rural communities gain better access to allied health services.
2002	Building Indigenous health workforce capacity.	The Puggy Hunter Memorial Scholarship Scheme inaugurated.
2003	Building Indigenous health workforce capacity.	Australian Rotary Health Indigenous Health Scholarship Program commenced.
2004	Medicare benefits for patients whose chronic conditions.	Strengthening Medicare package - Allied Health and Dental Care Initiative (AHDCl) This package included items for allied health services provided to patients with chronic disease management plans. It also included particular dental services (see dental table above).
2005	MBS access	Introduction of the Chronic Disease Management (CDM) items, which replaced the Enhanced Primary Care (EPC) multidisciplinary care planning Medicare items for patients with a chronic or terminal medical condition.
2006	MBS access	Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative. Medicare items for GP mental health care plans,

Time Period	Policy Drivers	Policy and Program Activity
		consultations on a new patient by a psychiatrist, and rebates for treatment by a range of mental health professionals;
2007	MBS access	Allied health items for group services to patients with type 2 diabetes when they are managed by their GP under a GP Management Plan
2008	Creation of the Office of Rural Health in response to the findings of the Audit of Health Workforce in Rural and Regional Australia.	Rural Primary Health Services (RPHS) program commenced, incorporating the More Allied Health Services program.
2008	MBS access	The Helping Children with Autism initiative Introduced new allied health items for a psychologist, occupational therapist or speech pathologist to assist with diagnosis and provide treatment services.
2008	Building Indigenous health workforce capacity.	The incorporation of Indigenous Allied Health Australia Inc. was preceded by a 12 month project to establish the Indigenous Allied Health Network, which was funded by the from July 2008.
2009	The Rural and Remote Health Programs Reform Strategy and the 2009-10 Budget process consolidating	The Rural Health Multidisciplinary Training (RHMT) program was established.
2010	Consolidation initiative 2010-11 Budget.	Nursing and Allied Health Scholarship and Support Scheme (NAHSSS) commenced.
2010	2010-11 Budget	Nursing and Allied Health Rural Locum Scheme (NAHRLS) created.
2010	COAG 2006 Ensuring safe practice standards for the public.	National Registration and Accreditation Scheme commences for a limited number of allied health disciplines.
2011	MBS access	The Better Start for Children with Disability initiative introduced: <ul style="list-style-type: none"> <li>○ amendments to existing allied health items for a psychologist, occupational therapist or speech pathologist to assist with diagnosis and provide treatment services for children with an eligible disability;</li> <li>○ new items for audiologists, orthoptists, optometrists and physiotherapists to assist with diagnosis and provide treatment services for children with an eligible disability.</li> </ul> Amendments to the Helping Children with Autism program which introduced: <ul style="list-style-type: none"> <li>○ new items for audiologists, orthoptists, optometrists and physiotherapists to assist with diagnosis and provide treatment services for children with autism or other pervasive developmental disorders.</li> </ul>

Time Period	Policy Drivers	Policy and Program Activity
2012	Ensuring safe practice standards for the public.	Four further professions joined the National Registration and Accreditation Scheme on 1 July 2012: Aboriginal and Torres Strait Islander health practitioners, Chinese medicine, medical radiation practitioners and occupational therapists.

**Source:** <http://www.aph.gov.au>  
[www.health.gov.au](http://www.health.gov.au)

## Appendix vi: Further information on the international health professional workforce

This appendix is intended to complement the issues covered in Chapter 6 about health workforce supply in Australia and provide further detail and some international context to the analysis of current health workforce supply initiatives.

Australia both imports and exports health professionals, as these often highly trained personnel move to further their education, knowledge and specialty skills in advanced health care settings. Australian graduates will travel to the United Kingdom, the United States of America, Canada and New Zealand to further their training and return to Australia, some of course do not return.

Overall Australia is a net importer of health professionals, particularly medical professionals, and competes against most other Organisation for Economic Cooperation and Development (OECD) countries for these keenly sought after personnel.<sup>240</sup>

Overseas trained doctors (OTDs) (also known as international medical graduates (IMGs)) are doctors who obtained their primary qualification overseas. OTDs provide a significant proportion of the Australian medical workforce, particularly in those areas where it is difficult to attract Australian trained doctors. Issues relating to the employment of OTDs within the Australian health workforce are discussed in detail in Chapter 6.

Australia has the stated aim of becoming self-sufficient in its health workforce by 2025, but as stated in earlier chapters all available evidence is that the increase in domestic graduates is unlikely to provide sufficient numbers to meet this aim. Importing health workers will continue to be a strategy for the foreseeable future to ensure Australians have access to health care services/providers.

Based on the place of basic qualification, approximately 25% of the medical workforce in Australia are OTDs.<sup>241</sup> OTDs who have applied to work in Australia have received initial medical training in 120 countries, and specialist qualifications from 91 different countries.<sup>242</sup> They enter Australia under a range of employment arrangements and visa categories. In 2009-10, 46%, of general practitioners in rural and remote areas were OTDs compared to 27% in 2000-01.

State and territory governments are the major employers of health professionals, as well as providing training opportunities, particularly in public hospitals. States and territories are able to sponsor OTDs on long stay visa subclass 457, as are private medical practices and/or medical recruiting companies. The Australian Government has an expectation that those who recruit OTDs to work in Australia abide by the appropriate Code(s) of Practice, relating to recruitment of international health personnel.

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<sup>240</sup> House of Representatives Standing Committee on Health and Ageing, *Lost in the Labyrinth: Report on the inquiry into registration processes and support for overseas trained doctors*, Canberra August 2012

<sup>241</sup> AIHW Medical Labour Force 2009

<sup>242</sup> Geffen L, editor. *Assuring medical standards: the Australian Medical Council 1985–2010*. Canberra, ACT: Australian Medical Council, 2010

It should also be noted that health professionals who obtained their initial qualifications overseas must still meet the requirements of the National Registration and Accreditation Scheme (NRAS) to practise in Australia. These standards are higher than the standards for immigration purposes, particularly the English language standards.

Many stakeholders in the Australian medical/health sector believe that Australia will be more dependent on OTDs and other overseas trained health professionals (particularly nurses) in the future in the light of an ageing 'baby-boom-generation' suggesting that many current health professionals will soon retire.<sup>243</sup>

The recruitment of international health personnel is governed by a range of international agreements and codes of practice (as described at the conclusion of this appendix) which adds some complexity to the arguments around substituting the domestic workforce with international health professionals.

These issues around projected medical workforce shortages do not affect Australia alone; the shortfall in the medical workforce can be seen worldwide with a subsequent overall migration of medical practitioners and specialists. Australia competes for medical specialists in a highly competitive market with other jurisdictions (e.g. Canada, United States, Scandinavia, Central Europe) with most conducting active recruitment and integration programs.

### Trends in international health professional entry to Australia

#### *OTD entry to Australia*

OTDs enter Australia to work as permanent residents or on temporary work visas.

Data from the 2006 Census (Survey of Population and Housing)<sup>244</sup> shows that there were 3,586 generalist medical practitioners and 1,566 specialists who had recently arrived in Australia.

- In 2006, India was the most common country of birth for recently arrived generalist and specialist medical practitioners, with 19.2% and 23.3% respectively born there.
- The proportion of recently arrived generalist medical specialists who were born in India increased from 8.3% in 1986 to 19.2% in 2006, whilst the proportion of recently arrived specialist medical practitioners who were born in India rose from 3.8% to 23.3%.
- The proportion of recently arrived medical practitioners who were born in England and New Zealand decreased over this time.

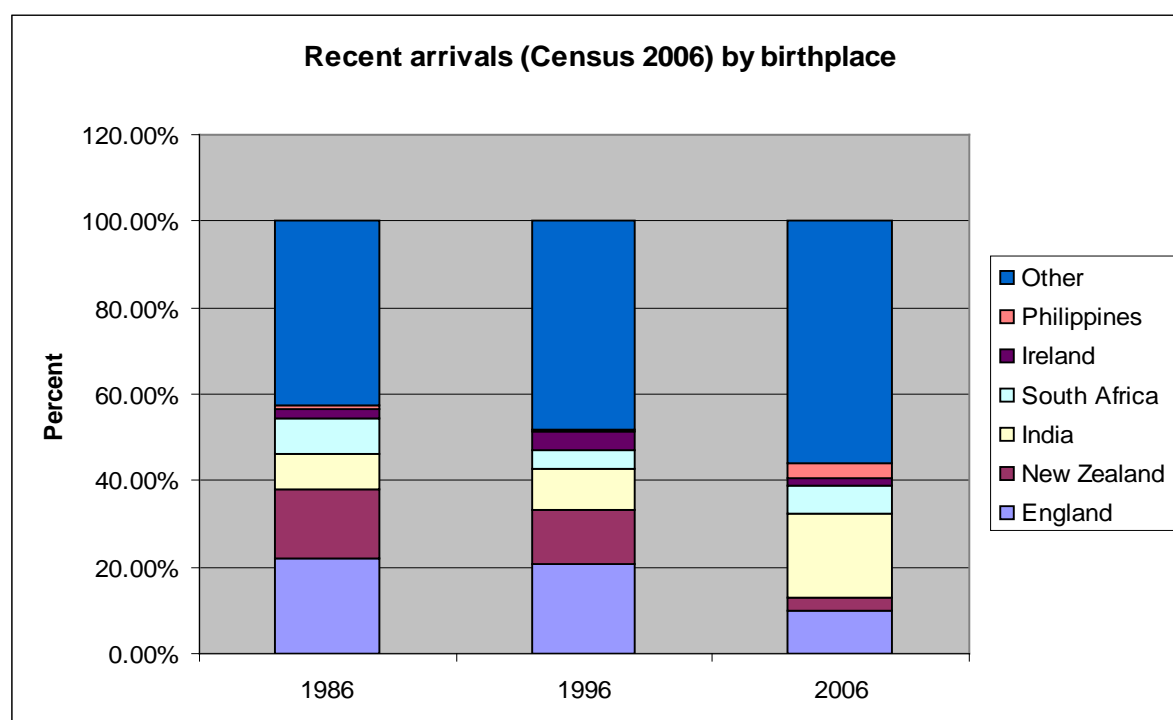
The following charts provide some general information on the origin of OTDs moving to Australia:

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<sup>243</sup> House of Representatives Standing Committee on Health and Ageing, *Lost in the Labyrinth: Report on the inquiry into registration processes and support for overseas trained doctors*, Canberra August 2012

<sup>244</sup> Equivalent data under the 2011 Census was not available at the time of this report's production.

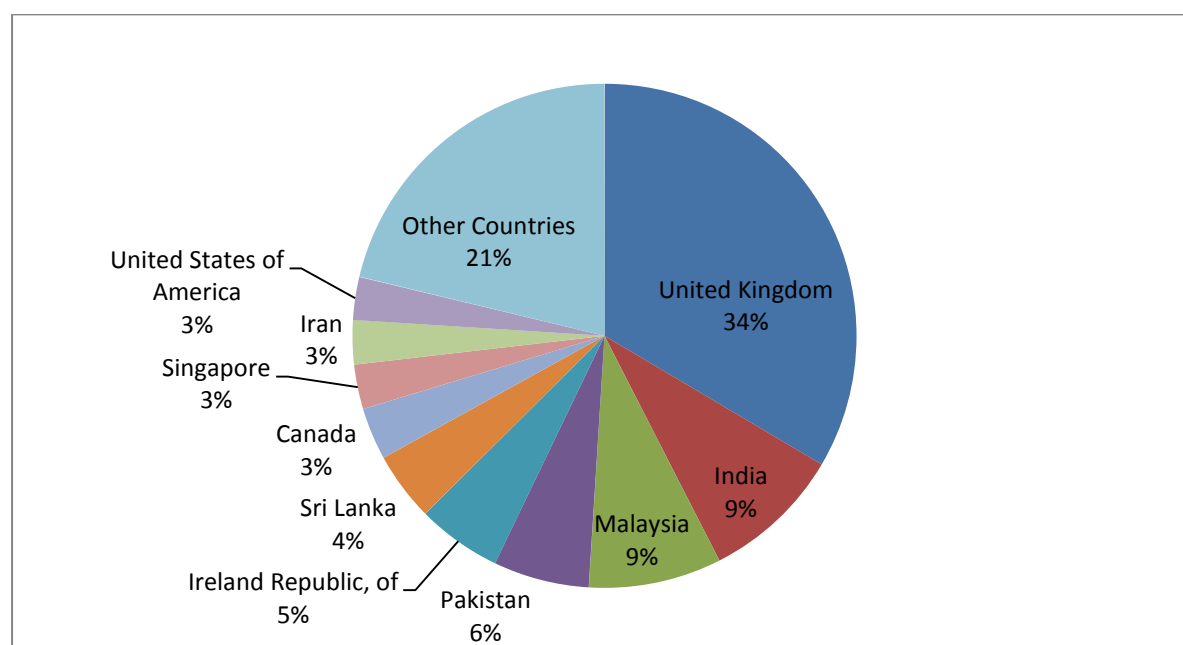
Figure vi.1: Arrivals by birthplace



Source: Australian Bureau of Statistics, Census 2006

Figure vi.2 shows that, in 2011-12, 34% of visa applications for medical practitioners came from the United Kingdom, followed by India and Malaysia.

Figure vi.2: Country of origin of 457 and 442<sup>245</sup> visa applications for medical practitioners, 2011-12



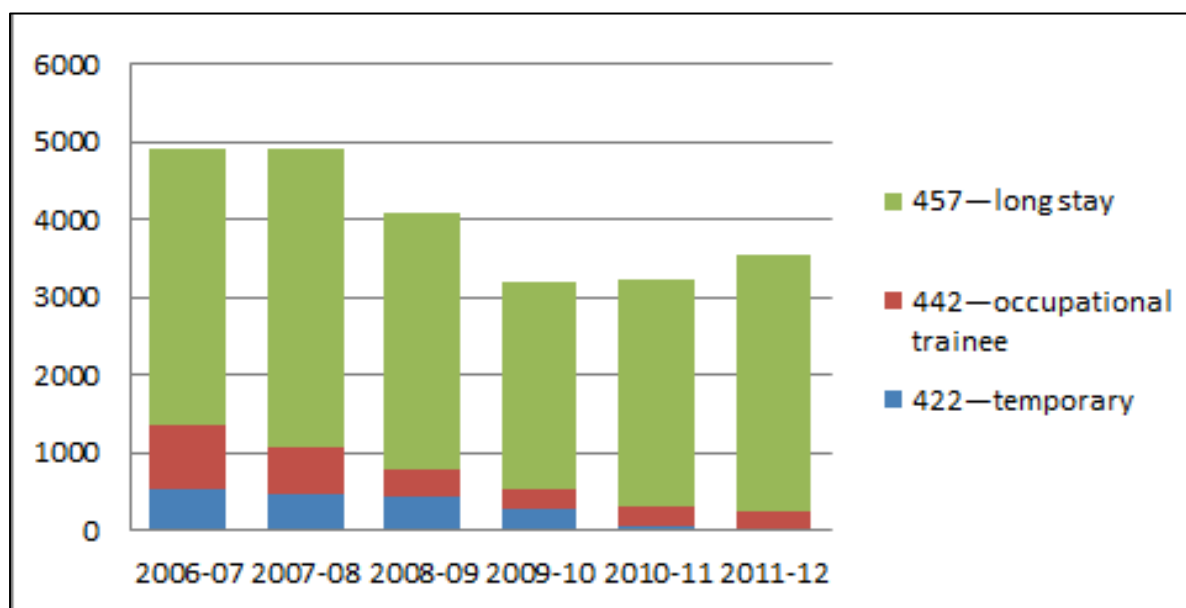
Source: Department of Immigration and Citizenship administrative data.

<sup>245</sup> Visa subclass 457 – Business (long stay). Since 24 November 2012 the 457 visa has been renamed as the temporary work (skilled) visa; Visa subclass 442 – Occupational trainee visa.



Figure vi.4 below shows the number of temporary visas granted to medical practitioners from 2006-07 to 2011-12.

Figure vi.4: Trends in OTD visa types 2006-07 to 2011-12<sup>246</sup>



Source: Department of Immigration and Citizenship administrative data.

#### *Trends in the immigration of internationally trained nurses*

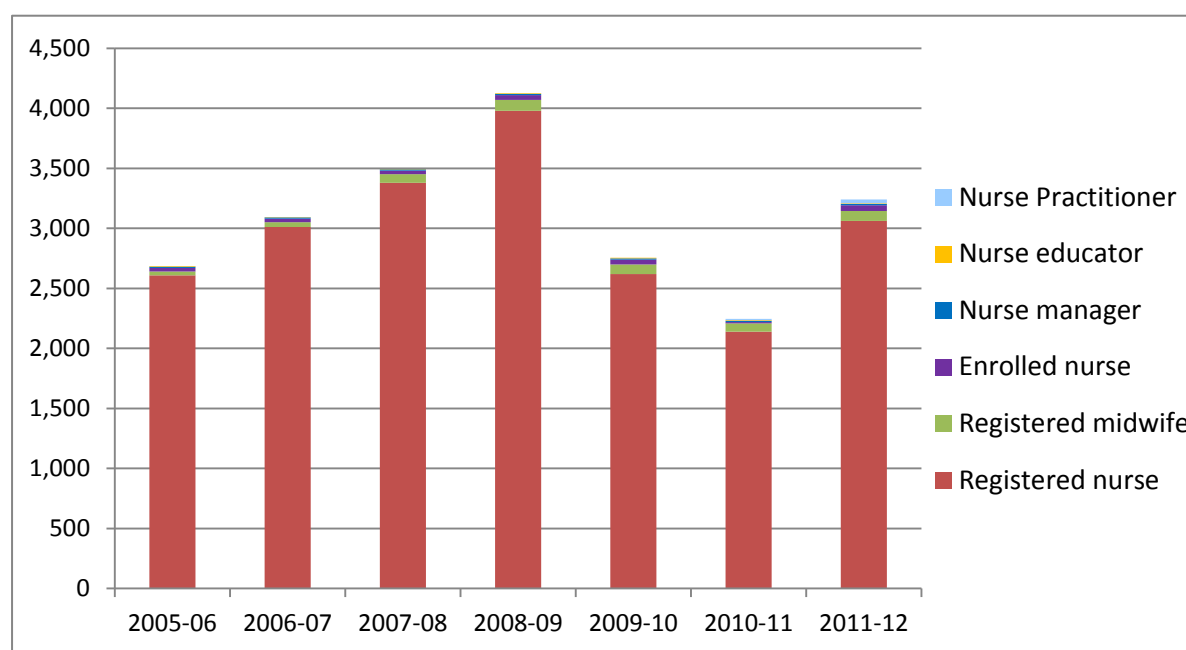
In Australia international recruitment activities are conducted through the Commonwealth funded International Recruitment Strategy (IRS) and the International Recruitment Program (managed by HWA), as discussed in Chapter 6. In addition, states and territories actively seek to recruit health professionals (particularly nurses) predominately to regional, rural and remote regions. Many jurisdictions have long standing relationships with specific countries.

Additionally, a number of projects are managed by AusAid aimed at improving nurse education in the Pacific region, predominately in the Philippines. The Australian Government holds bi-annual meetings at Ministerial level with the Philippines and this country has sought to investigate the possibilities of exporting more health professionals to Australia.

The data for nurses presented in the figure below mirrors the trends in immigration flows shown above for the international medical workforce and also shows a recent increase in numbers in 2011-12.

<sup>246</sup> Visa subclass 422 was the medical practitioner (temporary) visa. This visa class closed on 1 July 2010.

Figure vi.5: Trends in Visa 457 (long stay) issued to nurses and midwives 2005-06 to 2011-12



Source: Department of Immigration and Citizenship data released in August 2012

Note that the Commonwealth is not able to influence where internationally trained nurses work, as there is no distribution lever, such as s. 19AB of the *Health Insurance Act 1973*, relevant to nurses.

### Allied Health Professionals - Immigration trends

There is limited information on the immigration of allied health professionals. National data sets are immature for this group of health professionals. For those allied health professions subject to NRAS robust data sets will be developed over time. These data issues are discussed in previous chapters of this review.

### Recent changes in immigration arrangements

The broad environment for migration to Australia has a significant impact on the arrangements for international health workers seeking to move to this country.

The Australian Government, via the Department of Immigration and Citizenship (DIAC), seeks input from other Australia Government departments, relevant industry and education sectors and Skills Australia to develop a priority skills occupation list. Potential migrants who have skills that are perceived to be in demand in Australia, can earn additional points towards an entry visa. Doctors, nurses and many allied health professions are included on this list.

However, over recent years (2009-10 and 2010-11 budgets) DIAC has developed and implemented a new visa system, which became fully operational during 2012. This process involves reducing visa subclasses by up to 50%. Of relevance to international health professionals is that subclasses 422 and 442 have been removed. Health professionals who may have been eligible for these visas will now need to meet the conditions of other visa subclasses, and will now have to apply

under subclass 457. This will alter the pattern of entry and therefore close monitoring of trend data in the next few years will be important.

The new system replaces the visa application process for many groups, particularly those immigrating under skilled migration and long stay visa classes (such as visa subclass 457, which the majority of international health professionals use). This process was piloted /trialled in July/August 2012 and the results are being assessed by DIAC.

Revised immigration processes may impact on the health workforce trend data, as only those people who meet all immigration and employment requirements will be able to enter and work in Australia. Careful monitoring of the data related to internationally trained health professional in future years will be required to assess the impact of these changes on Australia's health workforce.

### **Codes of conduct or practice on international recruitment of health personnel**

Australia is a signatory to a number of voluntary codes of practice related to the recruitment of internationally trained health professionals. These codes include:

- The World Health Organization (WHO) Global Code of Practice on the International Recruitment of Health Personnel (2010)
- The Commonwealth Code of Practice for the International Recruitment of Health Workers (initially signed in 2003 and updated in 2005-06)
- The Pacific Code of Practice for Recruitment of Health Workers (2007 and last updated in 2010).

#### ***Purpose of these codes***

All these codes are intended to provide guidelines for the international recruitment of health workers in a manner that takes into account the potential impact of such recruitment on services in the source country.

The codes are intended to discourage the targeted recruitment of health workers from countries which are themselves experiencing shortages. Additionally, the codes seek to safeguard the rights of recruits, and the conditions relating to their profession in the recruiting countries.

#### ***Status of these codes***

The Commonwealth and Pacific codes are not legal documents. Within the context of Commonwealth principles of cooperation and consensus, it is hoped that governments will subscribe to the codes. The codes apply the principles of transparency, fairness and mutuality of benefits as these relate to relations among Commonwealth countries, and between recruits and recruiters.

The WHO Global Code of Practice on the International Recruitment of Health Personnel was adopted by the World Health Assembly (WHA) in May 2010. This code is voluntary. The Australian Government supported the global code of practice that was endorsed by the WHA in May 2010.

The OECD and the WHO jointly developed the WHO Global Code of Practice including holding joint meetings and working groups. There is an expectation that member states/countries will abide by and implement the WHO Code.

## Appendix vii: Recent reviews of the health workforce

Ensuring a skilled and appropriately distributed workforce is one of the key challenges for governments in delivering health services to the Australian community. Health workforce issues have therefore been the subject of significant government and parliamentary consideration. This appendix outlines the key national reviews of the health workforce that have been undertaken over recent years, commencing with the 2005 Productivity Commission study into Australia's health workforce, the recommendations of which have set the trajectory for health workforce reform since that time.

### Australia's Health Workforce - 2005 Productivity Commission Research Report<sup>247</sup>

In June 2004, the Council of Australian Governments (COAG) requested that the Productivity Commission undertake a research study into health workforce issues, including supply and demand pressures over the following ten years, in recognition that the successful delivery of health services is dependent on the availability of an appropriately skilled health workforce. The report was released on 19 January 2006.

The Productivity Commission was given a broad terms of reference, including consideration of institutional, regulatory and other factors affecting the supply of health workforce professionals, the structure and distribution of the health workforce and its consequential efficiency and effectiveness, the factors affecting demand for services provided by health workforce professionals, and provision of advice on the identification of, and planning for, Australian health care priorities and services in the short, medium and long term. The terms of reference also included a specific reference to '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'.<sup>248</sup>

The Productivity Commission found that Australia's health workforce system is inherently complex and interdependent, encompassing a large number of players, both government and non-government, that are involved in the planning, education and training, regulation and funding of the health workforce. The commission identified a range of systemic impediments that it saw as 'reflecting and compounding this complexity', including a fragmentation of responsibilities, ineffective coordination, rigid regulatory arrangements, perverse funding and payments incentives, and entrenched workplace behaviours.

The Productivity Commission recommended a package of significant system-wide reforms intended to address these impediments. The key recommendations were:<sup>249</sup>

- The establishment of an advisory health workforce improvement agency to evaluate and facilitate major health workforce innovation possibilities on a

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<sup>247</sup> Accessed at [http://www.pc.gov.au/\\_\\_data/assets/pdf\\_file/0003/9480/healthworkforce.pdf](http://www.pc.gov.au/__data/assets/pdf_file/0003/9480/healthworkforce.pdf), viewed 11 September 2012

<sup>248</sup> *ibid.*

<sup>249</sup> *ibid.*

national, systematic and timetabled basis, which would report publicly and make recommendations to the Australian Health Ministers' Conference (AHMC).

- The establishment of a single national accreditation board for health professional education and training, which would assume statutory responsibility for the accreditation functions carried out by the existing entities, including for overseas trained health professionals. Initially, the board could delegate responsibility for these functions to appropriate existing entities, selected on the basis of their capacity to contribute to the objectives to the new accreditation regime.
- The introduction of uniform national registration standards, and the establishment of a single national registration board for health professionals, with authority to determine which professions to register and specialties to recognise. Pending the new national registration standards, the board would subsume the operations of all existing registration boards and entities.

Other recommendations included the establishment of a number of independent national advisory bodies, including a health workforce education and training council focused on exploring better approaches for health education and training; a COAG-established taskforce to recommend changes to improve the transparency, coordination and contestability of the arrangements for clinical training; and a standing review committee subsuming the functions of the Medical Services Advisory Committee and the Medicare Benefits Consultative Committee and taking a broader, cross-professional approach towards services and referral arrangements under the Medicare Benefits Scheme, and prescribing rights under the Pharmaceutical Benefits Scheme. The recommendations also covered the need for explicit provision for the requirements of rural and remote areas and for special needs groups within broad health workforce frameworks, and Australian government consideration of an agreement with state and territory governments for the allocation of university places in health profession courses.

In response to the Productivity Commission's recommendations, COAG introduced a significant program of health workforce reforms, including the arrangements under the National Partnership Agreement on Hospital and Health Workforce Reform. These include the establishment of Health Workforce Australia and the National Registration and Accreditation Scheme (NRAS).

### Audit of Health Workforce in Rural and Regional Australia - April 2008<sup>250</sup>

The Department of Health and Ageing (DoHA) was asked to undertake an audit of the health workforce in rural and remote Australia, in order to determine the number and distribution of the health workforce in rural and regional Australia.

DoHA examined national data collections along with its own administrative data at the state/territory level, remoteness, and where possible, by Statistical Local Area (SLA) level. The audit included the professions of medicine, nursing, dentistry, chiropractics, optometry, osteopathy, pharmacy, physiotherapy and psychology (e.g. those to be initially included in NRAS).

The audit found health workforce shortages in rural and remote areas across most of the health professions examined. In particular, the audit found:

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<sup>250</sup> Accessed at <http://www.health.gov.au/internet/main/publishing.nsf/content/work-res-ruraud>, viewed 11 September 2012

- the supply of medical professionals is significantly lower in rural and remote areas, with the number of general practitioners in proportion to the population decreasing with greater remoteness, considerable variation across jurisdictions, and higher rates of overseas trained doctors in rural and remote areas;
- while there was a relatively even distribution of nurses across Australia, and growth in the number of nurses over time, there existed some variation in supply across jurisdictions, and stakeholder evidence of a shortage of midwives in regional and remote Australia;
- the supply of allied health professionals, particularly dentists, was low to poor, with three quarters of dentists working in metropolitan areas;
- the supply and distribution of health professionals largely corresponded with the distribution of state and territory funded health services;
- in addition to the supply and distribution issues, the logistical challenges of servicing a dispersed population over wide and diverse areas is a compounding factor to access problems in rural and remote areas; and
- difficulties in access persist in spite of the numbers of medical and nursing workforces (in proportion to the population) being similar to comparable Organisation for Economic Cooperation and Development OECD countries.

In response to the audit findings, the Australian Government established the Office of Rural Health within the Primary and Ambulatory Care Division in July 2008, which took on responsibility for rural workforce and rural service delivery programs and for progressing reform in rural health.

### DoHA internal review of rural health programs and geographical classification systems - 2008

In 2008 the newly formed Office of Rural Health was tasked with undertaking a review of the existing rural health programs and the classification systems for determining eligibility for rural program funding, to ensure that workforce programs and incentives were appropriately targeted and that service delivery programs and rural health professionals could respond to the needs of rural communities. The review focused on five themes:

1. improving access to appropriate health and medical services, including health promotion and prevention.
2. Investing more effectively in rural health infrastructure (including physical resources, electronic health, data collection/performance monitoring, research, and stakeholder organisations).
3. Addressing workforce shortages through better workforce distribution and support.
4. Strengthening workforce education and training.
5. Fostering partnerships between the Commonwealth and state and territory governments to improve health outcomes in rural and remote areas.

The review resulted in:

- the re-focussing and consolidation of a large number of targeted rural health programs;
- the replacement of the outdated Rural, Remote and Metropolitan Areas (RRMA) classification system that was based on 1991 Census data, with the Australian Standard Geographical Classification – Remoteness Area (ASGC-RA) system for determining eligibility to rural program funding;



- the introduction of ‘scaling’ to a number of Commonwealth initiatives, including rural incentive payments and return-of-service obligations for bonded medical programs, based on the principle of providing greater incentives for more remote areas; and
- a \$134.4 million budget package supporting rural health.

**Australian National Audit Office, 2008-09 - ‘Rural and remote health workforce capacity - the contribution made by programs administered by the Department of Health and Ageing’<sup>251</sup>**

In 2008, the Australian National Audit Office (ANAO) undertook a performance audit of the effectiveness of DoHA’s administration of health workforce initiatives in rural and remote Australia. The audit included an in-depth analysis of eight rural and remote health workforce capacity programs (representing a cross-section of DoHA’s activities in this area), and focused on whether DoHA:

- had strategies in place to maximise its contribution to Outcome 12 – Health Workforce Capacity;
- had effectively implemented Australian Government programs addressing health workforce shortages in rural and remote Australia; and
- monitored and evaluated its health workforce programs for rural and remote Australia.

The audit found that while DoHA had put in place appropriate structural arrangements for the administration and delivery of rural and remote workforce programs, it had not yet developed a cohesive approach to inform its strategies or to report on its contribution in achieving the specified outcome. In particular, the ANAO found that DoHA:

- only undertook limited monitoring of the key risks identified for Outcome 12;
- lacked a performance information strategy to monitor and assess the impact of workforce programs in contributing to the broader outcome objectives; and
- used out-dated data and geographic classification systems as the basis for providing incentives for rural and remote health professionals.

The report included three recommendations addressing these findings, which DoHA agreed to.

**Department of Education, Science and Training, 2008 - Review of Undergraduate Medical Education in Australia<sup>252</sup>**

In 2005 the Review of Undergraduate Medical Education was commissioned for the then Minister Nelson through the then Department of Education, Science and Training. It undertook a systematic examination of critical educational factors contributing to the outcomes of undergraduate medical education in Australia, in terms of how well it prepared graduates for their work as interns and meets the requirements of postgraduate training for future medical careers. There was also

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<sup>251</sup> Accessed at [www.anao.gov.au/uploads/documents/2008-09\\_Audit\\_Report\\_26.pdf](http://www.anao.gov.au/uploads/documents/2008-09_Audit_Report_26.pdf), viewed 11 September 2012

<sup>252</sup> Accessed at [www.deewr.gov.au/HigherEducation/Publications/HEReports/Pages/ReviewUGradMedEduAus.aspx](http://www.deewr.gov.au/HigherEducation/Publications/HEReports/Pages/ReviewUGradMedEduAus.aspx), viewed 11 September 2012

consideration of how undergraduate clinical education contributes to these outcomes, in terms of the effectiveness of different models of clinical education.

Key points noted in the synthesis report<sup>253</sup> of the review included:

- clinical education is regarded as a cornerstone of successful preparation for a medical career and was considered the most effective method of learning;
- there have been no predetermined standards or definitions of what constitutes the fundamental knowledge, skills and attributes required for medical graduates that would improve the articulation between medical schools and clinical practice, although there is agreement that medical sciences and procedural skills are critical;
- early integration of university and postgraduate education, and improved governance between education and health providers would assist in the development of the skills critical to the clinical experience; and
- there were concerns regarding ensuring adequate depth and breadth of clinical training for undergraduate students, in the context of increased students, reduced access to patients in the public health system, and difficulties in maintaining the apprenticeship relationship between the doctor and student.

#### Report on the 2010 Review of the Medicare Provider Number Legislation<sup>254</sup>

This review, required under legislation, examined the operation of the Medicare Provider Number Legislation (sections 3GA, 3GC and 19AA of the *Health Insurance Act 1973*) over the five years from 2005 to 2010.

Overall, the review found that s. 19AA of the Act, which (with a number of exceptions) limits access to Medicare benefits to medical practitioners who are vocationally recognised (VR), is well accepted by the profession. Section 3GA allows non-vocationally recognised (non-VR) doctors to access Medicare benefits if they are participating in an approved workforce or training program, and the review found that the s. 3GA workforce and training programs have assisted in placing doctors in areas where they are difficult to attract. However, the review also noted that the interaction of various parts of the legislation created complexity in implementation for government, specialist colleges and practitioners, and that the *Health Insurance Regulations 1975* required updating to reflect recent changes to training programs.

The review made 25 recommendations, covering areas including:

- providing a final opportunity for non-VR GPs to be grandfathered onto the vocational register;
- changes to the Medicare Benefits Scheme (MBS) to allow supervisors to bill for T8 items for specialist trainee doctors performing procedures in private settings;
- additional DoHA support for doctors on s. 3GA workforce programs;
- streamlining a number of administrative processes, including the arrangements for allocating provider numbers;

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<sup>253</sup> Accessed at [www.deewr.gov.au/HigherEducation/Publications/HEReports/Documents/SynthesisReport.pdf](http://www.deewr.gov.au/HigherEducation/Publications/HEReports/Documents/SynthesisReport.pdf), 11 September 2012

<sup>254</sup> Accessed at <http://www.health.gov.au/internet/main/publishing.nsf/Content/work-pubs-provleg-10>, viewed 11 September 2012

- amending the regulations to bring them up to date, including adding a number of certified training programs to Schedule 5, which lists the s. 3GA approved programs; and
- legislating to allow the Medical Training Review Panel to undertake additional monitoring activities and to develop formal links with Health Workforce Australia.

**Lost in the Labyrinth: Report on the inquiry into registration processes and support for overseas trained doctors - House of Representatives Standing Committee on Health and Ageing, March 2012<sup>255</sup>**

The *Inquiry into Registration Processes and Support for Overseas Trained Doctors* was established in response to concerns about the transparency and complexity of the arrangements an overseas trained doctor (OTD) must go through to be eligible to practise in Australia.<sup>256</sup> The inquiry was referred to the House of Representatives Standing Committee on Health and Ageing (the Committee) on 23 November 2010 by the then Minister for Health and Ageing, The Hon Nicola Roxon MP, following a private member's motion proposed by the Hon Bruce Scott MP.

The inquiry was established to examine the administrative processes and accountability measures around OTD assessment processes, the support programs available to assist OTDs in meeting registration requirements, and suggest improvements without lowering the necessary standards required by colleges and regulatory bodies. The inquiry's report was tabled in Parliament on 19 March 2012.

There were 45 recommendations made in the report, covering all major aspects of the assessment and registration of OTDs and proposing a range of improvements to reduce the administrative burden on, and improve support for, OTDs and their families. The key recommendations included:

- establishment of a 'one stop shop' to assist OTDs to in navigating accreditation and registration processes;
- a review of the ten year moratorium requiring OTDs to work in a District of Workforce Shortage for up to ten years to be eligible for a Medicare provider number;
- an increase in the validity period for English language test results from two years to four years when applying for certain forms of medical registration; and
- establishment of a central document repository for OTD paperwork to reduce duplication and administrative inefficiency.

Most of the report's recommendations were directed to the agencies that are responsible for the registration of OTDs and the maintenance of professional standards, such as the Medical Board of Australia, the Australian Medical Council and the specialist medical colleges.

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<sup>255</sup> Accessed at

[www.aph.gov.au/Parliamentary\\_Business/Committees/House\\_of\\_Representatives\\_Committees?url=haa/overseasdoctors/report.htm](http://www.aph.gov.au/Parliamentary_Business/Committees/House_of_Representatives_Committees?url=haa/overseasdoctors/report.htm), viewed 11 September 2012

<sup>256</sup> House of Representatives Hansard, 18 October 2010, p. 615

### Standing Council on Health, 2012 - National Strategic Framework for Rural and Remote Health<sup>257</sup>

In April 2012 the Standing Council on Health released the *National Strategic Framework for Rural and Remote Health*, designed to promote a national approach to policy, planning, design and delivery of health services in rural and remote communities.

The Framework is directed at decision and policy makers at the national, state and territory levels. It emphasises the need for health and prevention services, programs, workforce and supporting infrastructure designed to meet the unique characteristics, needs, strengths and challenges experienced in rural and remote parts of the country.

The Framework outlines five goals, and sets out objectives and strategies to achieve these. The five goals are:

1. Improved access to appropriate and comprehensive health care
2. Effective, appropriate and sustainable health care service delivery
3. An appropriate, skilled and well-supported health workforce
4. Collaborative health service planning and policy development
5. Strong leadership, governance, transparency and accountability.

### Senate Community Affairs Committee Inquiry into the factors affecting health services and medical professionals in rural areas - August 2012<sup>258</sup>

On 13 October 2011 the Senate called for the Community Affairs Committee to undertake an inquiry into the factors affecting the supply and distribution of health services and medical professionals in rural areas. The committee was given broad terms of reference, including examination of the impact of current incentive programs, the effect of Medicare Locals and the use of the ASGC-RA geographical classification system on the supply of health professionals and services. The inquiry report was released on 22 August 2012.

The inquiry made 18 recommendations. Key points included:

- The deficit of quality data on the numbers and types of health practitioners, which has limited the ability to analyse the factors impacting on the delivery of health services in rural areas. The committee recommended that collection of robust data be a priority for the upcoming review of rural health programs.
- The growing trend towards specialisation has had a disproportionate effect in rural areas, due to the reduction in generalist training pathways. The inquiry noted the importance of rural generalists and recommended the Standing Council on Health (SCoH) consider the expansion of rural generalist programs.
- The limited availability of rural placements for medical interns, both pre-vocationally and vocationally.

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<sup>257</sup> Accessed at [www.ruralhealthaustralia.gov.au/internet/rha/publishing.nsf/Content/EBD8D28B517296A3CA2579FF000350C6/\\$File/NationalStrategicFramework.pdf](http://www.ruralhealthaustralia.gov.au/internet/rha/publishing.nsf/Content/EBD8D28B517296A3CA2579FF000350C6/$File/NationalStrategicFramework.pdf), viewed 11 September 2012.

<sup>258</sup> Accessed at [www.aph.gov.au/Parliamentary\\_Business/Committees/Senate\\_Committees?url=clac\\_ctte/rur\\_hlth/report/index.htm](http://www.aph.gov.au/Parliamentary_Business/Committees/Senate_Committees?url=clac_ctte/rur_hlth/report/index.htm), viewed 11 September 2012

- The large disparity between support provided for allied health professionals and that for doctors to work in non-metropolitan areas, with recommendations that the HECS Reimbursement Scheme be extended to nurses and allied health professionals relocating to rural and regional Australia, and that a Rural and Regional Allied Health Adviser be established.
- A recommendation to replace the ASGC-RA with an alternative classification system that takes account of regularly updated geographical, population, workforce, professional and social data to classify areas where recruitment and retention incentives are required.
- A number of (minor) recommendations to support the role of universities and medical schools in encouraging graduates to practise in rural areas, including investigating options for incentives for medical students to study at regional universities, and better support for rural GPs who provide training to pre-vocational and vocational students in rural areas.
- the issue of accommodation for rural health training and placement programs, with a recommendation that a coordinated accommodation strategy, including for Aboriginal health workers, be developed as part of the forthcoming review of rural health programs.
- an acknowledgement of the potential for the Medicare Locals program to fill the gaps between hospital networks and GP community care provision, with the committee noting the primary importance of the needs assessment element of the work of Medicare Locals, and recommending these be made public.
- A recommendation that DoHA provide a bi-annual brief to SCoH on the existing or emerging gaps in service delivery, caused by misalignment between Commonwealth and state policy, and options to address these.

## Appendix viii: Health workforce program evaluations and reports

Program	Author	Year
Rural General Practice (GP) Locum Program	Rural Health Workforce Australia	2012
Specialist Obstetrician Locum Scheme	Royal Australian and New Zealand College of Obstetricians and Gynaecologists	2012
Australian General Practice Training Program	KPMG	2012
National Rural and Remote Health Workforce Program	Mosaic Health Service Improvement Support	2012
Aboriginal and Torres Strait Islander Health Workforce Program	Kristine Battye Consulting	2012
Medical Specialist Outreach Assistance Program and the Visiting Optometrists Scheme	Health Policy Analysis	2012
National Rural Locum Program	Communio	2011
Rural Health Communications Strategy	Woolcott Research	2011
General Practice Training Program	The Australian National Audit Office	2011
Expanded Specialist Training Program	Dr Bill Coote and Dr Ian McRae	2009
Other Medical Practitioner Programs	Allens Consulting Group	2009
Rural Continuing Education Program	KPMG	2009
Rural and Remote Health Workforce Capacity audit	the Australian National Audit Office	2009
Rural Health Multidisciplinary Training Program	Urbis	2008



<b>Program</b>	<b>Author</b>	<b>Year</b>
<b>Puggy Hunter Memorial Scholarship Scheme</b>	The Cultural and Indigenous Research Centre Australia	2008
<b>Rural Procedural Grants Program and Rural Locum Education Assistance Program</b>	Allens Consulting Group	2008
<b>More Doctors for Outer Metropolitan Areas Relocation Incentive Grant</b>	Woolcott Research	2007
<b>Prevocational General Practice Placements Program</b>	Australian College of Rural and Remote Medicine	2007
<b>Rural and Remote General Practice Program</b>	Client Solutions	2006
<b>General Practice Vocational Training Program</b>	ACIL Tasman Economic Policy Strategy	2005
<b>Nursing in General Practice Initiative</b>	Healthcare Management Advisors	2005

## Appendix ix: Recommendations of Battye Review

### Evaluation Recommendations - Training Package

**Recommendation 1:** The Department of Health and Ageing rename the Package a “Workforce Development and Support” Package and revise the overall goals of the Package to better reflect the scope of the Package inclusive of supporting a pathway into health careers, a culturally safe learning environment, high quality Aboriginal and Torres Strait Islander student and workforce support and increasing knowledge of non-Aboriginal and Torres Strait Islander people to work with Aboriginal and Torres Strait Islander clients.

**Recommendation 2:** The Department of Health and Ageing treat the funding under the Package in a more cohesive and comprehensive manner by implementing a common approach to the development of goals and objectives and by ensuring that each funded organisation has a clear understanding of the overall goals and objectives of the Package, and each organisation’s contribution to building Aboriginal and Torres Strait Islander workforce capacity. This should include bringing together all the organisations funded under the Package to outline goals and foster cooperative working relationships, identify opportunities for synergy and avoid duplication of effort.

**Recommendation 3:** The Department of Health and Ageing consider separate funding to organisations (external to the Package) with established linkages to schools to undertake projects or programs of work that focus on encouraging school aged Aboriginal and Torres Strait Islander students to take up careers in the health sector.

**Recommendation 4:** The Department of Health and Ageing actively work with the Department of Education, Employment and Workplace Relations (DEEWR) and the Department of Industry, Innovation, Science Research and Tertiary Education (DIISRTE) to embed adult numeracy and literacy education capacity in registered training organisations providing health and community services vocational training for Aboriginal and Torres Strait Islander people.

**Recommendation 5:** The Department of Health and Ageing take a consistent approach to the development of goals and performance indicators for its funding of the membership-based organisations (and ATSIHRTONN) including some common indicators relevant to:

- Governance and management
- Strategic and business planning
- Policy development
- Communication strategy
- Mentoring data

**Recommendation 6:** The Department of Health and Ageing consider funding a project aimed at ensuring the quality and effectiveness of teaching and learning of Aboriginal and Torres Strait Islander health in nursing and midwifery education, as well as best practice in the recruitment and retention of Aboriginal and Torres Strait Islander nursing and midwifery students.

**Recommendation 7:** The Department of Health and Ageing actively work with the Department of Employment, Education, and Workplace Relations (DEEWR) to identify sustainable funding linkages and overlaps that will enable funded organisations to directly link with key relevant university and VET sector committees to progress strategies and activities to support:

- Training pathways for Aboriginal and Torres Strait Islander health students including articulation between VET and university course;
- Retention in training; and
- Including of Aboriginal and Torres Strait Islander health curriculum

**Recommendation 8:** In recognition of the varying jurisdictional priorities and scope of the WIPOs:

- Performance indicators continue to be developed and agreed at a jurisdictional level to ensure consistency with local priorities and policy contexts, while referencing the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework.
- The outcome of negotiations regarding the development of performance indicators are agreed between state and territory offices of the Office for Aboriginal and Torres Strait Islander Health and the Health Workforce Division within the Department of Health and Ageing.
- Reporting requirements are drafted to reflect agreed performance indicators.

**Recommendation 9:** The Department of Health and Ageing review reporting requirements to ensure that reports are meaningful and provide relevant information for monitoring purposes for both the organisation and Department, and for policy development.

**Recommendation 10:** In the current climate of significant health system reform, the introduction of national registration and accreditation standards for health professions (inclusive of Aboriginal and Torres Strait Islander Health Practitioners), and establishment of national partnership agreements targeting Aboriginal and Torres Strait Islander health – many of which have workforce implications - the Department of Health and Ageing needs to establish a more robust, sustainable and stronger two-way communication strategy between central office in Canberra, state and territory OATSIH offices and the Office for Aboriginal and Torres Strait Islander Health to ensure activities are strategic and integrated, and blockages (inclusive of workforce) are identified early, such that mitigation strategies can be developed in a timely manner.

## Evaluation Recommendations - RTO

**Recommendation 1:** DoHA to commence negotiations with DIISRTE to fund core functions of the community-controlled RTOs either directly or through state and territory training authorities.

**Recommendation 2:** The community-controlled RTOs undertake to cost out their current and emergent training delivery models to provide DoHA and DEEWR with data to understand the “real” cost of delivering training to a small and dispersed workforce.

**Recommendation 3:** The workplace is recognised as a partner with the RTO in the training of ATSIHWs. To support this function, OATSIH allocates additional funding to Aboriginal community-controlled health services as a component of their comprehensive primary health care funding to source additional clinical capacity in the workplace.

**Recommendation 4:** OATSIH supports the establishment of clinical educator positions to work across clusters of Aboriginal community-controlled health services to provide clinical training and skills development to Aboriginal and Torres Strait Islander Health Worker students.

**Recommendation 5:** DoHA initiates discussion with the state and territory health departments to identify funding support to establish regional clinical educator roles to support the training and development of Aboriginal and Torres Strait Islander Health Workers employed in state and territory health services.

**Recommendation 6:** DoHA negotiate with NACCHO state affiliates their role in promoting and assisting their member services to pursue traineeships and apprenticeships as a mechanism to increase Aboriginal and Torres Strait Islander peoples’ participation in the workforce and provide financial support to the Aboriginal and Torres Strait Islander Health Worker students and employers in the training journey.

**Recommendation 7:** DoHA enters into negotiations with DIISRTE for a review of funding guidelines for the Mixed Mode Away from Base component of the Aboriginal and Torres Strait Islander Education and Training Program, with consideration of a flexible funding formula to reflect the distance the student resides relevant to the RTO, with consideration of transport options.

**Recommendation 8:** In order to minimise reporting burden but ensure accountability, DoHA and DEEWR as direct or indirect funders (i.e. through OATSIH and state and territory training authorities respectively) agree on key reporting requirements and frequency.

**Recommendation 9:** DoHA increase resourcing to the Aboriginal and Torres Strait Islander Health Registered Training Organisation National Network to enable ATSIHRTONN to support member RTOs through the new ASQA monitoring and compliance requirements.

**Recommendation 10:** Given the current intensity of reform within both the health and education sectors and the stated need for more professional development opportunities for RTOs, the Department of Health and Ageing increase funding for network meetings to support either two three-day meetings or one extra two-day meeting per year. The additional funding for network meetings should be reviewed at the conclusion of the next funding agreement when the shifts in the environment may have stabilised.

**Recommendation 11:** The Health Workforce Division of the Department of Health and Ageing review the purpose of the current data collection by ATSIHRTONN and clarify what question/s they require this data to be able to address.

**Recommendation 12:** The Health Workforce Division of the Department of Health and Ageing amend ATSIHRTONN deliverables.

## Appendix x: Summary of stakeholder roundtable and working group meetings

Roundtable	Attendees	Key points
<b>Rural Workforce Distribution, Attraction and Retention</b>  1 November 2012	Australian College of Rural and Remote Medicine Australian Medical Association Australian Medicare Local Alliance Australian Rural Health Education Network Federation of Rural Australian Medical Educators General Practice Education and Training Health Consumers of Rural and Remote Australia National Rural Health Alliance Royal Australian College of General Practitioners Rural Health Workforce Australia	<ul style="list-style-type: none"> <li>• A number of initiatives are being funded for recruitment and retention of health professionals to increase rural health workforce but these are seen to be disjointed and in some instances being delivered in isolation. There is a need to almost case manage the process and certainly to create a seamless training, recruitment and retention continuum.</li> <li>• Data, research and planning is required to better manage recruitment and retention.</li> <li>• There is a need to explore mechanisms for local coordination and integration.</li> <li>• The use of the ASGC-RA classification system should be revisited to ensure that incentives are provided at the right place for maximum benefit.</li> <li>• This review should focus on what workforce measures are currently working and how the Commonwealth can strengthen the existing system.</li> <li>• Junior doctor training in rural/remote locations need to be very well supported and establishment of mentoring systems should be considered to ensure help/advice is always available. This is particularly important for remote and very remote locations.</li> <li>• Funding for infrastructure, including accommodation, and maintenance of the infrastructure should be considered.</li> <li>• While there was general support for bonded places, the Australian Medical Association disagreed with this policy which was contrary to their stated position of “right to choose”.</li> <li>• Greater integration of primary and secondary care is needed and more specialist training is required in rural and remote regions for this integration to occur.</li> </ul>
<b>Rural Health Education</b>  2 November 2012	Australian College of Rural and Remote Medicine Australian Rural Health Education Network CRANaplus - Council of Remote Area Nurses Federation of Rural	<ul style="list-style-type: none"> <li>• Stakeholders expressed the view that Australia is well set to be domestically training sufficient medical graduates, however distribution continues to be a challenge.</li> <li>• There is a gap between rural undergraduate training and prevocational and vocational training and this will need to be filled to realise the full potential of the investment in rural undergraduate training programs.</li> <li>• A pathway is essential to these students who are ‘lost in the middle’ and one of the ways to do this would be to consider a brokerage model for Rural Clinical Schools (RCS) to buy federally funded</li> </ul>



Roundtable	Attendees	Key points
	<p>Australian Medical Educators La Trobe University National Rural Health Students Network Remote Vocational Training Scheme Rural Health Education Foundation</p>	<p>intern/specialist training spots.</p> <ul style="list-style-type: none"> <li>• The short-term placement for RCS should be made flexible and possibly replaced by a six week placement requirement to be undertaken in stages. The four week placement should occur with an initial two week placement as a 'taster'.</li> <li>• Rural/regional student recruitment should be 25% or capped at 33% to reflect the rural population.</li> <li>• Each region is unique and centralised planning does not work.</li> <li>• For students under the University Departments of Rural Health (UDRHs), longer term training (six weeks) is useful.</li> <li>• Service learning models should be widely implemented in all UDRHs.</li> <li>• Rural dental academic positions in UDRHs linked to dental student training may be an effective pathway to train as well as deliver services in rural and remote regions.</li> <li>• Aboriginal Health Worker (AHW) registration was an issue. AHW is an all-encompassing term as some are health practitioners and others are not but still termed as an AHW.</li> <li>• Infrastructure and accommodation continues to be an issue in rural and remote regions.</li> </ul>
<p><b>Allied Health Workforce</b> <i>7 November 2012</i></p>	<p>Allied Health Professions Australia Australian Association of Practice Managers Australian Health Practitioner Regulation Agency Australian Physiotherapy Association Australian Podiatry Council Australian Psychological Society Occupational Therapists Australia Optometrists Association of Australia</p>	<ul style="list-style-type: none"> <li>• All professional bodies highlighted the inequities in education and training support provided to the different health professions, with the perception that the bulk of Commonwealth funds goes to the medical profession whilst the allied health professions receive the smallest proportion. There was a suggestion that current medical support programs be expanded to include allied health professions (HECS Reimbursement Scheme, General Practice Rural Incentives Program, Practice Incentives Program, Telehealth consultations items between practitioners, MBS items for chronic disease management).</li> <li>• The lack of allied health workforce data is a significant hindrance to workforce planning and policy development.</li> <li>• Whilst noting that HWA is currently considering the allied health workforce, concerns were expressed about HWA's lack of engagement with the sector and application of a "public medical model" to what is primarily a private sector small business model.</li> <li>• The current "cluster" funding model for universities is inadequate to ensure appropriate skills and training in entry level allied health courses. Suggest that the funding of allied health courses be in the same cluster as medicine.</li> <li>• Participants expressed support for a Commonwealth Allied Health Officer as a mechanism to bring allied health into policy considerations, noting the success of this approach in state and territory governments. Preferably, this will be a person with private sector experience reflective of the working environment of most allied health professionals.</li> </ul>

Roundtable	Attendees	Key points
	Pharmacy Guild of Australia Rural Health Workforce Australia Services for Australian Rural and Remote Allied Health	<ul style="list-style-type: none"> <li>Concerns were raised about the lack of engagement by Medicare Locals with allied health practitioners either on their Boards or as members of advisory committees, and failure to engage with existing informal regionally-based allied health networks.</li> <li>The maldistribution of the allied health workforce, particularly in rural and remote areas, is in large part due to the lack of sustainable full-time positions in smaller communities which may require several part-time allied health professionals.</li> <li>Concerns were expressed that the DEEWR Skill Shortage List does not accurately reflect current and short-to- medium term future allied health workforce requirements (ie some professions included on the list are not experiencing a shortage).</li> </ul>
<b>Dental Workforce</b> 7 November 2012	Australasian Council of Dental Schools Australian Dental and Oral Health Therapists Association Australian Dental Association Australian Dental Council Dental Board of Australia Dental Hygienists Association of Australia Royal Australasian College of Dental Surgeons Rural Health Workforce Australia	<p><b>Dentistry and Medicine</b></p> <ul style="list-style-type: none"> <li>Comparisons between Government funding for dentistry and medicine were made, with a general consensus from professional bodies that more funding support should be provided for oral health practitioners and students.</li> <li>Base funding support for the medical workforce is significantly more than dentistry. There should be more of a focus on student HECS loans and rural incentives.</li> <li>Dentists have a significant education debt on completion of their dental qualifications, especially if they pursue dental specialties. The debt in some cases is between \$200,000 and \$300,000. Funding should be provided to dentists similar to programs such as the medical rural bonded scholarship scheme.</li> <li>Dentistry should not be categorised within allied health as it is more similar to medicine. There are some commonalities with medicine and this should be reflected in Government funding arrangements. There should be a focus on incentive based funding for dentists.</li> <li>Dentistry should have the same funding arrangements as for medicine in areas such as, rural incentives and initiatives, supervision and practice incentives.</li> </ul> <p><b>Funding (general)</b></p> <ul style="list-style-type: none"> <li>Consideration should be made on expanding the Dental Training - Expanding Rural Placements (DTERP) Program. ACODS indicated that dental schools could accommodate twice as many FTEs to what the program is currently funding (DTERP currently funds 5FTEs).</li> <li>There is concern that the current Government funding arrangements could set up a second tier level of oral health care by having the less experienced dentists (graduates) providing treatment to rural and remote and lower socio-economic cohorts. The dental treatment required by these groups, in most cases, is challenging and they should have access to experienced dental</li> </ul>

Roundtable	Attendees	Key points
		<p>practitioners.</p> <ul style="list-style-type: none"> <li>• The government needs to focus more on preventative measures rather than treatment – more funding needed.</li> <li>• More infrastructure investment is required in rural areas. Dental schools should play more of a role in rural oral health patient care.</li> <li>• There was a consensus that the National Advisory Council on Dental Health should continue and that the workforce recommendations from the Report should be implemented.</li> </ul>
		<p><b><i>Collaborative approach to oral health</i></b></p> <ul style="list-style-type: none"> <li>• Engaging the public and private public sectors in service delivery in rural areas is important if we want to have a viable and sustainable workforce.</li> <li>• There should be more of a coordinated approach regarding funding in rural areas from Commonwealth, state and council levels.</li> <li>• There are concerns about the lack of funding the jurisdictions are allocating to the oral health workforce. It was noted that the Commonwealth cannot control this.</li> <li>• There needs to be more focus on a team approach to oral health care (prevention and treatment), particularly in relation to the referral pathways.</li> </ul> <p><b><i>Oral health therapists and hygienists</i></b></p> <ul style="list-style-type: none"> <li>• Public sector employers need to embrace the flexibility of the dental, oral health therapist and hygienist workforce and utilise their full skill range in oral health care.</li> <li>• The oral health therapists and hygienists advocate for Commonwealth dental programs to further expand its scope of practice to include all registered oral health practitioners.</li> <li>• Oral health therapists have restrictions working in the private sector. Conversely there are restrictions for hygienists working in the public sector. These restrictions are at a jurisdictional level due to a misinterpretation of the national oral health practitioner registration requirements.</li> </ul> <p><b><i>Data collection</i></b></p> <ul style="list-style-type: none"> <li>• Historically, international student numbers were not significant in data collection. However now, with the increase of International Dental Graduates (IDGs), it is believed that 15 to 20% of dentists in the Australian workforce are IDGs. IDGs should be included in HWA workforce planning.</li> <li>• Dentists should not be included in the allied health workforce.</li> </ul>

Roundtable	Attendees	Key points
		<ul style="list-style-type: none"> <li>Australian Research Centre for Population Oral Health (University of Adelaide) data is the best available data for workforce evaluations, however some improvements could be made.</li> </ul> <p><b>Regulatory restrictions</b></p> <ul style="list-style-type: none"> <li>There were concerns regarding the state-based drugs and poisons acts and the restrictions they place on dentists. Further concerns were raised in relation to the significant costs associated with the registration requirements to set up a dental practice and other accreditation requirements. Dentists feel that they should be compensated for these costs and they should receive the similar incentives as GPs do to become accredited.</li> </ul>
<b>Nursing Workforce</b> 8 November 2012	Australian and New Zealand Council of Chief Nurses Australian College of Nursing Australian College of Midwives Australian Nursing and Midwifery Accreditation Council Australian Nursing Federation Coalition of National Nursing Organisations Congress of Aboriginal and Torres Strait Islander Nurses Council of Deans of Nursing and Midwifery (Australia and New Zealand) Nursing and Midwifery Board of Australia	<ul style="list-style-type: none"> <li>Projected workforce shortages in the future combined with the lack of available positions in the present represent a policy dilemma. It is important to continue to fund education and training but there must be a clear pathway for graduates to employment or else nursing will become less attractive as a future career.</li> <li>Retention strategies need to be further developed and targeted appropriately based on the needs of the local community and the practitioners working there.</li> <li>Participants discussed the concept of “work ready”, and the expectation that nurses should be able to perform at fully competent level at graduation. This is impacting on the employment of graduates and creating a perception that a graduate year is a necessity. This constricts the availability of overall employment as there are usually caps on graduate nurse places at each facility.</li> <li>There should be more of a focus on primary care rather than solely on acute care as part of a new, more inclusive model of nursing practice. Participants expressed that the nursing workforce needs to be flexible and have a broad based generalist skill set.</li> <li>In addressing health workforce issues there should be less of a focus on a ‘one size fits all approach’, as medical workforce models are not always appropriate for the nursing workforce.</li> <li>Participants raised concerns in relation to the cost and the amount of study associated with re-entry to the workforce for both registered nurses and enrolled nurses.</li> <li>Concerns were raised about the lack of Commonwealth support for and recognition of enrolled nurses.</li> <li>There needs to be more of an emphasis on nursing leadership, mentoring and supervision. Participants raised concerns about the lack of Commonwealth investment in this area.</li> </ul>
<b>Private Health</b> 8 November 2012	Australian Private Hospitals Association Baptist Community Services	<ul style="list-style-type: none"> <li>The lack of representation for the private health care sector on key decision making bodies in health workforce planning needs to be addressed.</li> <li>Participants all supported a suggestion from Catholic Health Australia that there could be value in</li> </ul>

Roundtable	Attendees	Key points
	Catholic Health Australia Healthscope Ramsay Healthcare	<p>establishing a specific private sector advisory body, with high level representation and engagement with Government, ideally reporting directly to the Minister for Health.</p> <ul style="list-style-type: none"> <li>• Significant capacity exists for the private sector to play a greater role in health education and private sector training, provided this is well organised and financial supports are appropriate to meet costs.</li> <li>• Participants expressed the view that nursing workforce issues need to be the primary focus of Health Workforce Australia.</li> <li>• Concerns were expressed regarding the variability of the quality of nursing graduates, with only a portion of Australian universities producing work ready graduates.</li> <li>• Concerns were also expressed about the complexity of the regulatory and industrial environment, which makes it difficult for private operators to implement flexible and innovative training and service delivery systems. Demarcation disputes in the use of the nursing workforce are a particular problem.</li> <li>• Participants were supportive of greater use of each of the different levels of nursing qualification but generally opposed to further regulation of health care professional groups, such as assistants in nursing or aged care assistant workers. Current scope of practice issues need to be resolved before further regulation is imposed. Participants also expressed that there should be greater use (and training) of enrolled nurses within the sector.</li> <li>• There is a need for involvement of the vocational education and training (VET) sector in health workforce planning.</li> <li>• There was broad support for the suggestion that health workforce implications should be considered in the development of new policy proposals.</li> </ul>
<b>Scholarships</b> <i>9 November 2012</i>	Australian College of Nursing Services for Australian Rural and Remote Allied Health National Rural Health Students Network National Rural Health Alliance Australian Rotary Health Australian College of Rural and Remote Medicine	<ul style="list-style-type: none"> <li>• Participants highlighted the inequity of funding across disciplines (nursing, medical and allied health) and that demand for scholarships far exceeds the current supply.</li> <li>• There was a consensus that scholarship schemes should be evaluated, including the value of each scholarship as there is inconsistency between disciplines and within categories (e.g. clinical placement scholarships).</li> <li>• Participants highlighted that support programs (such as mentoring or conference placement) to complement the scholarship programs should be considered.</li> <li>• There are insufficient positions in graduate year programs for newly graduated health professionals. For some professions (such as medical imaging) this postgraduate year is mandatory for registration under NRAS.</li> <li>• There is a lack of allied health data on which to base workforce planning and targeting of incentives.</li> <li>• Most participants did not consider bonded places to be an acceptable option for nursing, midwifery</li> </ul>

Roundtable	Attendees	Key points
	<p>Australian Nursing Federation</p> <p>Australian Institute of Radiography</p> <p>Royal Australian and New Zealand College of Obstetrics and Gynaecology</p>	<p>or allied health students.</p> <ul style="list-style-type: none"> <li>The possibility of a centralised funding pool for all scholarships was raised, rather than a different scheme with associated administration for each. Participants raised the following points: <ul style="list-style-type: none"> <li>All organisations stated that there was pride from students in receiving their specific scholarship (such as PHMSS or JFPP).</li> <li>Some stakeholders noted that it was difficult to navigate through scholarships.</li> <li>It was noted that each discipline has specific needs, which can be catered for better by different schemes. One participant stated that a ‘single Commonwealth funded scholarship scheme’ would only work if there were allocations for each purpose, for example, undergraduate scholarships, CPD scholarships and postgraduate scholarships. The allocation across disciplines could be determined by the number of applications from each discipline or else workforce shortages.</li> </ul> </li> <li>Most organisations expressed support for rolling out the HECS Reimbursement Scheme to all health students. However, it was noted this program is administratively difficult and to extend it would require careful consideration.</li> </ul>
<p><b>Aboriginal and Torres Strait Islander Workforce</b></p> <p>14 November 2012</p>	<p>Aboriginal and Torres Strait Islander Practice Board of Australia</p> <p>Australian Indigenous Doctors Association</p> <p>Congress of Aboriginal and Torres Strait Islander Nurses</p> <p>Indigenous Allied Health Australia</p> <p>James Cook University</p> <p>National Aboriginal Community Controlled Health Organisation</p> <p>Onemda VicHealth Koori Health Unit, University of Melbourne</p> <p>Queensland Health</p>	<ul style="list-style-type: none"> <li>A formalised body such as a College of Aboriginal Health “within the Academy” is needed as a conduit of advice for Government and to act as a focal point for the sector.</li> </ul> <p><b>Expanding Indigenous student horizons</b></p> <ul style="list-style-type: none"> <li>Young Aboriginal and Torres Strait Islander students at secondary education level are steered towards non-health vocational education sector occupations, for example, trades in preference to a career in health.</li> <li>Building pathways from school to the VET sector, and on to undergraduate studies, provides opportunities to enter tertiary education.</li> <li>Sometimes tertiary education is not presented as an option at all, particularly to high school students. At the point of tertiary education entry (VET and University) there needs to be promotion of scholarships to students to raise awareness that they are potentially eligible to access more than just the Puggy Hunter Memorial Scholarship scheme.</li> </ul> <p><b>Educating the current health workforce</b></p> <ul style="list-style-type: none"> <li>In the broader community there are stereotypical views about the distribution of Aboriginal and Torres Strait Islander nurses, Aboriginal health workers and Aboriginal and Torres Strait Islander health practitioners. Participants highlighted that not all positions are in rural and remote areas and not all clinical training needs to be completed solely in a rural area.</li> </ul> <p><b>Harmonisation of the state and territory poisons acts</b></p>



Roundtable	Attendees	Key points
	School for Indigenous Health, Monash University	<ul style="list-style-type: none"> <li>In the NT, the Poisons Act (via Chief Health Officer Gazettal) enables certain Aboriginal and Torres Strait Islander health practitioners to possess and dispense medication, which is not consistent with other jurisdictions. However, the impetus to train health workers with this capability does not exist where the legislation would prohibit these skills being utilised/practised. Limiting prescribing and dispensing rights for Aboriginal and Torres Strait Islander health practitioners and nurses is contrary to the goals of NRAS to enable movement of practitioners across jurisdictional lines.</li> </ul> <p><b>Addressing the current bottleneck for graduate nurses</b></p> <ul style="list-style-type: none"> <li>Participants highlighted that although a graduate nurse year is not required to practise, it is perceived as necessary by many employers and hospitals have arbitrary limits/quotas relating to how many graduate nurses they will employ. There was agreement that potential incentive payments for hospitals to take on a graduate/more graduates should be considered.</li> <li>Participants highlighted that the Practice Nurse Incentives Program may be a vehicle for nursing graduates and/or recruitment to Aboriginal Medical Services, with nurses rotating out from the larger tertiary hospital.</li> </ul>
<b>National Health Education</b> 21 November 2012	Australasian Council of Dental Schools Australian College of Nursing Australian Dental Council Australian Indigenous Doctors Association Australian Medical Association - Council of Doctors-In-Training Australian Medical Council Australian Medical Students Association Committee of Presidents of Medical Colleges Confederation of Postgraduate Medical Education Councils	<ul style="list-style-type: none"> <li>Concerns were raised about the capacity of the clinical training system to provide appropriate placements for increasing numbers of health students (all health professions, undergraduate, postgraduate and specialist training).</li> <li>Participants noted that the significant increases in enrolments over recent years are exerting considerable pressure on the clinical training system at a time of fiscal restraint on the part of state and territory governments (the main providers of clinical placements) and that this is likely to continue in the future.</li> <li>Participants (particularly those from the tertiary education sector) also noted that there is potential for a negative impact from HWA funding of clinical placements. That is, significant increases in the amount charged by providers (many of which did not previously impose a fee), and the reduction in availability of public sector clinical placements in favour of those funded by HWA.</li> <li>Concerns were also raised about the distribution of health professionals, particularly in regional, rural and remote areas.</li> <li>There were also concerns about the diversity of the health workforce, particularly the enrolment, retention and completion of courses by Aboriginal and Torres Strait Islander students.</li> </ul>

Roundtable	Attendees	Key points
	<p>Council of Academic Public Health Institutions Australia</p> <p>Council of Deans of Nursing and Midwifery (Australia and New Zealand)</p> <p>General Practice Education and Training</p> <p>General Practice Registrars Australia</p> <p>Health Workforce Australia</p> <p>Medical Deans Australia and New Zealand</p> <p>Royal Australian College of General Practitioners</p> <p>University of Sydney, Faculty of Health Sciences</p>	
<p><b>Rural Classification Systems Working Group</b></p> <p>6 November 2012</p>	<p>Australian Medical Association</p> <p>Australian Medicare Local Alliance</p> <p>General Practice Registrars Australia</p> <p>Royal Australian College of General Practitioners</p> <p>Rural Doctors' Association of Australia</p> <p>Rural Health Workforce Australia</p> <p>Monash University, Rural</p>	<p><b>Issues with the current system</b></p> <ul style="list-style-type: none"> <li>• There was general consensus across the working group that the current ASGC-RA classification system fails to categorise towns effectively in relation to health workforce requirements. There are instances where rural areas are competing with larger regional centres under the same classification, which has created inequity.</li> <li>• There are also boundary issues within the current system with substantial anomalies between adjacent towns. There are particular issues in relation to RA 2 and 3 classifications.</li> </ul> <p><b>Key principles for a new classification system</b></p> <ul style="list-style-type: none"> <li>• The working group proposed that a classification system should be a structured, macro level system with some flexibility to enable it to be adapted for individual program guidelines. The system needs to be one that all stakeholders can understand.</li> <li>• There was strong support for the idea that there should be flexibility at the local level in any new system. For instance, under a 'pooling of funding' approach, funding could be directed to regions or locations with local entities allocating those funds based on individual community need.</li> <li>• Participants highlighted that it is important for a classification system to use reliable and up-to-date</li> </ul>

Roundtable	Attendees	Key points
	<p>Health Research National Rural Health Alliance</p>	<p>data as population growth changes quite rapidly in some areas and affects community health needs. For example, towns who have been subject to the mining boom.</p> <ul style="list-style-type: none"> <li>There were concerns that the use of ABS data in relation to any new system may not correctly represent health issues in rural areas. On this point, DoHA noted that the new ASGC-RA can be updated every five years with ABS population census data.</li> </ul> <p><b>Possible model for adoption</b></p> <ul style="list-style-type: none"> <li>The working group discussed the Monash model which is a 13 category classification system. The model has been modified for potential use by Government to six categories. DoHA presented to the group on the revised six-category model including analysis of impacts on different locations within Australia.</li> <li>There was a strong view within the working group that remoteness should be included as an indicator. In addition, the model must include a population size categorisation.</li> <li>There was a consensus that all classification indicators must be justified so all stakeholders are aware of why they have been included, ensuring a transparent system.</li> <li>Establishing evaluation and monitoring parameters will be an important part of setting up a new classification system.</li> <li>Based on the discussions of the working group, the following key principles for classification system reform have been identified: <ul style="list-style-type: none"> <li>- Flexibility at the local level</li> <li>- Logical and easy to understand</li> <li>- Evidence-based</li> <li>- Objective</li> <li>- Regularly updated</li> <li>- Allows for discrimination between large and small towns</li> <li>- Cost-effective</li> </ul> </li> </ul> <p><b>Transition Process</b></p> <ul style="list-style-type: none"> <li>The working group noted that, should a decision be made to reform the classification system, it would be important that an announcement and transition dates be communicated to stakeholders as soon as possible. The transition period should allow stakeholders adequate time to adjust particularly in respect of reporting requirements.</li> <li>Working group members also strongly felt that consultations should be undertaken with stakeholders in relation to the implementation of any new system and the effect it will have on the health workforce. Health workforce bodies would be in a position to assist DoHA with a further consultation process to implement and refine changes recommended by the review. There was a suggestion that a reference group should be established to guide the implementation and</li> </ul>

Roundtable	Attendees	Key points
		monitoring of any new classification system.
<b>Districts of Workforce Shortage</b> 9 November 2012	Australian College of Rural and Remote Medicine Medical Board of Australia/Australian Health Practitioner Regulation Agency Australian Medical Association Committee of Presidents of Medical Colleges Health Workforce Principal Committee Royal Australian College of General Practitioners Rural Doctors' Association of Australia Rural Health Workforce Australia	<ul style="list-style-type: none"> <li>Participants agreed that there was a continued need for a system to identify those areas that have comparatively less access to medical services.</li> <li>Participants agreed that consideration should be given to applying a different name to this system as 'district of workforce shortage' may not provide the best reflection of the data that is being considered.</li> <li>Participants agreed that any system used for this purpose should consider the level of Medicare-rebated medical service provision within a local area against the national average, but not use this as the sole consideration when making workforce shortage determinations.</li> <li>Participants proposed that the following considerations may enhance the accuracy of workforce shortage determinations: <ul style="list-style-type: none"> <li>the possible application of a 10% buffer the national average level of service provision to ensure classifications identify those areas that have better access than the national average;</li> <li>the consideration of the availability and nature of any hospital services within a local area when providing workforce shortage determinations;</li> <li>the consideration of state and territory averages in an attempt to create a parity in the overall level of medical service provision within each state and territory; and</li> <li>the possible removal of services provided by locum medical practitioners from the billing statistics used to determine DWS.</li> </ul> </li> <li>DoHA suggested that the current system could be amended to treat general practice the same as the other specialties by providing annual updates and using remoteness classifications as a basis for providing determinations was agreed.</li> <li>The transition to using a FWE measure to support workforce shortage classifications was not agreed and is still being considered.</li> <li>Participants did not propose to apply DWS to other health professional groups.</li> <li>Participants agreed that benefit would be derived from DoHA providing additional communication materials to support stakeholder understanding of: <ul style="list-style-type: none"> <li>the methodology that is used for achieving determinations under DWS or a possible alternate system;</li> <li>the linkages and differences between DWS/alternate system and the AoN system; and</li> </ul> </li> </ul>

Roundtable	Attendees	Key points
		<ul style="list-style-type: none"><li>- the requirements applicable to GP Registrars under this system.</li><li>• Participants proposed that eligible locations for return of service obligations under the BMP Scheme be determined according to a remoteness classification system as opposed to DWS.</li><li>• Participants expressed support for consolidating the current suite of Other Medical Practitioner Programs (OMPs) into a single program.</li></ul>

## Appendix xi: List of submissions received

Arthritis Australia  
Australasian Podiatry Council  
Australian Medical Association (AMA)  
Australian Medical Students' Association (AMSA)  
Australian Medicare Local Alliance (AMLA)  
Australian Practice Nurses Association (APNA)  
Australian Rural Health Education Network (ARHEN)  
Curtin University, Faculty of Health Sciences  
Department of Health Victoria  
Dr Roianne West  
Federation of Rural Australian Medical Educators (FRAME)  
Flinders University  
General Practice Registrars Australia (GPRA)  
La Trobe University  
Melbourne Medical Deputising Service  
National General Practice Supervisors' Association  
National Rural Health Alliance  
North Metropolitan Health Service Public health and Ambulatory Care  
Painaustralia  
Remote Area Health Corps (RAHC)  
Rural Health Education Foundation (RHEF)  
Rural Health Workforce Australia (RHWA)  
University of Melbourne  
University of New South Wales  
University of Sydney, Sydney Medical School  
University of Sydney, University Centre for Rural Health (North Coast)