

## 14. Working for us: a sustainable health workforce for the future

### Key messages

- The dedication, diversity and dynamism of our health workforce are major strengths of the Australian health system. We can, and should, be legitimately proud of the critical contribution that our well-qualified health professionals make to helping us achieve better health.
- One in every eleven people (8.6 per cent) is employed in the health sector. Our health workforce includes almost 600,000 health staff and about another 275,000 support staff. About half the health workforce (300,000) are nurses. Outside the health workforce, about 470,000 Australians play a vital role as ‘informal carers’.
- Despite these strengths, we face major challenges relating to the number, distribution, training and demographics of our health workforce, both now and into the future. This was seen by many as the major problem facing the Australian health system. We need to act now to ensure we have a sustainable quality health workforce into the future.
- Our health workforce is ageing. With the exception of nurses, there is much less access to most health professionals in rural and remote Australia. The demands of an ageing population and the growth of chronic disease will place greater pressure on an already strained health workforce.
- Australia is not currently self sufficient on a net basis across all categories of health professionals.
- Existing professional boundaries restrict our ability to use fully the skills of the current health workforce.
- There is a disconnect between the priorities of health services and the need to educate and train the next generation of health professionals.
- In a rapidly changing world of practice, we need to find new ways to educate our future health workforce.

## Our reform directions

14.1 We propose supporting our health workforce by:

- improving workplace culture, management and leadership skills at all levels of the system (we would welcome feedback on proven mechanisms to achieve this); and
- implementing models that formally involve all health professionals in guiding the future directions of health reform and place value on their ongoing commitment to delivering care (e.g. Clinical Senates and Taskforces).

14.2 We propose facilitating access to care where doctors are scarce. Commencing in remote and some rural areas:

- Medicare rebates should apply to some diagnostic services and specialist medical services ordered or referred by nurse practitioners and other registered health professionals according to defined scopes of practice determined by health professional registration bodies.
- Pharmaceutical Benefits Scheme subsidies (or, where more appropriate, support for access to subsidised pharmaceuticals under section 100 of the National Health Act 1953) should apply to pharmaceuticals prescribed from approved formularies by nurse practitioners and other registered health professionals according to defined scopes of practice.
- Where there is appropriate evidence, specified procedural items on the Medicare Benefits Schedule should be able to be billed by a medical practitioner for work performed by a competent health professional, credentialed for defined scopes of practice.

14.3 We endorse a new education framework for all education and training of health professionals including:

- adopting a competency-based framework;
- moving towards a flexible, multi-disciplinary approach to the education and training of all health professionals;
- establishing a dedicated funding stream for clinical placements for undergraduate and postgraduate students; and
- ensuring clinical training infrastructure across all settings (public and private, hospitals, primary health care and other community settings).

14.4 We propose the establishment of a National Clinical Education and Training Agency:

- to advise on the adequacy of projected provision of health professional education in the university and vocational education sectors within each major region;
- to purchase in partnership with universities, vocational education and training, and colleges, clinical education placements from health service providers, including payments for undergraduates' clinical education and postgraduate training;
- to promote innovation in education and training of the health workforce;
- as an aggregator and facilitator for the provision of modular competency-based programs to up-skill health professionals (medical, nursing, allied health and aboriginal health workers) in regional, rural and remote Australia to perform tasks and address health needs met by other health professionals in major metropolitan areas; and
- to report every three years on the appropriateness of accreditation standards in each profession in terms of innovation around meeting the emerging health care needs of the community.

14.5 We support national registration to benefit the delivery of health care across Australia.

14.6 We propose implementing a comprehensive national strategy to recruit, retain and train Aboriginal and Torres Strait Islander health professionals at the undergraduate and postgraduate level including:

- setting targets for all education providers, with reward payments for achieving health professional graduations;
- funding better support for Aboriginal and Torres Strait Islander health students commencing in secondary education; and
- strengthening accrediting organisations' criteria around cultural safety.

14.7 We propose that a higher proportion of new health professional educational undergraduate and postgraduate places across all disciplines be allocated to remote and rural regional centres, where possible in a multidisciplinary facility built on models such as clinical schools or university departments of Rural Health.

## 14.1 Introduction

Australia has a highly qualified, dynamic, diverse and dedicated health workforce – the people who care for and treat us are a key strength of the health system. Working individually or as part of a team they provide the myriad of health services that Australians expect.

Given their critical role, it is not surprising that there have been several major studies and reports that identify challenges for Australia's health workforce, perhaps the most notable being the Productivity Commission's report in December 2005.<sup>1</sup> The challenges we face are not unique. Like the rest of the world, Australia is looking for answers to tackle expected increases in demand for health services and projected workforce shortages.

*Australia is fortunate in having a workforce that is highly skilled and dedicated to caring for patients notwithstanding the many systemic impediments faced in the performance of their roles. In the face of increasing global competition for health professionals, the ongoing sustainability of our workforce is of vital importance.<sup>2</sup>*

Australia, through the Council of Australian Governments (COAG), has endorsed a vision for a future health workforce and established the National Health Workforce Taskforce to develop strategies to meet this vision:

*Australia will have a sustainable health workforce that is knowledgeable, skilled and adaptable. The workforce will be distributed to achieve equitable health outcomes, suitably trained and competent. The workforce will be valued and able to work within a supportive environment and culture. It will provide safe, quality, preventative, curative and supportive care that is population and health consumer focused and capable of meeting the health needs of the Australian community.<sup>3</sup>*

In keeping with our principle of 'providing for future generations', we have explored ways for the health workforce and health system to adapt to future health needs.

## 14.2 The Australian context – our health workforce

It has been estimated that the health workforce makes up just over 8.6 per cent of the total workforce<sup>4</sup> and is the second largest workforce group.<sup>5</sup> Health is therefore a vital part of our national economy – 'producing health' helps us to grow a stronger economy.

At August 2006<sup>6</sup>, 593,300 people were working in a health occupation such as a doctor, nurse, or dentist. A further 276,000 people work in the health services industry as cleaners, clerks and

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1 See also, for example, The Blame Game: Report on the Inquiry into Health Funding, House of Representatives Standing Committee on Health and Ageing (2006); Report on the Audit of Health Workforce in Rural and Regional Australia (2008) (Commonwealth of Australia).

2 Catholic Health Australia (2008), Submission 57 to the National Health and Hospitals Reform Commission.

3 National Health Workforce Strategic Framework (2004), at: [www.nhwt.gov.au/theframework.asp](http://www.nhwt.gov.au/theframework.asp)

4 Australian Institute of Health and Welfare (2008), Australia's Health 2008 (Australian Institute of Health and Welfare: Canberra).

5 Australian Bureau of Statistics (2006), Census of Population and Housing, at: <http://www.abs.gov.au/AUSSTATS/abs@.nsf/ProductsbyCatalogue/A6D6129396973B5ACA257306000D4DB9?OpenDocument>

6 Australian Institute of Health and Welfare (2008), Australia's Health 2008 (Australian Institute of Health and Welfare: Canberra).

chefs, for example. Further still, there are 472,500<sup>7</sup> people across Australia who care for family and friends in the community who would otherwise need to be cared for in the health and aged care sector. We heard many times about the vital role of informal carers, usually family members:

*The availability of Australia's carers and their ability to continue their caring role is therefore critical to the long-term sustainability of the Australian health and community care systems.<sup>8</sup>*

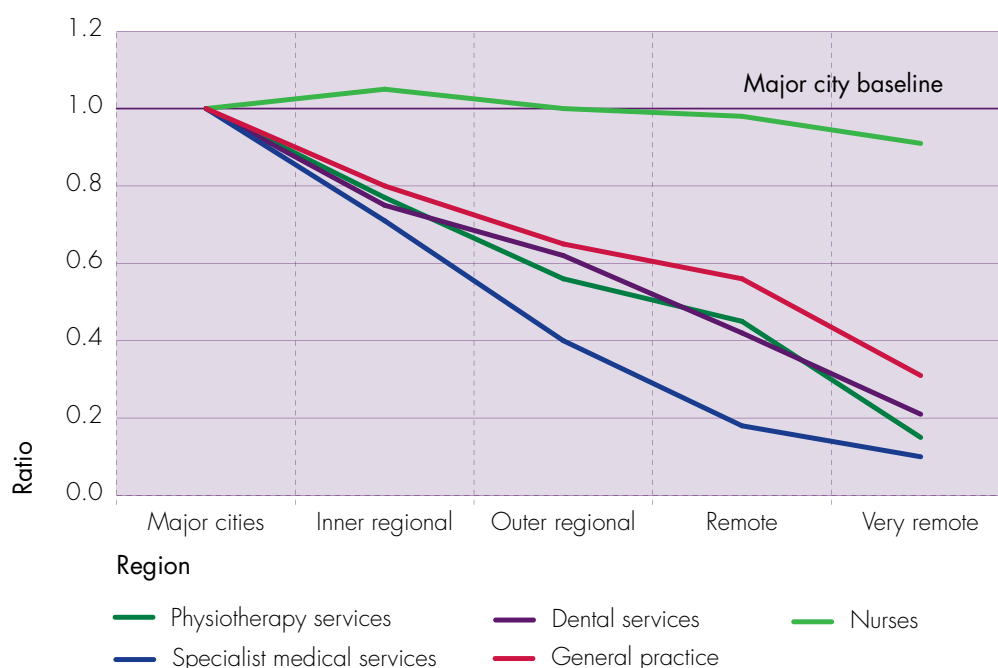
In 2006<sup>9</sup>, there were 298,100 nurses (including registered, enrolled, nursing and personal care assistants) making up 50 per cent of those working in a health occupation. Medical practitioners (general and specialists) made up 10 per cent (59,500) and dental practitioners and dental associate professionals and assistants made up six per cent (35,600).

Many health occupations are experiencing shortages

■ Many health occupations are experiencing shortages. A study by the Department of Employment and Workplace Relations identified state-wide shortages of dentists, pharmacists, registered nurses, occupational therapists, speech pathologists and podiatrists. Studies by the Australian Medical Workforce Advisory Committee and the Australian Health Workforce Advisory Committee identified estimated shortages of between 800 to 1300 GPs in 2002<sup>10</sup>, and a shortfall of nurses requiring between 10,000 and 13,000 new graduate nurses in 2010.<sup>11</sup>

There are also issues with their distribution across the country (see Figure 14.1). The numbers of general and specialist medical practitioners, dentists and physiotherapists all decline rapidly as you move further away from major cities while nurses are evenly distributed across regions.

**Figure 14.1: Nurses are the health professionals that are most evenly distributed across Australia**



Source: Productivity Commission (2008), Trends in aged care services, at: <http://www.pc.gov.au/research/commissionresearch/aged-care-trends>.

<sup>7</sup> Australian Bureau of Statistics (2003), Survey of Disability, Ageing and Carers, at: <http://www.abs.gov.au/ausstats/abs@.nsf/0/c258c88a7aa5a87eca2568a9001393e8?OpenDocument>

<sup>8</sup> Carers Australia (2008), Submission 56 to the National Health and Hospitals Reform Commission.

<sup>9</sup> Australian Institute of Health and Welfare (2008), Australia's Health 2008 (Australian Institute of Health and Welfare: Canberra).

<sup>10</sup> Australian Institute of Health and Welfare (2008), Australia's Health 2008 (Australian Institute of Health and Welfare: Canberra).

<sup>11</sup> Australian Institute of Health and Welfare (2008), Australia's Health 2008 (Australian Institute of Health and Welfare: Canberra).

Interestingly, Australia does not currently have a shortage of health workers relative to other countries. In 2005, Australia had higher numbers of general practitioners (1.4 per 100,000) and nurses (10.9 per 100,000) relative to population compared to New Zealand (0.7 and 9.5 respectively), Canada (1.0 and 10.0), the United States of America (1.0 and 8.0), and the United Kingdom (0.7 and 9.1).<sup>12</sup> The rate of dentists was similar in all these countries whereas the rate of medical specialists ranged from 0.7 to 1.7 per 100,000, with Australia in the middle of that range.<sup>13</sup>

In the next 40 years, the proportion of people aged 65 years and over is expected to double<sup>14</sup> and the prevalence of complex and chronic conditions will increase. This will increase demand for health services and influence the required skill mix in future years. For example, as the population continues to age, the number of people who develop dementia is expected to increase from about 220,000 to 730,000 in 2050.<sup>15</sup> This will require more people trained to deliver dementia care across a variety of health care settings including general practice, hospitals and residential facilities.

It has been estimated that 'Australia may need to have over 20 per cent of the total workforce in health-related areas by 2025 if we are to maintain the delivery of services that we currently have'.<sup>16</sup> Moreover, the demand for informal carers will rise by 160 per cent between 2001 and 2031 compared to the supply of informal carers increasing by around 60 per cent, with the expected carer shortfall to quadruple from 150,000 to almost 600,000.<sup>17</sup>

Australia relies on overseas-trained health professionals, particularly in regional and remote areas where it is often difficult to recruit Australian trained professionals. 'Medicare data shows that 36 per cent of doctors currently working in Australia were trained overseas, with more than 41 per cent of doctors working in rural and remote areas having trained overseas'.<sup>18</sup> This is neither sustainable, nor ethical, with the World Health Organization estimating there will be a global shortage of 4.3 million health workers over the next decade to 2016.<sup>19</sup> Very often, the overseas-trained professionals come from countries with quite different cultures and health systems to Australia. We are often putting health professionals with the most need for support into locations where the least support is available. Further, many of these overseas-trained professionals come from countries which can least afford to lose highly trained and skilled people.

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Australian health workforce policy should be guided by the long-term aim of ensuring that we are self sufficient on a net basis across all categories of health professionals.

While the health workforce is growing at a faster rate than other sectors (23 per cent compared to 12 per cent for all other occupations<sup>20</sup>), the average age of our health workers is increasing and therefore closer to retirement. In 2006<sup>21</sup>, 16 per cent of the health workforce was aged 55 years and over, compared with 12 per cent in 2001. Our ongoing capacity to meet health care requirements, especially when considered against the prospective future workforce, will be challenged (see Figure 14.2).

12 Australian Institute of Health and Welfare (2008), Australia's Health 2008 (Australian Institute of Health and Welfare: Canberra).

13 Australian Institute of Health and Welfare (2008), Australia's Health 2008 (Australian Institute of Health and Welfare: Canberra).

14 Productivity Commission (2008), Trends in aged care services, at: <http://www.pc.gov.au/research/commissionresearch/aged-care-trends>

15 Productivity Commission (2008), Trends in aged care services, at: <http://www.pc.gov.au/research/commissionresearch/aged-care-trends>

16 P Brooks, L Robinson and N Ellis (2006), 'Task substitution – where to from here?', Medical Journal Australia (185): 18–19.

17 Productivity Commission (2008), Trends in aged care services, at: <http://www.pc.gov.au/research/commissionresearch/aged-care-trends>

18 Australian Government Department of Health and Ageing (2008). Report on the Audit of Health Workforce in Rural and Regional Australia (Commonwealth of Australia, Canberra).

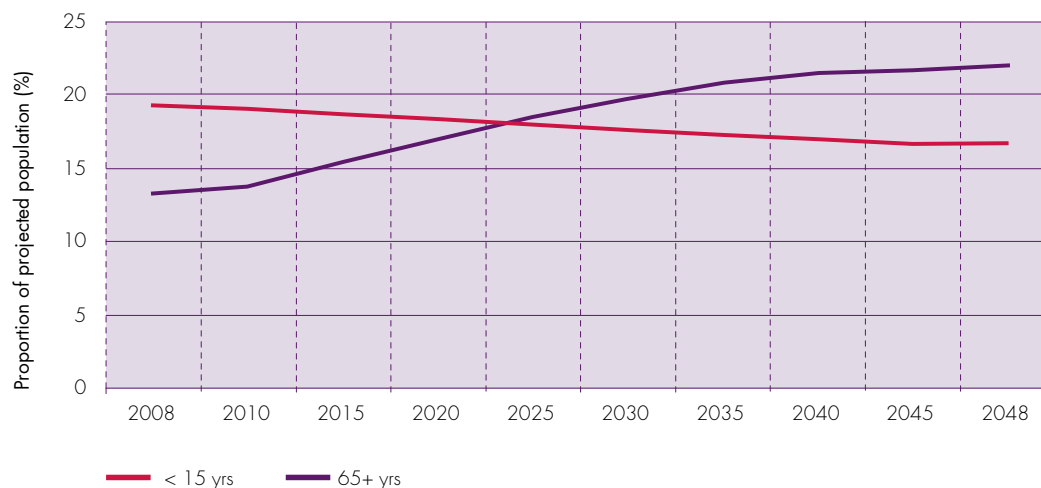
19 Health Workforce Report 2006, World Health Organization, at: [www.who.int](http://www.who.int)

20 Australian Institute of Health and Welfare (2008), Australia's Health 2008 (Australian Institute of Health and Welfare: Canberra).

21 Australian Institute of Health and Welfare (2008), Australia's Health 2008 (Australian Institute of Health and Welfare: Canberra).

Our future total workforce is shrinking rapidly. In 2001, it was estimated that the national workforce grew by around 170,000 people per year – by 2020, this was predicted to be just 12,500 people a year.<sup>22</sup>

**Figure 14.2: New workforce entrants will not replace those people leaving the workforce through age-related retirement**



Source: Australian Bureau of Statistics (2008), Population Projections, Australia, 2006 to 2101 (Commonwealth of Australia).

So, as our need for additional entrants into the health workforce increases, our pool of people to draw from will shrink. In 2006, the ratio of health professionals to population was 29.1 per 1000 population or 593,300 people. We estimate that, in 2051, in order to maintain this ratio the proportion of the younger population (18–21) studying to be a health professional will need to increase from 16 per cent to 19 per cent. If our population health status declines or an ageing population requires an increase in the ratio of health professionals per head of population, the proportion of young people enrolled to study for health professional courses will need to increase further.

### 14.3 Identifying the case for change

An increasing demand for health services coupled with a diminishing labour supply poses questions about how we will meet this demand in the future.

There are limited options for how we might respond to the workforce needs of the future: improve the productivity of the existing workforce, get the existing workforce to work more hours (or delay retirement), or recruit/train more people.<sup>23</sup>

22 National Health Workforce Strategic Framework (2004), at: [www.nhwt.gov.au/theframework.asp](http://www.nhwt.gov.au/theframework.asp)

23 S Birch, G Kephart, G Tomblin-Murphy and colleagues (2007), Human Resources Planning and the Production of Health: A Needs-Based Analytical Framework, Canadian Public Policy, Vol XXXIII, Supplement.

### 14.3.1 Supporting our health workforce

Health professionals across Australia told us that they were under pressure and that this impacted on their ability to do their job, and often resulted in their leaving their health profession. This brain drain is neither productive nor efficient when considered against the investment in time and resources to educate and train people, and the lead time to recruit and train others.

*Every nurse that leaves the profession represents a loss of public funds, and treating nurses who are rendered ill or injured from their work is a financial cost to taxpayers too. There are on-costs for the community of nurses leaving nursing, as the education of every nurse is undertaken with public dollars, and each exit from the profession is worth a loss of some \$AU150,000.<sup>24</sup>*

Reasons given for this pressure generally related to workforce conditions including lack of respect and professional recognition, lack of professional support particularly in rural and remote regions, limited career pathways and access to ongoing professional training as well as demand pressures caused by staff shortages and the potential impact this had on patient and staff safety.

*Many nurses now are leaving the workforce because of the lack of respect given to their profession<sup>25</sup>*

*There are lots of rewards working in remote practice but one of the problems is that for months on end there can be no off switch and you are always on call. This isn't just about locums over holidays; it's about sharing the load for a weekend here and there or something as basic as having a night off<sup>26</sup>*

*Aboriginal health workers face a lot of pressure in the community. They are called on to provide support and advice by family, friends and the community at large. They are on call 24 hours a day, seven days a week.<sup>27</sup>*

People we spoke to overwhelmingly wanted to stay working in their chosen profession but felt that something had to give. Participants at the national consultations said:

*We want to see a community that is proud of the health care system – that it is a profession where people want to come and work<sup>28</sup>*

*The system has to invest in its greatest resource and that is its staff.<sup>29</sup>*

One suggestion to address concerns about nurses (and other health professionals) leaving the workforce was to investigate the concept of 'Magnet' hospitals<sup>30</sup> (see Figure 14.3), or the 'nurse friendly facility programs' in Texas<sup>31</sup>, or the use of Clinical Nurse Educators.<sup>32</sup>

■ People we spoke to overwhelmingly wanted to stay working in their chosen profession but felt that something had to give

24 Australian Nursing Federation (2008), Submission 313 to the National Health and Hospitals Reform Commission.

25 Health professional (18 June 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Brisbane.

26 Health professional (12 June 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Alice Springs.

27 Participant (3 July 2008), National Health and Hospitals Reform Commission special interest forum on Indigenous health in Darwin.

28 Participant (19 June 2008), National Health and Hospitals Reform Commission special interest forum on hospitals in Brisbane.

29 Health professional (4 June 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Sydney.

30 Australian Nursing Federation (2008), Submission 313 to the National Health and Hospitals Reform Commission.

31 Council of Remote Area Nurses of Australia (2008), Submission 73 to the National Health and Hospitals Reform Commission.

32 Council of Deans of Nursing and Midwifery (2008), Submission 72 to the National Health and Hospitals Reform Commission.

### Figure 14.3: What is a Magnet Hospital?

The Magnet Hospital Recognition Program® evolved when an American taskforce investigating nursing workforce shortages in the 1980s found that some hospitals were able to retain and attract new staff. Developed by the American Nurses Credentialing Center, the program identifies and recognises excellence in nursing services – hospitals awarded Magnet designation are referred to as Magnet Hospitals. To achieve ‘magnet’ status, hospitals must be able to demonstrate 14 characteristics, known as the Forces of Magnetism: quality nursing leadership; effective organisational control; effective management style; promotional opportunities for personnel; professional models of care; quality care; quality assurance; expertise available to staff; high level of autonomy; active community outreach; positive teaching experience for nurses; positive perception of nurses; and high emphasis on personal growth and redevelopment.

The Princess Alexandra Hospital in Brisbane was granted magnet status in 2004: it reduced nursing staff turnover from 25 per cent in 1999 to just over 10 per cent two years later. A key feature of magnet hospitals is that ‘they provide greater autonomy for nurses and give nurses greater control over their work’ leading to improved nursing morale.

Source: F Armstrong, ‘Magnet Hospitals: What’s the Attraction?’, *Australian Nursing Journal* 12 (8): 14–17.

## 14.3.2 Improving access in rural and remote regions

Affordable and equitable access to health care services in rural and remote areas was identified as a major issue in submissions and during the national consultations. Underpinning this were concerns about convincing health professionals to move to the bush and keeping them there, as well as identifying solutions to ensuring health care in the absence of a general practitioner.

As outlined in Chapter 9, there is a need for flexible funding arrangements that focus on multidisciplinary practice. In theory, Australians have universal access to the Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS). In rural and remote regions, this isn’t the case, as access to the MBS and PBS is generally driven by access to a general practitioner (and in some circumstances other health professionals such as optometrists). Differential access to Medicare was raised in several submissions and in the national consultations.

*Medicare depends on doctors being there, therefore people in rural and remote areas experience less access to care than their urban counterparts<sup>33</sup>*

The National Rural Health Students’ Network suggests that flexible workplace models, such as outreach services need to be implemented to ensure Australians residing in such areas have equal opportunity to access the MBS and PBS.<sup>34</sup>

Complementing this approach, it was suggested that there is a need to extend MBS referral and PBS prescribing rights to allow all people and communities to access these services, in particular for nurse practitioners to enable them to practise to their full level of competence.<sup>35,36</sup>

■ Nurse practitioners have specific additional training and are registered and licensed within a field of competence by the relevant state nurses’ registration board

Nurse practitioners have specific additional training and are registered and licensed within a field of competence by the relevant state nurses’ registration board. While these changes have been legislated across states, no corresponding changes have been made to Commonwealth law to facilitate the practice of nurse practitioners. This prevents a nurse practitioner from writing a prescription that would be subsidised under the PBS. Similarly, diagnostic tests ordered by a nurse practitioner may not attract an MBS rebate.

33 Health professional (25 June 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Melbourne.

34 National Rural Health Students Network (2008), Submission 522 to the National Health and Hospitals Reform Commission.

35 Australian Nurse Practitioners Association (2008), Submission 14 to the National Health and Hospitals Reform Commission.

36 College of Nursing (2008), Submission 66 to the National Health and Hospitals Reform Commission.

In addition to strengthening and supporting independent roles, it was also suggested that we should recognise and support supervised or 'delegated' practice. In contrast to the role of nurse practitioners, who function as independent health professionals, supervised or delegated practice involves health professionals working under negotiated delegation arrangements from another health professional, most commonly under the supervision of a medical practitioner. For example, nurses can safely perform cystoscopies.<sup>37, 38</sup> A delegated model would involve appropriately skilled nurses working closely with urologists and performing cystoscopies under their supervision. Under that model, the urologists would then bill for the work of the nurses they supervise.

The Productivity Commission has previously supported this approach.<sup>39</sup> For procedural care, there is a natural limit to provision of services. Access to billing for delegated practitioners for attendance items should possibly be regulated more tightly to specific classes of practitioners, such as physician assistants.

Other strategies raised in submissions and consultations for improving access to health services for people living in rural and remote areas included expansion of specialist outreach services, telehealth, and referral and advice networks. These are discussed in Chapter 9.

### 14.3.3 Strengthening education and training

The siloed education and training of nurses, allied health professionals and doctors was identified as a major cause of service fragmentation in the national consultations and through the submissions received:

*... the education of health students needs to be in a common and more integrated educational environment. Integrated and common education in health allows for easier cross-discipline movement and the ability for graduates to be more flexible and mobile in their practice.<sup>40</sup>*

*Efforts should also be made to improve inter-professional learning across the health professions.*

*Inter-professional learning is seen as a particularly effective way of meeting contemporary health care needs through its capacity for developing interdisciplinary teamwork; improving collaboration between the professions and the patient; increasing the workforce skill mix; and supporting innovative work practices.<sup>41</sup>*

Universities are increasingly moving to single generalist degrees with further education offered in areas of speciality. For example, the University of Melbourne has moved all of its initial health professional education to graduate entry. Other universities are also increasing the range of programs which provide initial professional education as graduate entry programs. Students then specialise by undertaking postgraduate studies in areas such as medicine.

Clinical training and placements were also raised as issues. The uncertainty around the availability of places and the consistency of placements from one provider to the next was seen as an impediment to producing high quality graduates. One forum participant captured the sentiment of many participants:

■ The siloed education and training of nurses, allied health professionals and doctors was identified as a major cause of service fragmentation

37 S Radhakrishnan and colleagues (2006), 'Nurse-led flexible cystoscopy: experience from one UK centre'. *British Journal of Urology International* 98 (2): 256–8.

38 J de Bie and colleagues (2004), 'Reserved procedures in Dutch hospitals: knowledge, experiences and views of physicians and nurses', *Health Policy* 68(3): 373–84.

39 Productivity Commission (2005), *Australia's Health Workforce*.

40 Australasian Council of Paramedicine (2008), Submission 28 to the National Health and Hospitals Reform Commission.

41 Australian Nursing Federation (2008), Submission 313 to the National Health and Hospitals Reform Commission.

*The current health worker students are the future of the health and medical workforce and unless we invest in them, both through funding adequate clinical training capacity as well as quality and clinical training, then the health system will continue to suffer<sup>42</sup>*

At present the health sector is not accountable for the quality of clinical placements and the level of supervision. Conversely, universities and vocational education and training providers are not accountable to the health sector for the quality of the preparation students receive prior to clinical placements and the total number of clinical placement hours a student might receive.

We need to embrace all available training sites and create a culture where teaching and learning are considered 'core business' of our health system

In order to train the future workforce, we need to embrace all available training sites and create a culture where teaching and learning are considered 'core business' of our health system. At the moment this is not possible because of the lack of infrastructure and ongoing educational support outside of the traditional hospital setting, and to a lesser extent community setting (for example, general practice and community health centres). Participation by professionals in educating the next generation takes time and needs to be recognised and funded appropriately. This sentiment is echoed by the Australian Medical Students Association:

*Past experience has shown that you cannot simply turn the tap on or off when it comes to medical workforce. It takes a long time to train a medical practitioner and it is not possible to conjure up new resources such as supervisors, rooms, facilities, new operating theatres etc overnight. It takes time to put all of the supports in place to ensure that a medical practitioner gets the level of training and education that they need...Australia faces the real prospect of a training emergency ... The clock is clearly ticking and to that extent, above all else, our message to the Commission is that this issue needs to be tackled as a matter of urgency.<sup>43</sup>*

The only 'new' educational infrastructure that has been established in the last 10 years has been the Rural Clinical Schools (see Figure 14.4). Rural clinical schools have been successful in creating new educational opportunities that have begun to address the regional, rural and remote workforce gaps. Anecdotally, we were told that 75 per cent of rural students and 50 per cent of metropolitan students studying at Charles Sturt University in Dubbo remained in the area once they finished their training.<sup>44</sup>

We believe that this model of infrastructure and long-term educational support could be extended to urban and semi-urban environments, linked to universities and the vocational sector and across a broad range of professions.

**Figure 14.4: Rural Clinical Schools are encouraging more graduates to work in rural and remote centres**

*The Rural Clinical Schools program has been operating since 2000. They are designed to encourage medical students to take up a career in rural practice by enabling them to undertake extended clinical training placements in rural locations. The program is also designed to encourage professionals to take on rural academic positions – this is often undertaken with local health services.*

*There are now 14 Rural Clinical Schools across Australia, managed by 13 universities. These schools are required to provide 25 per cent of Australian Government supported medical students a minimum of one year of their clinical training in rural areas by the time they graduate.*

*The Rural Clinical Schools Program's annual placements increased from approximately 380 in the 2006 calendar year to 467 in 2007, reflecting the expansion of existing schools, and the three new schools that joined the program in 2006–07: the Australian National University, James Cook University and the University of Newcastle.*

Source: Department of Health and Ageing [www.health.gov.au](http://www.health.gov.au) and Department of Health and Ageing Annual Report 2007–2008

42 Health professional (18 June 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Brisbane.

43 Australian Medical Students Association (2008), Submission 503 to the National Health and Hospitals Reform Commission.

44 Health professional (3 June 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Dubbo.

### 14.3.4 Building and planning for a flexible workforce

By 2020, it is a fair assumption that technology advances will mean 'different models of care and new workforce practices will be required to accommodate the wider range of treatment possibilities'.<sup>45</sup> Already, in the last 10 years we have seen rapid advances in the treatment of heart disease with a shift in surgery from coronary artery bypass grafting to percutaneous coronary intervention with angioplasty. This has required significant change in work practice and skill mix. The changing burden of disease and an ageing workforce will also impact on the skill mix required.

Tied in with this concept is the need to make better use of our existing workforce to address workforce shortages (or uneven distribution) of health professionals, to improve access to health services and to continue to provide high quality health care.

Strategies to meet these concerns included extending the role of existing professionals (for example, reporting on X-rays might be undertaken by a medical imaging technologist) and creating new types of health workers (for example, physician assistants, hospitalists). The Queensland Government is undertaking a 12-month pilot program to employ physician assistants as one way to 'help us improve health care delivery in the face of a worldwide shortage of doctors'.<sup>46</sup> Using information technology more effectively to improve efficiency and placing more emphasis on prevention and health promotion<sup>47</sup>, as well as extending national registration<sup>48,49</sup> have also been suggested.

The national consultations and submissions also suggested planning for a multi-skilled team-based workforce<sup>50</sup> with an emphasis on matching skills to patient needs and the complexity of health care required. Submissions provided the following comments:

*... we've got lots of turf wars and what we would like to see is a focus on what the actual patient needs or client needs are, the community needs along different care pathways or from wellness through sickness and from being able to die well. And then what are those care needs and then let's design the health workforce around that instead of turf. So we could have a lot of new roles such as paramedic practitioners in the community. It's ridiculous that a paramedic practitioner, a paramedic in the community, can't catheterise a patient and they bring him into hospital for that.<sup>51</sup>*

*A controlled trial in Victoria has demonstrated that experienced, well qualified physiotherapists can competently and safely undertake screening of patients referred to public hospital orthopaedic outpatient clinics with non-urgent musculoskeletal pain. In that study nearly two-thirds of patients with non-urgent musculoskeletal conditions referred by their GPs to one public outpatient orthopaedic department did not need to see a surgeon at the time of referral, and were appropriately assessed and managed by experienced, qualified physiotherapists.<sup>52</sup>*

There was recognition that in some regions, health professionals need to be better skilled or supported to treat a wider range of conditions, particularly in the absence of a general practitioner. Suggestions<sup>53</sup> included enhancing the use of nurse practitioners, training and up-skilling Aboriginal

■ In some regions, health professionals need to be better skilled or supported to treat a wider range of conditions

45 Productivity Commission (2005), Australia's Health Workforce, Research Report, Canberra.

46 Minister for Health, The Honourable Stephen Robertson, Media Release, Physician's Assistant Trial Sites Announced, Saturday 16 August 2008.

47 Australian Health Workforce Institute (2008), Submission 37 to the National Health and Hospitals Reform Commission.

48 Australian Nurse Practitioners Association (2008), Submission 14 to the National Health and Hospitals Reform Commission. College of Nursing (2008), Submission 66 to the National Health and Hospitals Reform Commission.

49 Royal College of Pathologists of Australasia, Pathology Associations Committee (2008), Submission 161 to the National Health and Hospitals Reform Commission.

50 Health professionals (June 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Sydney, Darwin, Perth and Canberra.

51 Health professional (28 May 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Hobart.

52 Australian Physiotherapy Association (2008), Submission 41 to the National Health and Hospitals Reform Commission.

53 Health professionals (June 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Brisbane, Dubbo, Sydney, Cairns, Shepparton, Geraldton and Canberra.

health workers, using paramedics to suture or unblock catheters, using dental hygienists to clean teeth to free up dentists to do complex treatment and procedures, and using nurses to triage patients. One submission suggested that:

*The expanded use of non-medical health professionals, such as nursing assistants, paramedics and allied health practitioners, in remote locations may enable the delivery of a wider range of low-risk health services. Such non-medical care providers may be able to improve access to a limited range of interventions based on standardised practice guidelines and protocols, including minor illness and injury care, patient education and chronic condition monitoring.*<sup>54</sup>

There are enormous possibilities.

It is important that we have a structure that will facilitate the building of a workforce that will be flexible to meet changing workforce practices and workforce shortages. A suitable framework would allow for skills development and up-skilling in the shortest possible timeframe without compromising safety and quality but ensuring a workforce competent to meet the needs of all Australians including Aboriginal and Torres Strait Islander people, people with intellectual disabilities and people from non-English speaking backgrounds. At the same time, we need a workforce planning model that, in addition to identifying areas of workforce shortage, incorporates identification of pipeline technologies that will impact on future skill mix.

Equally important is the need to manage these functions. Catholic Health Australia proposes the establishment of a National Health Workforce Commission to plan and manage the range of health workforce issues including planning, regulation, training, accreditation and registration, as well as reviewing the roles and boundaries of current professional occupations with a view to increasing flexibility and expanding the scope of practice to better reflect the skills and competencies of those professionals.<sup>55</sup>

### 14.3.5 Increasing the number of Aboriginal and Torres Strait Islander peoples in the health workforce

Aboriginal and Torres Strait Islander people are under-represented in the health professions

Aboriginal and Torres Strait Islander people are under-represented in the health professions. While 2.3 per cent of the Australian population is Aboriginal or Torres Strait Islander, only 1.6 per cent of the national health workforce is made up of Aboriginal and Torres Strait Islander people.<sup>56</sup> The under-representation is magnified when you consider that Aboriginal and Torres Strait Islander people account for 95.5 per cent of Aboriginal health workers, but they only represent 0.2 per cent or less of all other health professions.<sup>57</sup>

In 2001, there were 90 Aboriginal and Torres Strait Islander medical practitioners (see Figure 14.5). This is 90 per cent (928) less than the 1,018 that would be representative of the Aboriginal and Torres Strait Islander population. In 2001, there were fewer than 800 Aboriginal or Torres Strait Islander nurses, more than 2500 short of the pro rata expectation (see Figure 14.5).

54 Defence Health Services Division (2008), Submission 76 to the National Health and Hospitals Reform Commission.

55 Catholic Health Australia (2008), Submission 57 to the National Health and Hospitals Reform Commission.

56 Pathways into the health workforce for Aboriginal and Torres Strait Islander people: A blueprint for action (Commonwealth of Australia 2008).

57 Pathways into the health workforce for Aboriginal and Torres Strait Islander people: A blueprint for action (Commonwealth of Australia 2008).

Figure 14.5: We need to train more Aboriginal and Torres Strait Islander health professionals

Health occupation	Number in 2001	Pro rata	Gap
GP/medical specialist	90	1018	928
Medical imaging	14	163	149
Dentist	13	174	16
Registered nurse	789	3359	2570
Retail pharmacist	10	285	275
Occupational therapist	7	126	11
Optometrist	5	64	59
Physiotherapist	29	242	213

Source: A report by Access Economics for the Australian Medical Association, 2004, 'Indigenous Health Workforce Needs'

It is important to 'maximise Aboriginal and Torres Strait Islander participation in the health workforce'<sup>58</sup> including as doctors, nurses, dentists and specialists to improve health outcomes of and reduce the life expectancy gap for Aboriginal and Torres Strait Islander peoples.<sup>59</sup>

Aboriginal health workers are highly valued for the work that they do.

*Aboriginal health workers are so important because a blackfella will go to a blackfella when they won't go to a whitefella.<sup>60</sup>*

We were told that barriers to the education and training of an Aboriginal and Torres Strait Islander health workforce were: lack of role models; having to leave families and communities to undertake training; the lack of recognition of prior learning; the lack of support both financial and academic; and undefined pathways to higher education. Participants in the national consultations emphasised:

*We need to investigate why Indigenous people are not getting involved in the health workforce. There is currently a culture where Indigenous people are not motivated to consider a career in health or feel that 'they can ('t?) do it.' All Indigenous young people hear are the disaster stories – you'll be sicker, you have a lower life expectation.' These messages directly impact on their aspirations for life and the future.<sup>61</sup>*

*When Indigenous children are asked what they want to do, it is hardly ever a health career. The only time Indigenous children think about entering a health profession is when they have role models, such as a family member, working in the health field. If they do not have role models, children are not properly informed of career choices and are less likely to think of working in the health sector.<sup>62</sup>*

58 Pathways into the health workforce for Aboriginal and Torres Strait Islander people: A blueprint for action (Commonwealth of Australia 2008).

59 Australian Indigenous Doctors' Association (2008), Submission 467 to the National Health and Hospitals Reform Commission.

60 Health professional (8 July 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Geraldton.

61 Participant (26 June 2008), National Health and Hospitals Reform Commission special interest forum on Indigenous health in Melbourne.

62 Participant (26 June 2008), National Health and Hospitals Reform Commission special interest forum on Indigenous health in Melbourne.

The Australian Health Workforce Institute informed us that most Aboriginal and Torres Strait Islander students study health-related courses at James Cook University, the University of Newcastle, the University of Western Australia and UNSW because these universities have committed resources to programs that include outreach into high schools, bridging programs and dedicated student support. They also argued that there is a need to ensure that the responsibility for educating Indigenous doctors is spread more evenly and not left to a small number of medical schools.<sup>63</sup>

The recently released report, *A Blueprint for Action: Pathways into the health workforce for Aboriginal and Torres Strait Islander people*, also identified the need to improve the education outcomes of Aboriginal and Torres Strait Islander students in primary as well as secondary schools. This report provides a well argued comprehensive set of recommendations to redress the shortages of Aboriginal and Torres Strait Islander people in the health professions. We believe that this report and its recommendations could be used to guide planning for future Aboriginal and Torres Strait Islander workforce needs.

### 14.3.6 Building a health workforce for Aboriginal and Torres Strait Islander people

As outlined in Chapter 8, there are several barriers to Aboriginal and Torres Strait Islander people accessing health care including inadequate training for health professionals to deal with cross-cultural issues, complex multiple morbidities and issues specific to Aboriginal and Torres Strait Islander health. The Australian Indigenous Doctors Association emphasised that

*Australia must strive for a medical system which will equip all graduates with the necessary knowledge, skills, attributes and cultural understanding to competently practice in Australia.*<sup>64</sup>

This is also the intent of the Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework which was endorsed by the Australian Health Ministers Advisory Council in 2002.

People across Australia emphasised the importance of cultural sensitivity and respect in gaining the confidence of Aboriginal and Torres Strait Islander people to access health services. We heard that:

*Aboriginal and Torres Strait Islander people are more likely to access, and will experience better health outcomes from, services that are respectful and culturally safe places for Aboriginal and Torres Strait Islander people.*<sup>65</sup>

All people need to receive high quality clinical care that respects their cultural backgrounds

■ The need for clinical and cultural competence is not restricted to Aboriginal and Torres Strait Islander people. All people need to receive high quality clinical care that respects their cultural backgrounds.

Our reform directions proposed in Chapter 8 (including the proposed National Aboriginal and Torres Strait Islander Health Authority and strengthened accreditation processes) will contribute to building a clinically and culturally competent workforce, as will increasing the number of Aboriginal and Torres Strait Islander people across the health professions.

63 Australian Health Workforce Institute (2008), Submission 37 to the National Health and Hospitals Reform Commission.

64 Australian Indigenous Doctors' Association (2008), Submission 467 to the National Health and Hospitals Reform Commission.

65 Australian Indigenous Doctors' Association (2008), Submission 467 to the National Health and Hospitals Reform Commission.

## 14.4 Creating a better future

Our reform directions are aimed at providing the building blocks to enable the current and existing workforce to be more productive and efficient and to ensure patient safety and quality of services are not compromised.

We want the workforce of the future to be a dynamic team, comprising individuals who are highly qualified, adaptable and technically competent. Strong leadership will make sure that the right care is provided at the right time, in the right place by the right person. These teams will be shaped by the need to work 'smarter', advances in technology, and community expectations, and will be facilitated by a multidisciplinary, rather than a solitary, approach to care.

Our first reform direction relates to our current workforce. We believe that the Australian health system has an outstanding group of health professionals who are under stress and need to be supported.

### Reform direction 14.1

We propose supporting our health workforce by:

- improving workplace culture, management and leadership skills at all levels of the system. We would welcome feedback on proven mechanisms to achieve this.
- implementing models that formally involve all health professionals in guiding the future directions of health reform and place value on their ongoing commitment to delivering care (e.g. Clinical Senates and Taskforces).

We believe that supporting people in the workplace will maintain and increase participation rates. This is an important step in making sure we keep and attract as many people as possible to the health professions and workplaces. Keeping good, experienced staff in the system is more efficient than relying on a production line of new, junior staff. We need to show our current staff they are valued, particularly through strengthening morale and improving culture. This will require good leadership throughout the system and listening to and valuing the opinions of staff.

■ Keeping good, experienced staff in the system is more efficient than relying on a production line of new, junior staff

We would welcome feedback on mechanisms to improve workforce culture, management and leadership.

Clinical Senates currently operate in Western Australia<sup>66</sup> and South Australia and are used as a forum for clinical leaders to share their 'knowledge, provide advice, leadership and guidance on clinical issues and participate in the decision making process in relation to clinical service planning'.<sup>67</sup> In South Australia, the Clinical Senate has been instrumental in informing the developments around the new model of clinical care for the newly planned tertiary hospital, the creation of state-wide clinical networks, the establishment of new clinical research fellowships and innovations in workforce models (e.g. physician assistants) and education. A Clinical Senate is also to be established in Queensland.

Some states have used other processes to involve clinicians in health planning. In 2000, NSW Health established a Clinical Council, supported by a series of Clinical Implementation Groups, to involve clinicians more actively in setting and monitoring clinical policy. Clinicians were strongly involved in implementing the Government Action Plan, arising from the 2000 Menadue report. The model used by NSW was to establish specialty or service-specific working groups, co-chaired by a leading clinician and a senior bureaucrat, to review the strategic directions for particular services. This evolved subsequently into the Greater Metropolitan Clinical Taskforce.<sup>68</sup>

66 See, for example, information on the Western Australian Clinical Senate, at: <http://www.clinicalsenate.health.wa.gov.au/home/>

67 [www.health.sa.gov.au](http://www.health.sa.gov.au)

68 Information on the Greater Metropolitan Clinical Taskforce is at: <http://www.health.nsw.gov.au/gmct/index.asp>

Our second reform direction addresses issues of productivity and improves access to health care in geographic locations that do not always have access to a doctor. We believe it is important to ensure equity of access across the country, and that in the absence of a doctor we need to maximise the use of health professionals to the level of their competency.

The proposed strategies recognise that nurses are relatively evenly distributed across Australia but other professions are not. We need to use the nurses in areas of workforce shortage to the maximum level of their competence, and to enhance the productivity of the other professions who are practicing in areas of workforce shortage.

#### Reform direction 14.2

We propose facilitating access to care where doctors are scarce. Commencing in remote and some rural areas:

- Medicare rebates should apply to some diagnostic services and specialist medical services ordered or referred by nurse practitioners and other registered health professionals according to defined scopes of practice determined by health professional registration bodies.
- Pharmaceutical Benefits Scheme subsidies (or, where more appropriate, support for access to subsidised pharmaceuticals under section 100 of the National Health Act 1953) should apply to pharmaceuticals prescribed from approved formularies by nurse practitioners and other registered health professionals according to defined scopes of practice.
- Where there is appropriate evidence, specified procedural items on the Medicare Benefits Schedule should be able to be billed by a medical practitioner for work performed by a competent health professional, credentialed for defined scopes of practice.

Third, we believe a new education framework will facilitate the development of high functioning, multidisciplinary teams to make more efficient use of the health workforce. There are several inter-related components to this framework, including dedicated funding for clinical placements and establishing a new training infrastructure. It is crucial that the health system needs to revalue and support the education of our future health workforce and we are concerned that with the ever increasing service needs, education will be ignored. This funding should follow the students.

#### Reform direction 14.3

We endorse a new education framework for all education and training of health professionals including:

- adopting a competency-based framework;
- moving towards a flexible, multi-disciplinary approach to the education and training of all health professionals;
- establishing a dedicated funding stream for clinical placements for undergraduate and postgraduate students; and
- ensuring clinical training infrastructure across all settings (public and private, hospitals, primary health care and other community settings).

We believe a competency-based framework will enhance the effective use of all professional groups and individuals in ways that maximise the use of skills without compromising patient safety and quality of services. Competencies are what a person needs to do, and to know, to carry out a particular job role or function. For example, competency-based training for wound care is designed to suit the nurse or health care worker who is caring for those at risk of developing wounds or currently have a wound that is slow to heal and includes topics such as tissue identification, different wound care products and bandaging.

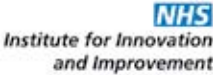
We expect that a competency framework would allow for a wide variety of entry points into health care careers, recognise prior learning and would foster more flexible, multidisciplinary training across all undergraduate programs.

The idea of a competency framework is not new. In Australia, the National Health Workforce Taskforce’s work program includes examining the feasibility of a core competency framework for all health professions, as well as the development of core competencies for acute and aged care, and maternity services. Further, the Community Services and Health Industry Skills Council are well advanced in the development and implementation of core competency-based modules for health care workers’ education in the vocational education and training sector. Internationally, the United Kingdom has implemented workforce reforms underpinned by a competency framework, commonly referred to as the ‘Skills Escalator’ (see Figure 14.6).

**Figure 14.6: The United Kingdom Skills Escalator**

The Skills Escalator is a nine-level career framework introduced by the National Health Service in Britain. It provides multiple entry points into health care careers and staff are encouraged through a strategy of lifelong learning to constantly renew and extend their skills and knowledge, enabling them to move up the escalator. Staff may wish to develop their skills at a particular level of responsibility. Others may choose to develop the skills necessary for the next level of responsibility.

**A Career Framework for the NHS**



More Senior Staff	9
Consultant Practitioners	8
Advanced Practitioners	7
Senior Practitioners/Specialist Practitioners	6
Practitioners	5
Assistant Practitioners/Associate Practitioners	4
Senior Healthcare Assistants/Technicians	3
Support Workers	2
Initial Entry Level Jobs	1

Source: Presentation by B Crump, NHS Institute for Innovation and ‘Introduction to the Skills Escalator’. At: [www.dh.gov.uk](http://www.dh.gov.uk)

Clinical training for health professionals should be embedded in all undergraduate and postgraduate courses, and be provided in both public and private hospital and community settings to foster quality educational experiences and bridge the current siloed model of training.

Our fourth reform direction brings together the component parts necessary to build and plan for a flexible workforce.

#### Reform direction 14.4

We propose the establishment of a National Clinical Education and Training Agency:

- to advise on the adequacy of projected provision of health professional education in the university and vocational education sectors within each major region;
- to purchase in partnership with universities, vocational education and training, and colleges, clinical education placements from health service providers, including payments for undergraduates' clinical education and postgraduate training;
- to promote innovation in education and training of the health workforce;
- as an aggregator and facilitator for the provision of modular competency-based programs to up-skill health professionals (medical, nursing, allied health and aboriginal health workers) in regional, rural and remote Australia to perform tasks and address health needs met by other health professionals in major metropolitan areas; and
- to report every three years on the appropriateness of accreditation standards in each profession in terms of innovation around meeting the emerging health care needs of the community.

The establishment of a National Clinical Education and Training Agency would improve accountability and transparency of the education and training of health professionals. A key role of this agency would be national workforce planning to identify future skill needs to assist in the allocation of education and training funding. We expect that this work would include the consideration of potential labour-saving technologies (for example, digital/computer radiology) on skill mix, and therefore planning. This function could be outsourced to the Australia and New Zealand Horizon Scanning Network.

Another key role of this agency is to identify and facilitate the up-skilling of health professionals in areas of workforce shortage to ensure that Australians living outside major cities have their health needs met. Efficiencies can be gained if a national approach is taken.

This agency would also be responsible for identifying gaps in specialist medical training. Available data<sup>69</sup> suggests that for some specialities it is difficult to obtain a clinical placement. In 2007, there were 56 applicants for a first-year basic training placement in dermatology but only 30 per cent (17) were successful in achieving a place. Also in 2007, there were 189 applicants for a first-year advance training placement in obstetrics and gynaecology but only 32 per cent (61) were successful in achieving a place.

We expect this agency would have mechanisms to involve representatives from the state, territory and Commonwealth departments responsible for health and education, the university and vocational education and training sector, the private health sector, and other appropriate professional organisations.

We note the National Health Workforce Taskforce is doing work in this area, but there is a need to formalise, continue and expand its work.

Our fifth reform direction builds on the current Council of Australian Governments (COAG) work on national registration for health professionals. We were consistently told during our consultations that the fact that each health professional in moving across state boundaries had to reapply for registration was inefficient and illogical. This impediment would be removed by national registration. We believe that national registration will allow for improved workforce planning which at the moment is disjointed and uncoordinated.

69 Medical Training Review Panel, Eleventh Report, December 2007 (Commonwealth of Australia 2008).

#### Reform direction 14.5

We support national registration to benefit the delivery of health care across Australia.

Next, we believe that a comprehensive national strategy to recruit, retain and train Aboriginal and Torres Strait Islander health professions is needed. This reform direction is consistent with the strategic directions outlined in *A Blueprint for Action*.

#### Reform direction 14.6

We propose implementing a comprehensive national strategy to recruit, retain and train Aboriginal and Torres Strait Islander health professionals at the undergraduate and postgraduate level including:

- setting targets for all education providers, with reward payments for achieving health professional graduations;
- funding better support for Aboriginal and Torres Strait Islander health students commencing in secondary education; and
- strengthening accrediting organisations' criteria around cultural safety.

As outlined in Chapter 9, building a quality workforce in rural and remote Australia is a complex challenge and requires sophisticated strategies of recruitment and support from undergraduate through to specialist training and continuing professional development across all disciplines, including medicine, oral health, nursing and other allied health groups. In addition to the reform directions mentioned above, we believe there is a need to train people locally so they either stay or return.

#### Reform direction 14.7

We propose that a higher proportion of new health professional educational undergraduate and postgraduate places across all disciplines be allocated to remote and rural regional centres, where possible in a multidisciplinary facility built on models such as clinical schools or university departments of Rural Health.