Catholic Health Australia

Proposal for a National Health Workforce Commission

Policy Proposal: January 2009

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About Catholic Health Australia

Twenty-one public hospitals, 54 private hospitals, and 550 aged care services are operated by different bodies of the Catholic Church within Australia. These health and aged care services are operated in fulfilment of the mission of the Church to provide care and healing to those who seek it. Catholic Health Australia is the peak member organisation of these health and aged care services. Further detail on Catholic Health Australia can be obtained at www.cha.org.au.

Introduction: Action needed to overcome a health workforce crisis

Australia faces a complex health workforce problem, which is set to significantly worsen over the coming decades.

The most recent data available indicates shortages of between 800 and 1300 general practitioners; and from 10,000 to 13,000 nurses. There are also shortages of many medical specialists – particularly in regional locations in disciplines including psychiatry, obstetrics, pathology and radiology – dentists and allied health professionals – especially in physiotherapy, occupational therapy, speech pathology and podiatry.

Interestingly and perhaps alarmingly, the recent Garling report in New South Wales identified that around 25% of nurses in that state would reach retirement age in the next three years.

The ageing of the population will increase demand for (and change the mix of) of health services at the very time that many current health workers will also be retiring and the pool of new entrants to the workforce will be shrinking. Australia's problems will be exacerbated by a deepening shortage of health professionals worldwide.

Current responses

The response by governments across all jurisdictions and political persuasions to this issue has to date fallen well short of what is required. Too often their responses have been uncoordinated, inconsistent and designed to protect individual jurisdictional interests regardless of the impact on the wider health system. Responses have included: seeking to immediately import ready-made professionals from other countries; rapidly increasing undergraduate medical school places; imposing restrictions on practise in certain geographic areas; and introducing inadequate re-entry incentives (such as the current Bringing Nurses Back to the Workforce scheme).

Whilst some of the above responses may offer small contributions to addressing the workforce issue, they have generally failed to incorporate a long-term, national approach that comprehends changes in the demographic profile of the Australian population, including the associated changes in prevalence of disease types and the resultant impact on demand for health services. They also fail to address the ethical concerns of a developed country such as Australia importing badly needed health professionals from developing countries.

Long-term changes in patterns of practice by health professionals including reduced hours of work and increasing reluctance to practise in regional areas have not been well understood or taken into account in modelling. Policy responses to health workforce needs also have not taken into account the impact on and needs of related sectors including aged care and community care.

Importantly, the impact of the introduction of new technologies on demand for services and patterns of service provision have largely been ignored; as have the opportunities available through ensuring skilled health professionals are able to fully utilise their skills and competencies (where safe to do so) without running up against narrow, traditional job boundaries.

Proposed solution

CHA proposes the establishment of a National Health Workforce Commission that will take a long-term and system-wide approach to health workforce planning.

To end the fragmentation of current planning, the commission will need to bring together governments at all levels (and at the Commonwealth level it needs to include the health, education, employment and immigration portfolios as well as the appropriate central agencies), the non-government sector (including hospitals and the aged and community care sectors), the professions and consumers.

To ensure it is effective, the commission will need to have responsibility for resource

allocation (for at least the current budgetary allocation by the Commonwealth for training of health professionals). It will also need to have a research and policy development role, underpinned by rigorous data collection, to enable it to drive more effective use of technology and role redesign. Regular, detailed annual reporting to the Australian public and parliaments of the status of the Australian health workforce will also need to be a key feature of the Commission's work.

CHA welcomes the initiatives announced by COAG in December 2008 to establish a national workforce agency and data registry as a positive move in the right direction. We look forward to working with governments to ensure the agency has the resources and robust terms of reference needed to make a meaningful difference.

Part 1: The Problem of the health workforce

The most recent data available (AMWAC 2002) indicates shortages of between 800 and 1300 general practitioners and a continuing annual shortfall of around 700 new practitioners who are needed to maintain the GP workforce into the future; and between 10,000 to 13,000 nurses. There are also shortages of many medical specialists – particularly in regional locations - in disciplines including psychiatry, obstetrics, pathology and radiology; dentists; and allied health professionals, especially in physiotherapy, occupational therapy, speech pathology and podiatry.

A number of factors are now converging that will serve to intensify the problem. These include:

- Ageing of the population – which will increase the demand for health services,
- Ageing of the health workforce – which will decrease the availability of health service providers at the very time that demand is rising,
- Population ageing in other developed countries (US, Canada, Europe) – which will intensify international demand for qualified health professionals, and
- Rapid economic development in developing countries such as China and India will also increase demand for qualified health professionals in those countries and will likely reduce the supply of health professionals willing to migrate to Australia to practise.

In the very short term, the change of Administration in the US may also lead to the implementation of policies aimed at providing health cover to the 40 million currently uninsured Americans - which again could place strong demand on the existing health workforces within a range of developed and developing countries including Australia.

Medical workforce

In the context of an overall shortfall of practitioners, there are particular shortages in areas of lower socio-economic status (such as outer suburban locations) and areas of low perceived amenity (remote inland locations). The gaps in these areas are at least in part, filled by overseas trained medical graduates, who are often poorly supported by the mainstream health system; many are dumped in remote communities with minimal cultural orientation and professional supervision. Catholic Health Australia questions the ethical approach of maintaining a policy that is based on attracting scarce health professionals from developing countries where access to health professionals is far more limited than in Australia.

A key issue is the extent to which the profile of the medical profession continues to match the emerging demand for health services. As the population ages, there will be increasing demand for those practitioners able to manage the complex, chronic conditions of the elderly and to manage end of life issues. Demand for entry to vocational training programs remains skewed towards the better remunerated procedural specialties rather than the more generalist disciplines – suggesting that the future profile of the medical profession will struggle to effectively manage the ageing population.

Nursing workforce

Along with the current shortage of between 10,000 to 13,000 nurses, a particularly concerning feature is the ageing of the nursing workforce.

The proportion of employed nurses aged 55 and over has increased from 9% in 1997 to 19% in 2005.

Whilst the ratio of FTE nurses to the general population has been maintained over the period from 1997 (1,054 FTE to 100,000 population) to 2005 (1,133 FTE per 100,000), this has been achieved partially by an increase in average working hours from

31 to 33 hours per week. Given the rapidly ageing profile of the workforce, this trend is unlikely to continue.

Unlike the medical workforce, the nursing workforce is more evenly distributed across the general population, including in regional areas. This underscores the critically important role that nurses play in providing access to health services – especially in regional and outer-metropolitan areas.

Allied health workforce

Data is more patchy in relation to the balance between supply and demand for allied health practitioners. Nevertheless, State and Territory Government employers report shortages in the occupational areas of: medical imaging, dentistry, physiotherapy, occupational therapy, speech pathology, pharmacy and podiatry.

Part 2: Current Government Policies

Australia's health workforce planning and management is multifaceted – extending across a range of professions (medical, nursing, allied health), specialties and sub-specialties, geographic regions, the public and private sectors (including multiple government departments and agencies at both the Commonwealth and State levels).

It is perhaps because of the sheer complexity of the issues underpinning workforce supply and future demand – and the inherent multi-jurisdictional responsibilities – that governments have shied away from comprehensively addressing this subject area other than to put in place short-term fixes for problems that cannot be ignored until later or preferably blamed on another level of government.

Our understanding of the dynamics of workforce supply have not been well developed. In particular, the impact of the increased feminisation of the medical workforce and the generational change in attitudes to work-life balance (by both males and females) on the reduction of working hours and an increased desire to reside in areas of higher residential amenity was grossly underestimated.

This led to a dramatic change in the approach of the Federal Government to the funding of medical undergraduate places. During the 1990s, there was understood to be a surplus of medical practitioners, with a mal-distribution which resulted in an undersupply in regional areas and oversupply in metropolitan areas.

This led to a restriction in medical undergraduate places together with a suite of initiatives designed to provide incentives to practice in regional areas. By the early 2000s, it was becoming increasingly clear that rather than an over-supply, there was actually a worsening shortage. This was supported by an AMA-commissioned study of supply and demand in the GP workforce (released in February 2002).

Some of the more specific initiatives introduced by the Commonwealth to address shortages in regional areas have included:

- The establishment of Rural Workforce Agencies (RWAs) in 1998 to provide incentives and support for rural practice (including the better measurement of services not funded under Medicare),
- Bonded medical places for those prepared to practice in areas of need and un-bonded scholarships for students of rural origin,
- Granting provider numbers to overseas-trained doctors to work in areas of need and assistance with recruitment of overseas-trained doctors to regional areas,
- Funding of regional medical schools, which have included affirmative action programs that preferentially given places to students from rural backgrounds,
- Funding for university departments of rural health,
- Provision of incentive payments for GPs working in areas of need,
- Funding for practice nurses and other health professionals such as indigenous health workers and physiotherapists, and
- a range of initiatives to encourage and support specialists in providing services to regional areas.

The 2006 COAG package agreed to a number of initiatives aimed at streamlining movement of health professionals across jurisdictions, including the introduction of national registration and accreditation. Support was also provided for a limited number of medical training places in settings outside the traditional pubic teaching hospitals, as well as for the establishment of the National Health Workforce Taskforce.

The 2008 COAG package included support for additional GP training places, additional resources for clinical training for jurisdictions, additional places in extended

settings such as private hospitals and private doctors rooms, establishment of a National Health Workforce Agency and data registry.

In addition to the above initiatives, the number of medical graduates is set to double to 3,000 by 2012. Whilst this increase is strongly welcomed its implementation is reflective of the dysfunction that characterises health workforce planning in Australia.

Whilst the Commonwealth has responsibility for funding undergraduate places, vocational training is overseen by the specialist medical colleges in clinical places mostly funded by States and Territories – with some limited private sector involvement (some of which has been recently funded by the Commonwealth). Ensuring appropriate clinical placements and supervision for such a rapid increase in the numbers of medical graduates is going to be a major challenge for our health system – referred to colloquially as a looming "tsunami". At this stage it is not at all clear that the State/Territories are going to be sufficiently geared up to meet this challenge.

It is clear the private sector and the large non-profit Catholic hospitals in particular will need to (and will be able to) play a significant role in providing some of the additional clinical training places. In the meantime a number of Catholic hospitals have been rather bemused by the almost oppositional approach played by some State/Territory health departments in the roll-out of the Extended Specialist Training Program – especially given the huge increase in clinical training places that will be required of all sectors in the coming years.

Whilst the announcement from the recent COAG meeting in December 2008 is welcome, there is very little detail available. At this stage, it is not clear that current approaches have yet to fully comprehend changes in:

- Current and future population demographics and changing patterns of illness,
- Changes in technology, and
- The potential for re-design of roles to make better use of the skill of all health professionals, particularly the unnecessarily controversial resistance to enabling appropriately skilled nurses to take on some responsibilities currently performed by doctors.

Part 3: Proposed solution of a National Health Workforce Commission

In developing a solution to the workforce crisis, it is important that the structural problems of fragmentation and short termism are addressed. This means that the responsibility for workplace planning should fall to a single, national agency and this agency should be sufficiently independent of the political process to enable it to operate with a long-term timeframe. It is also important that this agency is not merely a recommendation-making entity that can routinely be ignored, but is one that actually has responsibility for making funding allocations, and being accountable to parliaments and the public for these decisions.

CHA therefore proposes the establishment by the Commonwealth of a National Health Workforce Commission (the Commission).

Terms of Reference

The Commission would be responsible for:

- ensuring Australia has an adequate supply of appropriately trained health workers to meet the long-term health and aged care needs of Australia's population,
- establishing and maintaining detailed data collections in relation to workforce planning for each health occupation group (working closely with the AIHW to complement its existing collections),
- research, policy development, planning, modelling, coordination and oversight of workforce planning and training arrangements,
- managing Commonwealth funding of all health and aged care related workforce training activities, including funding directed through the university and VET sectors,
- advising on immigration requirements for overseas trained clinicians;
- determining national criteria for designating geographic areas of workforce shortage and developing and managing appropriate incentives to overcome need and ensuring consistency of criteria,
- administering the national registration arrangements of the health professions, and
- providing annual "State of the Health Workforce Reports."

In undertaking the above functions the Commission will have particular regard to those groups that currently experience difficulty of access to health care - namely indigenous Australians, those living in rural, regional and outer metropolitan areas, those suffering from a mental health condition and those from lower socio-economic backgrounds.

Governance

There are several potential models for the governance arrangements for the Commission, which variously attempt to take account of the potentially conflicting principles of administrative clarity and simplicity on the one hand, whilst recognising the existing dispersed responsibilities for workforce planning and development in the Australian federation on the other hand.

CHA's preference is that the Commission is established as a joint statutory entity underpinned by legislation and funding from each jurisdiction and the Commonwealth. Its Board would comprise representatives from each of these governments together with representation from the non-government sector – hospitals, aged and community care services, and professional and representative bodies and unions. The Commission would be required to report to each parliament.

In terms of Commonwealth representation and sponsorship, it is essential that both the health and education portfolios are represented within the Commission governance arrangements. Additionally the immigration portfolio plays a significant role which needs to be taken into account. The substantial funding resources required also

suggest the additional involvement of appropriate central agencies.

There is currently much good work being carried on by agencies in particular jurisdictions, for example the rural workforce agencies. These agencies often have detailed specialist knowledge of specific areas of workforce demand and supply, and their knowledge needs to be available to inform the work of a national agency. The structure of a new national Commission needs to be able to incorporate the work of these specialist bodies.

Structure and Responsibilities

CHA proposes that the Commission would have the structure and responsibilities outlined below.

A key output would be the publication of an annual "state of the health workforce" report which would set out a snapshot of data on the current workforce by occupation/specialty, geographic location, and practice setting, and identify current maldistribution (shortages and/or surpluses) issues. The report would also set out its modelling of future requirements for at least the next two decades, matched with existing training capacity and identified areas of shortage. Additionally the report would set out the work program for the coming year including micro level examinations of particular occupations/specialties.

Data Collection

Proposed responsibilities for the Commission in relation to data collection include:

a) To ensure up to date information on current workforce (ie. medical, nursing, allied and VET sectors) in each grouping by:

- specialty/sub specialty,
- geographic location,
- practice setting (hospital, community etc),
- age,
- gender,
- hours worked, and
- work force entry point (ie. Australian trained [institution], overseas trained, returning to workforce, etc).

b) To establish and maintain a data set in relation to future entrants to workforce (ie.data in relation to numbers currently enrolled in training programs as well as those pending through the immigration program).

c) To establish and maintain a data set in relation to exits from the workforce according to the demographic breakdown above through:

- retirements,
- deaths,
- leaving for family reasons,
- reduction in hours worked, and
- emigration.

The Commission would publish annual reports of all the data collected.

Policy Development

Proposed responsibilities for the Commission in relation to policy development include:

a) To examine emerging trends and develop and make recommendations in relation to:

- demographic change in the general population including identifying future burdens of disease that will impact on the demand for health services (both the extent of demand and the types of services demanded),
- demographic change within the workforce (age, gender, hours worked etc) that will impact on the future supply of health workers,
- changes of labour markets in health and wider industry in Australia and overseas that will impact on the potential supply of health workers,
- technological changes that will impact on both demand for and supply of health services, and
- roles of occupational groups – including their potential for redesign - to work out how to best utilise their skills to ensure the health and aged care needs of the Australian population are met over the immediate and long terms.

b) Prepare reports and policy papers to inform public knowledge and debate on health and aged care workforce issues.

Modelling

Proposed responsibilities for the Commission in relation to modelling include:

- Developing and publishing models of demand and supply of health and aged care occupation groups over the short, medium and long term (30+ years) time frames,
- Making recommendations in relation to training and immigration levels for each occupational group to ensure that the short, medium and long term health and aged care needs of the population will be met, and
- Publishing detailed annual reports on the short, medium and long term supply and demand status of each occupational group/specialty.

Management and allocation of funds

Proposed responsibilities for the Commission in relation to the management and allocation of funds includes:

a) Allocating all Commonwealth funding in support of health and aged care workforce development, and seeking to create an environment in which all States and Territories also allocate their funding in accordance with national decisions. More specifically this will include Commonwealth allocation of funds to:

- training providers, universities, VET providers, Medical Colleges,
- private sector settings (private hospitals, specialist and GP medical practices, community health settings etc), and
- States/Territories in relation to their provision of training.

Conclusion

In a global environment where skilled health professionals are becoming increasingly scarce, the establishment of a National Health Workforce Commission along the lines proposed by CHA in this paper offers members of the Australian community the chance to ensure that they will continue to be able to access highly, skilled health professionals over the coming decades.

Failure to adopt this approach will inevitably see a further worsening of current shortages, increasing fragmentation of the delivery of services and even greater disparities in ability to access necessary services.