4

Funding a sustainable health workforce

> *If you are in metropolitan Sydney, or if you are in New South Wales, the further you are from the Harbour Bridge, the greater the impact of the shortage of trained doctors, nurses and allied health staff brought about by the restriction on places in universities and other colleges. The more it impacts on the workforce, this acts as a cap on the availability to provide services.*[1]

4.1 A skilled health workforce is critical to addressing the healthcare needs of the Australian community. Health funding arrangements need to give the right incentives for governments and health care providers to respond to the current demands for health services — as well as provide for a system that can train a health workforce that will meet the community's future health needs.

4.2 The committee's health funding inquiry overlapped with a significant review of Australia's health workforce conducted by Productivity Commission at the request of the Council of Australian Governments (COAG) during 2005.[2]

4.3 The COAG response to the Productivity Commission review included a number of significant structural changes such as medical professionals' registration and accreditation arrangements, workforce innovation and workforce planning.[3] Where relevant, the COAG response is discussed further in this chapter.

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1 Clout T, Hunter New England Health Services, transcript, 20 July 2006, p 5.

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

3 Council of Australian Governments, *Communique*, 14 July 2006.

4.4 A recurring theme in submissions and oral evidence to the inquiry was that current health funding arrangements do not allow the health system to deliver a workforce that is able to meet current demands or have a training system that will be able to meet future health needs.

4.5 Some of the areas where workforce shortages were raised with the committee included general practice,[4] nursing,[5] allied health professionals such as psychologists and podiatrists,[6] dentists[7] and pathologists.[8] Other health workforce professions where shortages have been identified include hospital and retail pharmacists, occupational therapists, physiotherapists, psychiatrists and sonographers.[9]

4.6 Part of the shortage of health workforce professionals is likely to be due to an underinvestment in the number of training places over the past 15–20 years. The committee considers, however, that health funding arrangements have also contributed to the current shortage in several ways including:

- a mal-distribution of health professionals across Australia, with shortages of GPs and most other health professionals in outer suburban areas, regional and rural areas;
- high levels of 'stress' in public hospital training environment that leaves less time for quality training. In an environment where staff are trying to respond to high demands on service, there is little time or energy to take on professional roles with students, or with other staff; and
- Visiting Medical Officers (VMOs) in public hospitals providing training for which some believe they are not adequately paid.

4.7 This chapter examines the current and future workforce needs of the Australian health system and how workforce training is structured and funded. Opportunities to address concerns about the number and quality of health professionals through changed funding and

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4 Australian Divisions of General Practice, sub 15, p 3; Australian Medical Association, sub 31, p 16; Rural Doctors Association, sub 31, p 16; Redcliffe-Bribie-Caboolture Division of General Practice, sub 81, p 5.

5 Australian Nursing Federation, sub 39, p 4.

6 Australian Healthcare Association, sub 62, p 5.

7 Australian Dental Association, sub 28, p 26.

8 Graves D, Royal Australian College of Pathologists, transcript, 5 July 2005, p 2.

9 Productivity Commission, *Australia's Health Workforce* (2005), p 337.

administration arrangements for health workforce training are also considered.

Australia's health workforce

4.8 The Australian health workforce consists of people employed in a wide range of occupations that provide health care, including doctors, nurses, dentists, pharmacists and allied health professions (such as physiotherapists, psychologists and podiatrists).

4.9 There were around 569,700 Australians employed in health occupations in 2005, accounting for around 5.7 per cent of the total workforce.[10] While the health workforce increased in absolute terms by almost 118,000 (26 per cent) since 2001, there were some occupations where the number of health practitioners per 100,000 declined, such as generalist medical practitioners and pharmacists (table 4.1).

4.10 People employed in health occupations are often assisted in the delivery of health services by volunteers and people employed in other professions, such as social workers and administrative staff. While they make a valuable contribution the health system, the remainder of the discussion on health workforce concentrates on people employed in health occupations.

10 Australian Institute of Health and Welfare, *Australia's health 2006* (2006), p 316.

Table 4.1 Persons employed in health occupations, 2000 and 2005

	2000		2005		
Occupation	**Number**	**Per 100'000 population**	**Number**	**Per 100'000 population**	**% growth 2000–2005**
Health services managers	4,200	21.8	8,600	42.5	107.5
Generalist medical practitioners	36,700	191.5	36,300	178.6	–1.0
Specialist medical practitioners	16,000	83.7	23,600	116.3	47.4
Medical imaging professionals	8,600	45	10,600	52.4	23.4
Dental practitioners	7,000	36.8	8,700	42.9	23.6
Dental associate professionals	4,300	22.5	5,700	28.1	32.5
Dental assistants	12,200	63.7	17,300	85.2	42.0
Nursing workers: professionals	181,100	945.6	204,700	1,006.9	13.0
Enrolled nurses	24,800	129.5	32,200	158.2	29.6
Personal care and nursing assistants	36,100	188.7	68,500	336.9	89.5
Pharmacists	15,300	80	14,900	73.3	–2.8
Physiotherapists	12,100	63.4	14,300	70.6	18.1
Psychologists	9,300	48.4	13,900	68.6	50.5
Occupational therapists	5,400	28.4	7,800	38.4	43.3
Podiatrists	1,400	7.1	2,100	10.2	52.9
Other allied health workers	14,800	77.1	14,000	69.0	–4.9
Complementary therapists	7,800	40.6	11,400	55.9	46.1
Other health workers	54,600	284.9	74,900	368.5	37.3
All health workers	**451,800**	**2,358.80**	**569,700**	**2,802.40**	**26.1**

Source *Australian Institute of Health and Welfare, Australia's health 2006 (2006), p 316.*

4.11 Changes in the numbers of hours worked and the distribution of medical professionals also affects community access to health services. There has been a general reduction in the average hours worked in most health occupations due to a range of factors including:

- higher income levels allow some health workers to reduce workloads;
- a recognition that the long work hours traditionally worked in some medical professions may contribute to lower quality health care;

- an increase in the proportion of female health workers, who are more likely to work part-time or reduced hours over their careers; and
- an ageing workforce that reduces hours worked as they approach retirement.[11]

4.12 International comparisons of the numbers of health professionals can be difficult because of differences in how each profession is defined and how workers are registered.[12] Compared to all OECD countries, Australia is in the top third of numbers of general practitioners per 100,000 population (see figure 2.5 in chapter 2).

4.13 In 2003, Australia had higher numbers of general practitioners and nurses per 100,000 population than several selected countries with economies and health systems similar to Australia (table 4.2).

Table 4.2 Health professionals employed in selected OECD countries, per 100,000 population, 1998 and 2003

Occupation/year	Australia	New Zealand	Canada	USA	United Kingdom
General Practitioners					
1998	1.3	0.8	1.0	0.8	0.6
2003	1.4	0.7	1.0	0.8 (a)	0.6
Medical specialists					
1998	1.1	0.7	1.1	1.4	1.3
2003	1.2	0.7	1.1	1.5 (a)	0.7
Dentists					
1998	0.5	0.4	0.5	0.5	0.4
2003	0.5	0.4	0.6	0.5 (a)	0.5
Nurses					
1998	10.6	9.6	10.2	7.9	7.9
2003	10.4	9.1	9.8	7.9 (a)	9.1

Note *(a) relate to 2002.*

Source *Australian Institute of Health and Welfare, Australia's health 2006 (2006), p 330.*

11 Australian Institute of Health and Welfare, *Australia's health 2006* (2006), p 322; Foster P, *Queensland Health Systems Review: Final Report* (2005), p 211; Wronski I, James Cook University, transcript, 16 March 2006, pp 21–22; O'Reilly B, Australian Dental Association, transcript, 5 July 2005, p 31.

12 Australian Institute of Health and Welfare, *Australia's health 2006* (2006), p 330.

Health workforce shortages

4.14 Many inquiry participants pointed out that a critical area of concern for the health system is workforce shortages.[13] The National Rural Health Alliance noted that:

> It is well known that there are currently national shortages in all parts of Australia's health workforce. Wherever there are shortages, the worst of them are in rural and remote areas.
>
> The Alliance has, over the years, emphasised not only the shortage of doctors in rural and remote areas (which is well known) but also the shortages of nurses, allied health professionals, dentists, pharmacists and managers — which are less well known and recognised.[14]

4.15 Australia is not unique in experiencing health workforce shortages, competing overseas to attract and retain skilled health professionals that are in short supply internationally.[15]

4.16 Health workforce shortages in Australia have developed over a long period. In response to a perceived oversupply in the medical workforce in the early to mid 1990s, a cap on the number of medical school places was announced by the Commonwealth in May 1995.[16] Under the cap, the number of new places in Australian medical schools was restricted to approximately 1,250 per year.[17]

4.17 The impact of workforce shortages, which initially were experienced in remote areas, has gradually spread to the suburbs of major cities. Professor Wronski noted that:

> The tide has gone out in the health and medical workforce in the last 25 years. In the seventies and the eighties, I remember talking about the lack of workforce supply in Indigenous

13 See for example, Australian Medical Association (Queensland), sub 104, p 6; Australian Healthcare Association, sub 62, p 5; Australian Divisions of General Practice, sub 15, p 2; Australian Nursing Federation, sub 39, p 3; Kidney Health Australia, sub 58, p 5.

14 National Rural Health Alliance, sub 59, p 4.

15 Bach S, 'International migration of health workers: Labour and social issues', International Labour Organisation working paper no. 209 (2003); Simoens S., M. Villeneuve and J. Hurst, 'Tacking nurse shortages in OECD countries', OECD Health working papers no. 19; Department of Health and Ageing, submission to the Productivity Commission Health Workforce Study (2005), pp 28–29.

16 Birrell B, 'Medical manpower: the continuing crisis', *People and Place* (1996), vol 4, no 3.

17 Department of Health and Ageing 2003, Submission to the Senate Select Committee on Medicare Inquiry into the access to and affordability of general practice under Medicare, p 9.

> communities. Then there was a lack of workforce supply in remote communities, a lack of workforce supply in rural and regional communities and now we have a lack of workforce supply in many of the metropolitan areas as well. It is just a feature of shortages spreading throughout the country.[18]

4.18 Not all inquiry participants agreed that there was necessarily a health workforce shortage. For some allied health professions or geographical areas, such as some areas of major capital cities, there appear to be sufficient numbers of health professionals.[19] Others noted that it was possible to changing models of care, which expanded the role of allied health professionals and other health workers would lead to the workforce being used more efficiently.[20] Mr Menadue noted that:

> We have a workforce structure which really has not been changed for the last 100 years. We have seen the very considerable public and social benefits of workforce restructuring in the blue-collar manufacturing area, but unfortunately the professions, particularly the health professions, have not really been touched by workforce restructuring. Demarcations and restrictive work practices abound. Professional people are trained in boxes and then they work in boxes. They are kept separate.[21]

4.19 Most Australian governments have recognised that there are workforce shortages in a number of medical professions and that there are also shortages in different regions. The National Health Workforce Framework, endorsed by Australian health ministers in 2004, includes a National Health Workforce Action Plan. The framework sets the vision that:

> 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

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18 Wronski I, James Cook University, transcript, 16 March 2006, p 17.

19 Stevenson C, Hospital Reform Group, transcript, 26 May 2006, p 3.

20 Needham K, Hospital Reform Group, transcript, 26 May 2006, p 4; Wronski I, James Cook University, transcript, 16 March 2006, p 26; Chater B, Australian College of Rural and Remote Medicine, transcript, 16 March 2006, p 33.

21 Menadue J, transcript, 21 July 2006, p 29.

> supportive care, that is population and health consumer focused and capable of meeting the health needs of the Australian community.[22]

Training and recruitment pathways

4.20 The Department of Health and Ageing noted that the Commonwealth had a key responsibility for workforce planning outcomes:

> The Australian Government undertakes to ensure that there is an adequate number of health professionals to meet population need now and into the future; that the health workforce is appropriately distributed to meet that need; and that suitable education and training arrangements are put in place for the health workforce. The health care workforce is a shared issue between the Australian Government and the states and territories.[23]

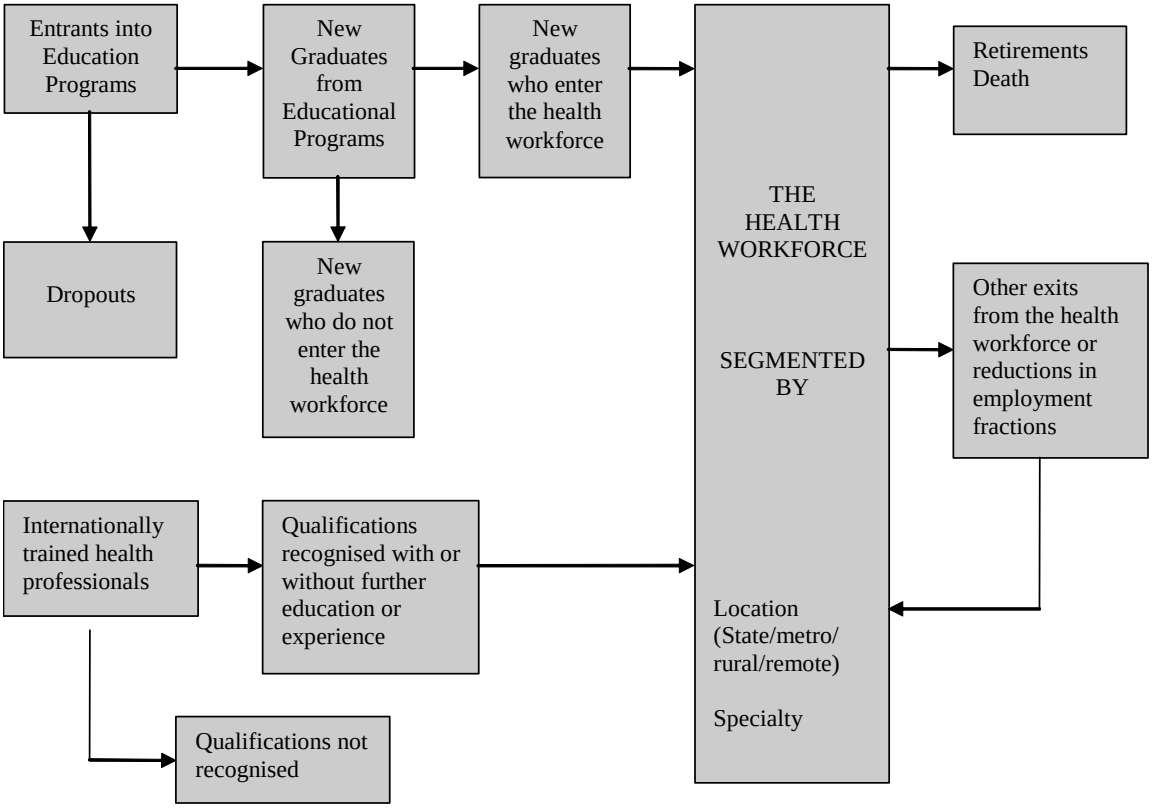
4.21 There are several points of entry and exit that affect the size and distribution of the health workforce (figure 4.1). Key inflows are from new Australian-trained graduates and internationally-trained health professionals who move to Australia on both a short and long term basis.

4.22 The number of domestic medical graduates has remained relatively unchanged over the period 1986 to 2004, averaging around 1,200 graduates per year (figure 4.2).

22 Australian Health Ministers Conference, *National Health Workforce Strategic Framework* (2004), p 13.

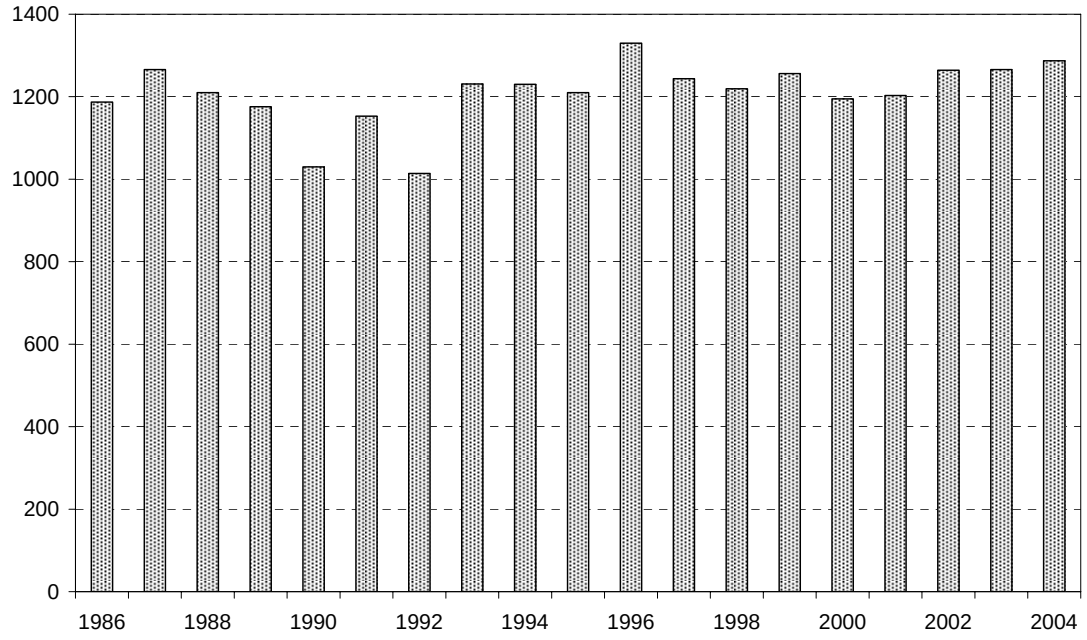
23 Department of Health and Ageing, sub 43, p 13.

Figure 4.1 Factors affecting health workforce supply



Source *Adapted from Duckett, S, The Australian Health Care System (2004), p 75.*

Figure 4.2 Medical course graduates, domestic students, 1986 to 2004 (number)



Source *Council of Deans of Australian Medical Schools, Student statistics, Table 5, viewed on 26 September 2006 at www.cdams.org.au/pdf/2005%20Stats%20Tables%20for_%20website.pdf.*

4.23 Data on graduates from allied health degrees at universities is less complete than for medical students. The available evidence indicates that there is an increase in the number of students completing courses in most allied health professions (table 4.3).

Table 4.3 Allied health university completions, 1993 to 2002

Course	1993	1996	1999	2002
Nutrition and dietetics	163	265	270	341
Occupational therapy	496	443	720	727
Pharmacy	479	621	301	846
Physiotherapy	744	724	893	869
Podiatry	102	114	129	114
Radiography	300	560	579	667
Rehabilitation therapies	244	308	334	367
Speech pathology	272	256	346	408

Source *Australian Health Workforce Advisory Committee, The Australian Allied Health Workforce: An Overview of Workforce Planning Issues (2006), pp 90–97.*

4.24 In the case of nursing, there has been a significant increase in the number of students commencing tertiary nursing courses, with the number of commencing nursing students rising from 7,790 in 2001 to 9,675 in 2005.[24]

4.25 Recent increases in the number of medical school graduates and new medical schools will lead to significant rise in graduates — rising from 1,300 in 2005 to more than 2,100 in 2010.[25] These projections do not take account more recent announcements by governments to expand the number of medical training places:

- 400 extra places announced in April 2006;[26]
- 235 extra places for Queensland announced in May 2006;[27] and
- 200 extra places announced in July 2006.[28]

24 Department of Education, Science and Training, Students 2005 [full year]: selected higher education statistics, viewed on 13 October 2006 at www.dest.gov.au/NR/rdonlyres/F1331710-F793-4E81-8867-B5FAF1AEC4DE/13781/2005_student_full_year_data.pdf.

25 Joyce C, J McNeil and J Stoelwinder, 'More doctors, but not enough: Australian medical workforce supply 2001–2012', *Medical Journal of Australia* (2006), vol 184, no 9, p 441.

26 Hon John Howard MP, Prime Minister, media release, *More doctors and nurses for the health system*, 8 April 2006.

27 Hon Stephen Robertson MP, Minister for Health, media release, *Queensland signs historic deal to produce more locally-trained doctors*, 10 May 2006.

4.26 The rising numbers of medical graduates and allied health graduates will place significant pressure on universities and public hospitals to provide sufficient clinical training opportunities. The situation in Western Australia was highlighted by the Doctors Reform Society (WA):

> … we have gone from having, I think, in my year just over 100 graduates; in about three years time there are going to be 250. That means that now they are starting to have a bulge of about 250 entering clinical training in their third and fourth years of med school, and exactly how those people are going to be well trained when you have got a system that is understaffed and therefore busy and stressed, who are then going to need to find the time to teach two and a half times as many students, is going to be a very interesting period of time for our health system.[29]

4.27 The Australian Medical Association (Queensland) also pointed out that there would be a similar situation in Queensland:

> In 2004, the number of domestic graduates from Queensland Medical Schools was 225, or 5.79 per 100,000 population (compared with 6.34 per 100,000 population for all Australian Medical Schools). In 2005, 276, or 23 per cent more students graduated.
>
> The intake to medical schools last year was 496, and this will increase to 554 by 2007 (based on current approvals). Assuming the usual two per cent attrition rate, this means 543 graduates will be graduating by 2011 or 12.65 per 100,000 population, compared with 10.65 per 100,000 for all Australian Medical Schools. This means 318 extra graduates over 2004 levels, or a 141 per cent increase.[30]

4.28 Funding and delivery of health workforce training is complex, with the Commonwealth and states contributing to various degrees to undergraduate (university) training and clinical training within public hospitals. This complexity was highlighted by the Hospital Reform Group:

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28 Hon John Howard MP, Prime Minister, media release, *More doctors, nurses and allied health professionals for Australia's health system*, 13 July 2006.

29 Douglas S, Doctors Reform Society (WA), transcript, 24 August 2006, p 20.

30 Australian Medical Association (Queensland), sub 104, p 6.

> As an undergraduate you belong to the universities, which are Commonwealth funded. You train in the hospitals, which are state funded places. You are taught by clinicians, who are paid for by the state or are privately funded, on their own time. You then become an intern, where you are part of a state system. But you are subject to credentialing by the Australian Medical Council, which is a federal system. You are registered by the state. You work in a state-paid position.
>
> You then become a registrar in the college, which is a national or often international organisation. For example, my college, which is the College for Emergency Medicine, covers New Zealand and Singapore as well. You pay for all of the training courses that you have to undertake as part of that college training yourself. They are quite often delivered by unpaid people. Then you are expected to work numerous hours in the state system, which is part of your training, delivering essential services for which you have to undertake training courses that you pay for yourself.[31]

4.29 Meeting the clinical training needs of rising numbers of health trainees is likely to be a significant challenge for the health system in the short to medium term. The next section discusses how training is funded and delivered and how overseas doctors make a significant contribution to delivering health services, particularly in rural areas.

Undergraduate training arrangements

4.30 People wanting to join many health workforce occupations are generally required to undertake university undergraduate training, with the length of degree varying from 3 years for nursing up to 6 years for medicine. Entry for many health care professions is also possible through shorter post graduate courses for those students with an accredited undergraduate degree.

4.31 Funding for university places is negotiated annually through funding agreements, which set out the number of Commonwealth supported places in ten broad disciplines, including the two national priority areas of nursing and teacher education. Each discipline is funded at a different rate with agreements specifying the number of places for which the higher education provider will receive regional, enabling or medical loading.

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31 Skinner C, Hospital Reform Group, transcript, 26 May 2006, p 12.

4.32 In 2006, medical places attracted a Commonwealth payment to universities of around $16,000 per place, nursing received around $10,000 per place and allied health professions such as physiotherapy received around $7,000 per place.[32]

4.33 Funding agreements are primarily based on discussions between the Department of Education, Science and Training and providers. However, for medicine new places are jointly determined by the Minister for Education, Science and Training and the Minister for Health and Ageing.

4.34 Governments are increasingly recognising the benefits of delivering health workforce training outside the major capital cities in sustaining health services in regional areas.[33] In recent years the Department of Health and Ageing has made direct contributions to the establishment of new medical clinical schools and departments of rural health at several universities, including 10 rural clinical schools.[34]

4.35 Universities can also enrol full fee-paying domestic and international students within certain limits. The Commonwealth recently announced an increase in the cap on domestic full-fee paying students from 10 per cent to 25 per cent, adding around 300 extra medical places.[35] At the same time, assistance to full fee paying students through a loan program was increased from $50,000 to $80,000 and to $100,000 for medicine.[36]

4.36 The vocational education and training sector, funded by a mix of government funding and student fees, has a lesser overall role in health workforce education and training. Workforce groups that are typically educated in a vocational education and training setting include enrolled nurses, 'assistants' to more qualified professionals, some Aboriginal health workers and personal care workers.

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32 See for example, Department of Education and Training, *Funding Agreement between the Commonwealth of Australia as represented by the Minister for Education, Science and Training through his delegate in the Department of Education, Science and Training and Griffith University regarding funding under the Commonwealth Grant Scheme in respect of the grant year 2006*, schedule 1.

33 Wronski I, James Cook University, transcript, 16 March 2006, p 19; Chater B, Australian College of Rural and Remote Medicine, p 31; Tobin P, Catholic Health Australia, transcript, 24 August 2005, p 13.

34 Hon Tony Abbott MP, Minister for Health and Ageing, media release, *Tamworth to become a medical training centre*, 14 February 2006.

35 Council of Australian Governments, *Communique,* 10 February 2006, p 12.

36 Hon Julie Bishop MP, Minister for Education, media release, *Growing our universities*, 9 May 2006.

Clinical training arrangements

4.37 While undergraduate medical training takes place in predominantly Commonwealth funded universities, clinical training is usually delivered in public hospitals — funded jointly by the Commonwealth and the states with the states wholly responsible for hospital service delivery (see chapter 7). Trainers are either salaried employees or VMOs.

4.38 There are three broad stages of clinical training for trainee doctors, each of which involves differing degrees of supervision:

- medical school (4 to 6 years) — At various stages of their course, the medical student will spend time in a clinical placement. This is normally in a public teaching hospital, although increasingly students are spending time in other settings such as general practice;
- pre-vocational training — following graduation from medical school, junior doctors must complete a 12 month internship in a public hospital. An intern position is accredited by the relevant state postgraduate medical education council and will involve rotations into a number of disciplines, which generally include emergency medicine, surgery and medicine. Once they have completed this they will be granted general medical registration. Following this it is common for junior doctors to spend another 1 to 2 years in a variety of pre-vocational positions while they gain extra skills and determine which specialty they would like to pursue; and
- vocational (specialist) training — junior doctors enter a specialist training program where they work as registrars in medical college accredited positions in public hospitals, and in the case of GP registrars - general practice. Once they have completed the College training program, they are granted Fellowship - which allows them to practice independently.

4.39 Public hospitals receive funding from state governments to provide clinical training. Additional funding is sometimes received from universities for the use of their facilities and for clinical training purposes as part of the explicit clinical training component in the Australian Government's contribution to medical and nursing course costs. However, for allied health courses, there is no separately identified clinical training component in government funding and

universities must meet the cost of any payments to public hospitals (or other training providers) from general funding sources.[37]

4.40 Funding for specialist post graduate clinical training typically involves contributions from governments and trainees. In addition to supervision by specialist medical colleges:

- States meet infrastructure costs for the training conducted in their hospital facilities, as well as the labour component of training delivered by salaried hospital staff and, depending on contractual arrangements, some of the cost of supervision provided by College Fellows.
- States also meet the salary and infrastructure costs of some unaccredited training positions in particular specialties.
- Trainees make a contribution through payments to the relevant colleges, including meeting the administrative costs for the colleges of oversighting training programs and assessing trainees.
- Private hospitals are providing and funding a small but growing amount of training to postgraduate medical students. A study of training in private hospitals noted an investment of $35 million a year in the education and training of surgeons, doctors, nurses and other health care professionals.[38] In areas like dermatology, pathology and rheumatology, the private sector also provides training outside of the hospital setting (with some of these training places supported by subsidies from the Australian Government). The private hospital sector has also long played a role in postgraduate nurse training.[39]

4.41 There are no health system wide estimates of the costs of clinical training. The Productivity Commission noted estimates of the cost of specialist training with the Royal Australasian College of Surgeons, which were in the order of $100,000 to $120,000 per trainee in 2003. The total trainee costs including additional infrastructure, equipment, nursing and allied health could amount to some $1 million to $2 million, depending on the sub specialty.[40]

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37 Productivity Commission, *Australia's Health Workforce* (2005), p 71.

38 Allen Consulting Group, *Education and training of health and medical professionals in private hospitals: Report to the Australian Private Hospitals Association* (2005).

39 Productivity Commission, *Australia's Health Workforce* (2005), p 72.

40 Productivity Commission, *Australia's Health Workforce* (2005), p 73.

Migration

4.42 In recent years, Australia has generally relied heavily on recruiting doctors and nurses from overseas, with overseas trained doctors comprising around 25 per cent of the overall medical workforce.[41] The distribution of overseas trained doctors is uneven, with the Rural Doctors Association of Australia noting that overseas trained doctors now make up over 30 per cent of the rural medical workforce generally and closer to 50 per cent in some states.[42]

4.43 Overseas trained doctors have been an important source of recruitment to areas of shortage, with the number of doctors issued temporary visas between 2000-01 and 2002-03 rising from 2,062 to 2,739. Queensland was the major beneficiary, taking over 1,000 of these doctors.[43]

4.44 Recognition of the skills and competencies of overseas health professionals and allowing them to practice in areas appropriate to their competencies supports good workforce deployment.

4.45 There have been a number of instances in recent years where the quality of services provided by some overseas trained doctors in public hospitals and general practice has been found to be unsatisfactory, or where overseas trained doctors have performed tasks for which they were not qualified or have not been appropriately supervised.[44]

4.46 The committee considers that existing state-based and profession-based registration and accreditation arrangements would be strengthened by adopting a national framework. Of equal importance, however, is that the states ensure that overseas trained medical professionals are employed at levels for which they have been assessed, with appropriate supervision.

4.47 The committee supports COAG's positive response to the Productivity Commission's health workforce study that recommends establishing a national registration board and a national accreditation

41 Department of Health and Ageing, submission to the Productivity Commission Health Workforce Study, August 2005, p 4.

42 Rural Doctors Association of Australia, sub 31, p 4.

43 Birrell B and L Hawthorne, 'Medicare Plus and Overseas Trained Doctors', *People and Place* (2004), vol 12, no 2, p 89.

44 Mr Anthony Morris QC, sub 72; Australian Medical Association (Queensland), media release, *Change must occur at the coalface*, 10 August 2006; Dunlevy S, 'Doctor heal thyself: quacks in the system', *Sydney Morning Herald*, 2 September 2006, p 28; Oakley V, 'Bungles cost millions: Taxpayers set to foot the bill', *Sunday Telegraph*, 27 August 2006, p 9.

board. The committee also supports the agreement by COAG that the new national accreditation board recommended by the Productivity Commission should assume responsibility for the range of accreditation functions in relation to overseas trained health professionals carried out by existing profession-based entities.[45]

Coordinating international recruitment efforts

4.48 The Commonwealth and states are active in recruiting health professionals from overseas. While the number of trainees within the Australian health system will significantly increase in the next five years, Australia is likely to remain reliant on attracting health professionals from overseas in the short to medium term.

4.49 The Commonwealth's recruitment has targeted doctors to work in areas of workforce shortage.[46] Most overseas doctors recruited by Commonwealth contracted recruitment agencies are general practitioners. However, 73 of the 233 overseas trained doctors placed in areas of workforce shortage as at May 2006 were working as specialists in areas such as surgery, radiology, psychiatry, pathology, orthopaedics, obstetrics and gynaecology and anaesthetics.[47]

4.50 The Commonwealth and states do not directly compete for the same health professionals.[48] The Department of Health and Ageing noted that:

> … the Commonwealth is not in competition with the States in regards to recruiting overseas trained doctors.
>
> The recruitment activity being undertaken through the Australian Government recruitment program requires the medical practitioner to be providing services in approved districts of workforce shortage and have a minimum Medicare billing component. This recruitment activity assists states and territories to fill vacancies. The state and territory governments are still able to, and should be encouraged to, undertake recruitment to fill shortages within their state or territory.[49]

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45 Council of Australian Governments, *Communique, 14 July 2006*.

46 Department of Health and Ageing, sub 142, p 71.

47 Department of Health and Ageing, sub 142, p 71.

48 Tait S, Family Care Services, transcript, 17 March 2006, pp 28–29; Department of Health and Ageing, sub 142, p 71.

49 Department of Health and Ageing, sub 142, p 71.

4.51 Recruitment of overseas doctors by state governments is broadly focused on staffing public hospital positions, although all states also work with the Commonwealth to facilitate the recruitment of general practitioners within their jurisdictions. The committee noted that in 2006 several states were also actively recruiting in overseas markets for doctors and nurses to staff public hospitals and that individual hospitals and health services were also involved in recruitment efforts.[50]

4.52 While the committee recognises that competition between the Commonwealth and states is limited, the move to adopt national registration and accreditation frameworks strengthens the need for the Commonwealth to better coordinate international recruitment efforts.

Recommendation 4

4.53 **The Department of Health and Ageing take a lead role to better coordinate the existing jurisdiction-based recruitment of overseas trained health professionals by the Commonwealth and state and territory governments.**

Reducing reliance on overseas-trained health professionals

4.54 Overseas trained health professionals are a valued part of the Australian health system. While overseas trained health professionals play, and will continue to play, a crucial role in addressing health workforce shortages, they must not be seen as a long-term solution.

4.55 Several inquiry participants expressed support for increasing the number of Australian-trained health workers to reduce our reliance on overseas health professionals.[51] The Australian Health Care Association noted:

> Looking at a very significant proportion of doctors imported from developing countries, one must stop and query the

50 Hon Stephen Robertson MP, Minister for Health (Qld), media release, *Queensland steps up recruitment drive for more doctors and nurses*, 13 July 2006; Hon John Hill, Minister for Health (SA), media release, *Bid for more medical places*, 29 May 2006; Mackender D, Hospital Reform Group, transcript, 26 May 2006, p 18.

51 Australian Medical Association, sub 30, p ; Armstrong F, Australian Healthcare Reform Alliance, transcript, 21 July 2006, p 49; Wronski I, James Cook University, 16 March 2006, p 29

> ethics of trying to solve Australia's workforce problems with professionals who are even more urgently needed in their home countries.[52]

4.56 The Commonwealth supports the principles in the Commonwealth Code of Practice for the International Recruitment of Health Workers that discourages the recruitment of doctors residing in developing countries. Medical recruitment agencies contracted by the Australian Government are prohibited from undertaking recruitment marketing activities or approaching doctors residing in developing countries.[53]

4.57 The committee considers that Australia should aim to be self sufficient in producing adequate numbers of medical graduates to meet projected demand rather than rely on overseas trained doctors to supplement its existing limited, albeit expanding, supply. Given the length of time to train doctors and medical specialists, such a target could be realistically achieved over the next 10–15 years. The Commonwealth should also consider using the aid budget to expand training opportunities to assist developing countries improve their own skilled health workforce.

4.58 While this would require a significant up front investment by governments, it is likely to reduce the need to offer the significant incentives required to encourage health professionals to work in regional and rural areas.

Recommendation 5

4.59 **The Australian Government implement a strategy for Australia to:**

- **be self sufficient by 2021 in producing adequate numbers of health profession graduates to meet projected demand;**
- **provide the necessary funding to expand the training system to accommodate the required number of students; and**
- **consider using the AusAID budget to expand medical training to further assist developing countries.**

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52 Australian Health Care Association, sub 127, p 6.

53 Department of Health and Ageing, Overseas-trained doctor initiatives: the benefits, viewed on 28 September 2006 at www.health.gov.au/internet/wcms/publishing.nsf/Content/factsheet-overseas_trained_doctors.

Sustainable health workforce training

4.60 This section examines different stages of health workforce training, focussing on the need to expand clinical training across the health system.

4.61 Health workforce planning and funding is integral to the national health agenda proposed by the committee in chapter 3. It is important that governments, as part of the national health agenda, provide mechanisms that are able to identify areas of health workforce shortage and rectify these in a timely manner.

4.62 Public hospitals perform a key role in training the future health workforce. There is evidence to suggest that in some states there is a declining emphasis on training:

> The three missions of public hospitals, teaching, service and research, remain essential elements of our health system today, yet with the increasing demands of a growing population and poor Queensland Health management, the primary role of public hospitals has moved. Teaching and research have been gradually subsumed by the escalating demands of service delivery.[54]

4.63 Notwithstanding this declining emphasis, some health professionals remain committed to ensuring that training continues to be an important part of working in the public hospital system.[55] The Australian Medical Association noted that:

> Many of the cushions that used to make people think 'I would still like to do my work here' are being taken away. They are losing their ability to teach. Clinicians are just doing service delivery; they are not teaching. They are not having the time to do additional training. Ongoing innovative care and research, which is why we have got to where we are, is all but excluded from the sector now because of lack of funding and lack of time. We need to address those things.[56]

4.64 The complexity and culture of training arrangements between the health and education sector was noted by Professor Wronski:

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54 Dr Ross Cartmill, sub 107, p 4.

55 Skinner C, Hospital Reform Group, transcript, 26 May 2006, p 17.

56 Haikerwal M, Australian Medical Association, transcript, 28 November 2005, p 34.

> … there is clearly still a cultural element in how the health system accommodates the education, training and research responsibilities. It is a very significant part of the quality and safety agenda in Australian hospitals. There is the big health system's relationship to university medical schools, nursing schools and those sorts of things. The fact that there are professors of surgery and professors of medicine wandering around the wards being paid quite often by a separate agency has a very important, implicit and explicit function in the quality and safety systems of our health system.[57]

4.65 Health funding arrangements need to recognise the important role that hospitals and other service providers play in training and take advantage of other opportunities to improve the skills of the health workforce. This may include the need to be able to purchase training opportunities across the public and private sectors.

University-based health workforce training

4.66 It is important that the administrative arrangements that support health workforce training are sufficiently responsive to identify and fund the appropriate numbers of students for the health workforce.

4.67 The committee welcomes COAG's positive response to the Productivity Commission's recommendation that the Australian Government develop an agreement with the states for the allocation of places for university-based education and training of health professionals within each jurisdiction.[58]

4.68 While the Department of Education and Training would remain the lead agency in negotiating with universities under the model agreed by COAG — albeit in consultation with the Department of Health and Ageing — the committee noted that there were several different approaches that could be adopted:

- giving the Department of Health and Ageing a direct involvement in setting priorities for the future health workforce and funding universities accordingly;[59]

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57 Wronski I, James Cook University, transcript, 16 March 2006, p 17.

58 Council of Australian Governments, *Communique*, 14 July 2006.

59 Duckett S, 'Interventions to facilitate health workforce restructure', *Australia and New Zealand Health Policy* (2005), vol 2, No 14; Productivity Commission, *Australia's Health Workforce: Position Paper* (2005), p LXXI.

- the Department of Health and Ageing providing funding directly to the medical schools for academic positions, outside the university funding process, to ensure parity with the hospital salaried positions of those with comparable qualifications and expertise;[60] or
- the Department of Health and Ageing providing top up funding to universities to ensure that they are able to 'purchase' clinical training time.[61] Additional university funding to support clinical training for nursing students announced as part of the Department of Education, Science and Training 2006-07 budget.[62]

4.69 The committee considers that the Department of Health and Ageing should play a greater role in working with the states and universities to identify and support the appropriate number of medical and nursing students and allied health trainees. This would be consistent with the department's increasing involvement in supporting infrastructure for the establishment of new medical schools.

4.70 Recognising that COAG's proposed arrangements are yet to be implemented, the committee considers that the Department of Education and Training should retain its place as the lead agency in relation to university funding for health workforce places. However, the Department of Health and Ageing needs to be well placed to provide advice, and possibly additional funding on a flexible basis, to ensure that quality research and teaching staff can be retained in universities and that students receive sufficient high quality clinical training opportunities.

60 Australian Medical Association (Queensland), sub 104, p 5.

61 Australian Physiotherapy Association, media release, *100 physios at risk of not graduating, APA warns*, 6 July 2006.

62 Department of Education, Science and Training, *Budget information: 2006 at a glance, May 2006*, p 4.

Recommendation 6

4.71 **The Minister for Science, Education and Training ensure that agreements about health workforce allocation and funding between the Department of Education, Science and Training and universities allow for supplementary funding by the Department of Health and Ageing to:**

- **provide support to universities to attract and retain key academic staff; and**
- **ensure appropriate clinical training opportunities for medical and other health workforce students.**

Public sector clinical training

4.72 As previously noted, health workforce trainees are generally required to undertake significant amounts of clinical training as part of their education. Clinical training is generally conducted in public teaching hospitals, with trainees supervised by academic and medical staff.

4.73 A significant issue raised with the committee was the unavailability of sufficient clinical training opportunities for the large increase in medical students currently in, or about to enter, the training 'pipeline'.[63]

4.74 Without access to high quality clinical training there is a risk that graduating students do not have the appropriate skills and experience to work safely and effectively. The lack of opportunities for postgraduate training was highlighted by Family Care Services:

> We are training more doctors now in Australia, and that is ramping up over the next five years. But there is no point in training more doctors if you cannot give them their postgraduate experience in the hospitals. The Royal Australasian College of Surgeons for a long time has been telling people that there are not the registrar positions in the public hospitals to be able to train the people that they want to train. I know that the College of Surgeons gets blamed all the time for supposedly trying to manipulate its market to restrict entry to others doctors. Nothing could be further from the truth. We know that the College of Surgeons is desperate

63 Tait S, Family Care Services, transcript, 17 March 2006, p 29; Australian Medical Association (Queensland), sub 104, p 6; Iliffe J, Australian Nursing Federation, transcript, 7 April 2006, p 14; Australian Medical Association, sub 138, p 1.

> to train another 150 surgeons, but there are no registrar positions left in the public hospitals.[64]

4.75 The Australian Medical Association (Queensland) made a similar point after noting that there would be a significant increase in medical students in the next few years:

> The issues would not appear to be a lack of medical students, but rather the ability to train them to become solo doctors. Without academics and staff specialists in place, there can be no future doctors. The change in medical student numbers therefore, must happen in a controlled manner. The issue with regard to academic staff is critical. When you quadruple the number of medical schools it is obvious that there will follow a significant increase in demand for academic staff. Couple this with the situation of lack of parity in salaries with the staff specialists and the crisis needs urgent attention.[65]

4.76 Some of the areas that need to be urgently addressed to ensure that there are sufficient opportunities for quality clinical training within the public hospital system and within universities include:

- remuneration arrangements with medical trainers working in universities not keeping pace with public sector practitioners, reducing the incentives for people to remain as teachers and researchers within universities;[66]
- remuneration arrangements for VMOs not always recognising that training is part of work arrangements or payment rates for VMOs are not sufficient to attract specialists to maintain or increase their work in public hospitals;[67]
- exposure to patients and the acquisition of procedural skills being limited by the inadequate bed numbers and the cancellation of operating theatre schedules;[68]
- high levels of stress and pressure in public hospitals that emphasise patient throughput, limiting the available time for quality teaching and learning;[69] and

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64 Tait S, Family Care Services, transcript, 17 March 2006, p 29

65 Australian Medical Association (Queensland), sub 104, p 6.

66 Wronski I, James Cook University, transcript, 16 March 2006, p 18.

67 Dr Ross Cartmill, sub 107, p 4; Goulston K, Hospital Reform Group, transcript, 26 May 2006, p 14.

68 Australian Medical Association (Queensland), sub 104, p 6.

- the ageing profile of experienced medical practitioners leading to a significant reduction in the quality and number of available health professionals to train medical students in the next few years.[70]

4.77 The committee considers that the urgent need to create more clinical training opportunities and the Commonwealth's significant financial contribution to health workforce training warrant the Commonwealth taking greater responsibility for training outcomes across the health system. The Australian Medical Association noted that:

> While public hospitals are the responsibility of the States/Territories, it is time for the Commonwealth to take a much stronger position on the resources committed by State/Territory Governments to support the training of the future medical workforce. The Commonwealth must demand answers that include concrete strategies, backed by funding allocations. If necessary, the Commonwealth should consider explicitly outlining what funding is provided for medical training in future Australian Health Care Agreements and linking these monies to performance benchmarks.[71]

4.78 The committee would support a move to the explicit funding of clinical training in public hospitals by the Commonwealth. This could be part of, or separate to, future public hospital funding arrangements. Better identification of the costs of training and how existing funds are allocated to clinical training should lead to an improved understanding of how training funds can be more effectively used.

4.79 Funding clinical training outside the Australian Health Care Agreements may involve payments directly from the Commonwealth to public hospitals. The identification of the quantum of funds within current agreements for training and appropriate adjustments to other aspects of public hospital funding will also need to be considered as part of any new arrangements.

4.80 Such an approach has some risks, including diluting the strong culture of training that exists in public hospitals and within health workforce professions generally. However, better support for trainers

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69 Mackender D, Hospital Reform Group, transcript 29 March 2006, p 9; Haikerwal M, Australian Medical Association, transcript, 28 November, p 34.

70 Goulston K, Hospital Reform Group, transcript, 29 March 2006, p 1; Cartmill R, transcript, 16 March 2006, p 59.

71 Australian Medical Association, sub 138, p 2.

and training infrastructure may lead to the strengthening of training over the long term.

4.81 The committee considers that a purchasing agreement for training needs to recognise the importance of training in regional areas, which may sometimes be delivered at a higher cost than in a capital city location.

Recommendation 7

4.82 **The Australian Government develop explicit purchasing agreements for clinical training with public health care providers. The purchasing agreement would cover:**

- **funding levels — adequate to support existing and planned levels of training in both metropolitan and regional locations;**
- **specified outcomes — including the quantity and quality of training conducted; and**
- **performance measures — allowing timely assessment of progress in meeting obligations.**

Private sector training

4.83 While the public sector is the most significant provider of clinical opportunities for training future health professionals, the private sector also makes an important contribution to training the health workforce.

4.84 As previously noted, a study of training undertaken for the Australian Private Hospitals Association found that Australia's private hospitals invest $35 million a year in the education and training of surgeons, doctors, nurses and other health care professionals.[72] Private hospitals receive no funding from governments or private health funds to support this investment in the nation's future medical workforce.[73]

72 Allen Consulting Group, *Education and training of health and medical professionals in private hospitals: Report to the Australian Private Hospitals Association* (2005).

73 Roff P, Australian Health Insurance Association, transcript, 23 August 2005, p 16.

4.85 Some training in private hospitals is supported by formal links to a university. Areas where the private sector is already involved in training include:

- a range of graduate and postgraduate nursing courses in areas such as critical care nursing, peri-operative nursing, oncology, rehabilitation and midwifery;
- specialist medical programs such as ear, nose and throat surgery, ophthalmology and cardiology; and
- allied health professional training for physiotherapy and nutrition and dietetics — including both postgraduate courses and continuing medical education.[74]

4.86 The need for greater opportunities for training in the private sector is also supported by the fact that there some medical procedures are now more likely to be performed in a private hospital setting rather than in public hospitals.[75] Experiencing the differences between public and private sectors during training was also seen as a benefit. The Hospital Reform Group told the committee that:

> The private sector and the public sector offer very different training opportunities as well. The public sector offers good, general bedside medicine. The private sector offers people with one problem, people with surgical procedures and people in outpatient settings.
>
> I think there are different training opportunities. Current trainees miss out on some of those opportunities available in the private sector, and we need to get more of them as well.[76]

4.87 There appears to be widespread acceptance by health professionals for greater involvement of the private sector in participating in training.[77] The Hospital Reform Group told the committee that:

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74 Allen Consulting Group, *Education and training of health and medical professionals in private hospitals: Report to the Australian Private Hospitals Association* (2005), pp 12–19.

75 Australian Private Hospitals Association, sub 24, p 2.

76 Skinner C, transcript, 26 May 2006, p 21.

77 Australian Private Hospitals Association, sub 24, p 2; Australian Medical Association, sub 30, p 30; Catholic Health Australia, sub 35, p 20; Iliffe J, Australian Nursing Federation, transcript, 7 April 2006, p 14; Tait S, Family Care Medical Services, transcript, 17 March 2006, p 29; Parkes H, Department of Health (SA), transcript, 7 April 2006, p 30; Australian Medical Association (Queensland), sub 104, p 11; Guerin M, Australian Diagnostic Imaging Association, transcript, 7 April 2006, p 27.

> We have now a large number of private hospital beds but private hospitals do very little teaching, whether it is of doctors, medical students, radiographers or physiotherapists. The teaching is primarily done in the public sector. I think the Commonwealth could use some stick nationwide to encourage the inevitable, which is that teaching has to occur in the private hospital sector. It will happen. We will deal with the culture change amongst our colleagues; it would help if you did something on a national scale to encourage hospitals in the private sector to teach. Ramsay have done this successfully at Greenslopes in Brisbane. But not much is happening elsewhere.[78]

4.88 The committee supports an expansion of training opportunities in the private sector. However, significant effort will need to be given to overcome some of the impediments to expand training within the private sector. In a study commissioned the Australian Private Hospitals Association, some of the barriers identified by private hospitals providing education and training included:

- cost;
- lack of capacity or facilities; and
- insufficient flexibility in rostering.[79]

4.89 A further barrier to more widespread acceptance of training in the private sector is likely to be acceptance by patients that some medical and nursing staff involved in their treatment will be at varying stages of training. The Australian Medical Association (Queensland) noted that:

> There are issues with regard to patient understanding of privately funded care and their consent to being used for teaching purposes within the private system. Public education is needed if training were to proceed in this context.[80]

4.90 The committee considers that the Commonwealth needs to take a lead role in promoting to the community the need for, and benefits of,

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78 Goulston K, transcript, 26 May 2006, p 20.

79 Allen Consulting Group, *Education and training of health and medical professionals in private hospitals: Report to the Australian Private Hospitals Association* (2005), p 26.

80 Australian Medical Association (Queensland), sub 104, p 11.

appropriate clinical training for health workforce trainees to be undertaken in the private sector.

4.91 The Commonwealth has direct experience in negotiating and funding training outcomes with the private sector. The most recent memorandum of understanding with the pathology profession has directly provided funding for 10 pathology training positions for five years.[81] The arrangement provides for funding to the private pathology sector to provide the training for private employees, with the Royal College of Pathologists of Australasia setting the criteria for the training. Registrars must spend at least two years of training in the public sector with the remaining training in the private sector. The positions are divided up by state – two in Queensland, four in New South Wales, three in Victoria and one in Western Australia.[82]

4.92 The committee considers that Commonwealth is best placed to build on the existing training culture in the private sector and address the barriers to expanding training. The adoption of a more explicit purchasing framework for funding training in the public sector (see above) should assist in identifying and funding training opportunities in the private sector.

4.93 The committee also considers that rather than wait for the development of purchasing agreements, in the short-term the Commonwealth should also look at opportunities to directly fund private and not-for-profit health care providers.

Recommendation 8

4.94 **The Australian Government take advantage of expanding opportunities for private sector health providers to conduct clinical training and, where appropriate, enter into purchasing arrangements to fund this training.**

81 Department of Health and Ageing, *Pathology Quality and Outlays Memorandum of Understanding between the Australian Government and the Australian Association of Pathology Practices and the Royal College of Pathologists and the National Coalition of Public Pathology, 1 July 2004 to 30 June 2009* (2004), clause 11.

82 Nogrady, B, 'Countdown to Crunch Time', *Pathway*, viewed on 4 October 2006 at www.rcpa.edu.au/pathway/article.asp?article=31.

Health workforce flexibility

4.95 Health workforce flexibility has several different aspects, including changing the tasks that health workers perform and how they are able to move across different jurisdictions, employers and different types of health and aged care service providers.

4.96 Several governments have recently announced arrangements that involve a degree of task substitution including support for nurses working in general practice and the introduction of 'hospitalists' (a clinician with specialist training in acute care) at NSW public hospitals.[83]

4.97 An efficient health system needs flexible workforce arrangements to adapt to changes in priorities, technology, models of care and market conditions for attracting and retaining an internationally mobile health workforce.

4.98 In some areas of health care, funding arrangements can directly affect the tasks health professionals perform. For example, in recent years, the role of some allied health professionals, including physiotherapists and Aboriginal health workers, has been expanded through changes to the Medicare Benefits Schedule (MBS).[84] In other areas of health service delivery, such as within public hospitals, health funding arrangements have less influence on who performs different tasks and how models of care are structured.

Facilitating task substitution

4.99 As discussed in chapter 3, the Commonwealth-funded Medicare Benefits Schedule (MBS) is influential in shaping new models of care. While new models of care include elements of task substitution, there are areas of health care where there are opportunities for task substitution without changing models of care.

4.100 Health funding arrangements can directly and indirectly affect the tasks performed by health workers. The Productivity Commission noted that payment arrangements can affect:

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83 Hon Tony Abbott, Minister for Health, media release, *More Government support for nurses working in general practice*, 11 April 2006; Hon Paul McLeay, Parliamentary Secretary for Health, media release, *New career for doctors in NSW public hospitals*, 24 August 2006.

84 Hon Tony Abbott MP, Minister for Health and Ageing, media release, *Exercise physiologists eligible to provide services under Medicare*, 6 September 2005; media release, *New Medicare items for Indigenous health, refugees and palliative care*, 1 May 2006.

- decisions by consumers about what sort of health care services to consume and from whom they acquire them;
- the career choices of health care workers — both as to fields of study and to the extent of specialisation within chosen fields;
- the location decisions of those workers and whether they practise in the public or private sectors;
- the boundaries between health professions; and
- methods of practice, including referral patterns and the willingness to assess different models of service delivery, or to countenance changes in scopes of work.[85]

4.101 For the most part, the MBS only covers non-medical services provided after referral by doctors. This reduces the participation of nurses and many allied health professions in providing primary health care services.

4.102 Expanded access to the MBS was suggested as a potential solution for general practitioner shortages, with allied health professionals often in a position to provide appropriate care for patients.[86] The Australian Physiotherapy Association noted that:

> … on some occasions, the physiotherapist diagnoses a condition that requires care by a medical specialist. The physiotherapist then advises the patient that they must see a specialist, but in order to attract a Medicare rebate for the specialist's services, a GP referral is required. Naturally the patient attends the GP, although there is no clinical reason to do so. Thus, the patient's and GP's time is wasted and an MBS consultation is billed unnecessarily.
>
> There is no clinical reason why the patient should not receive a rebate on the physiotherapist's referral. In fact, the current system can lead to a delay in patients receiving the required intervention and thus exacerbate the consequences of their injury or condition. There is precedence for this change to MBS referral for physiotherapy arrangements, as patients currently receive a full rebate on an optometrist referral to an ophthalmologist.[87]

85 Productivity Commission, *Australia's Health Workforce* (2005), p 154.

86 Australian Physiotherapy Association, sub 118, p 4; Australian Healthcare Reform Alliance, sub 127, p 75; Australian Psychological Society, sub 136, p 8.

87 Australian Physiotherapy Association, sub 118, p 4.

4.103 Another example of increasing task substitution was in the area of child birth. Mr Menadue told the committee that:

> In Australia about 10 per cent of normal births are delivered by midwives. In the United Kingdom that figure is 50 per cent and in Sweden it is 70 per cent. That situation exists in Australia due to restrictive practices, usually in the name of quality and safety. They abound across the health system.
>
> There are big productivity dividends to be obtained by addressing this question of the health workforce. One way of doing that is, frankly, by political, administrative or executive leadership by governments in Australia, and the second is by using the MBS system to encourage and promote greater up-skilling, sharing and teamwork within the health system.[88]

4.104 Not all inquiry participants supported moves towards task substitution, noting that the quality and safety of care could be compromised.[89] The Australian Medical Association (Queensland) noted that:

> AMA Queensland supports a medical led team approach to patient care. The supervised collaborative approach is the best approach for quality care. I am a GP. We work in a team approach. We have practice nurses; we work with our allied health colleagues. We are really committed to this sort of a process and we believe that our patients are best cared for in this situation. But we do have some concern as to the person who is to take the ultimate responsibility. Interestingly enough, usually it is the doctor who has to take ultimate responsibility, even when something goes wrong. But in fact they are not there leading the decision making. So we see that as a huge issue.[90]

4.105 The committee broadly supports moves towards expanding the role of allied health professionals and changing referral pathways in areas where the efficiency of the health system can be improved without compromising the quality of care. However, decisions about task substitution should be made by an expert group that examines the potential effects on the quality of patient care.

88 Menadue J, transcript, 21 July 2006, p 29.

89 Australian Medical Association, media release, *COAG Reform Agenda for Health – A Blurred Vision*, 14 July 2006; Australian Medical Association (Queensland), sub 104, pp 8-10;

90 Hodge Z, Australian Medical Association (Queensland), transcript, 16 March 2006, p 70.

4.106 As previously noted, the committee supports COAG's positive response to the Productivity Commission's recommendation that a single accreditation board be established for health professional education and training.[91] The committee considers that the establishment of this body should lead to greater discussion about task substitution within the health workforce. It will be important that this body focus on the quality of care from the view of the patient, rather than the competing interests of different medical and allied health professions.

4.107 A single national accreditation framework is an important step in highlighting areas where task substitution can be explored. However, the committee also considers that payment systems through the MBS or other methods of funding (such as grants to Divisions of General Practice) need to be closely integrated with decisions about task substitution so different models of care can be implemented in a timely fashion.

Recommendation 9

4.108 **The Australian Government ensure that the new national health professions' accreditation body's decisions about changes in models of care arising from task substitution are also reflected in funding arrangements.**

Fringe benefits tax exemptions

4.109 Health services are provided by a range of government and non-government providers. Many non-government providers operate on a not-for-profit basis. The relative importance of not-for-profit providers varies across different health care settings, with not-for-profit providers delivering a high proportion of services in the private hospitals, public teaching hospitals and aged care services.[92]

4.110 Under the *Fringe Benefits Tax Assessment Act 1986*, 'public benevolent institutions' and certain public hospitals have some advantages in attracting and retaining staff through providing fringe benefits tax (FBT) exemptions.[93]

91 Council of Australian Governments, *Communique*, 14 July 2006.

92 Catholic Health Australia, sub 35, pp 5–6.

93 *Fringe benefits Tax Assessment Act 1986*, s 57A.

4.111 Assessments of public benevolent institution status and whether public hospital employees qualify for FBT exemptions are made by the Australian Tax Office, which has developed guidelines to assist providers in establishing whether their employees qualify for the FBT exemptions.

4.112 Public benevolent institution status is not automatically given to a not-for-profit service provider, which is generally required to satisfy a range of criteria including organisational form, activities and operations, and the policies and procedures that guide operations.[94] Likewise, there are a number of elements that define eligibility for public hospital status, including how public ownership is structured, the provider's predominant objectives and specific services provided.[95]

4.113 For providers with public benevolent institution status, the FBT exemption is limited to certain excluded fringe benefits and $30,000 of each employee's individual grossed-up non-exempt amount of fringe benefits. For public hospitals, or where the employer is a government body and the employee works exclusively for a public hospital or a non-profit hospital, or a public ambulance service, a limit of $17,000 of non-exempt fringe benefits applies.[96]

4.114 The Treasury estimates that the capped exemption for certain public hospitals and non-profit hospitals cost $240 million in foregone tax revenue in 2005-06.[97] The exemption for public benevolent institutions, some of whom may not provide health care or aged care services, is estimated to cost a further $250 million in foregone tax revenue in 2005-06.[98]

4.115 The high degree of interaction and movement of the health workforce between the public and private sectors and across different types of health services suggest that it is important that skilled workers are attracted to and retained in areas where health care is most effective.

4.116 The Productivity Commission's recent health workforce research report noted a range of ways FBT arrangements could be modified to

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94 Australian Taxation Office, Taxation Ruling 2003/5, Definition of a Public Benevolent Institution for Taxation Purposes.

95 Australian Taxation Office, ATO Practice Statement 2001/19, Definition of Hospital for FBT Purposes.

96 *Fringe benefits Tax Assessment Act 1986*, s 57A.s

97 The Treasury, *2005 Tax expenditures statement* (2005), p 118.

98 The Treasury, *2005 Tax expenditures statement* (2005), p 120.

favour those working in rural and remote areas, so as to facilitate recruitment and retention.[99]

4.117 While remuneration is only one aspect of an employee's working conditions, access to FBT exemptions appear to give some health service providers an advantage in attracting and retaining staff. The Institute of Medical and Veterinary Science (IMVS), a South Australian government authority that provides a comprehensive range of diagnostic and consultative services in pathology and a key trainer of pathology students, told the committee that:

> As a State Government Statutory Authority the IMVS recruits the majority of its staff from within the Health Sector, at either a state, national or international level. With the loss of [public benevolent institution] status the IMVS is significantly disadvantaged in recruiting staff in comparison with other health units, at both intra and interstate levels, as these organisations have the hospital [public benevolent institution] status.
>
> This results in a situation whereby staff working at the IMVS are paid less than commensurate staff doing identical duties at other institutions.[100]

4.118 Not having access to FBT exemptions for staff was considered by IMVS to adversely affect their ability to attract and retain staff:

> To enable the IMVS to continue to provide quality pathology services it must be able to continue to recruit the best staff. This has not always been achievable and has resulted in some staff declining positions in preference to other organisations when the IMVS offers what are in effect inferior salary rates.
>
> Not only is our ability to attract staff compromised by the current inequity, but we have also had difficulty in retaining our existing staff. Staff have sought employment elsewhere, were they have access to salary sacrifice benefits.
>
> This is not only an issue with respect to medical staff and scientists but has become an issue in those areas where there is clearly a defined skill shortage such as human resources, information technology, cytology screening, nursing and finance, all of which are areas that have lost staff to

99 Productivity Commission, *Australia's Health Workforce* (2005), p 219.

100 Institute of Medical and Veterinary Science, sub 128, p 4.

> alternative institutions that enjoy the Hospital Public Benevolent Institution status.[101]

4.119 These problems in attracting skilled staff were also shared by the City of West Torrens, an owner and operator of a 115 bed residential aged care service (St Martins):

> … one of the most significant problems facing Council in the recruitment and retention of registered and enrolled nurses to its aged care facility, was the [Australian Taxation Office's] refusal to grant St Martins the very same taxation status afforded other not for profit and charitable providers of approved residential aged care services.[102]

4.120 The City of West Torrens summarised a relative order of advantage for health care service providers in attracting and retaining skilled nursing staff as:

> It is clear therefore that the agencies best placed to recruit and retain [registered nurses] and [enrolled nurses] in South Australia are, in order,
>
> - public hospitals, with 10-15% better pay rates and [public benevolent institution] status;
> - private hospitals, better pay rates but no [public benevolent institution] status;
> - aged care providers with [public benevolent institution] status;
> - private aged care providers, with pay rates higher than the industry average but funded by (private) client fees; and
> - aged care providers without private clients and no [public benevolent institution] status.
>
> The City of West Torrens falls into the last category, a very small group![103]

4.121 Removing impediments to health workforce mobility is not only based on balancing mobility between for-profit and not-for-profit health providers. A broader argument for removing barriers to workforce mobility is based on allowing the workforce to move to areas of need to facilitate the introduction of new models of care, such

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101 Institute of Medical and Veterinary Science, sub 128, p 4.

102 City of West Torrens (SA), sub 133, p 1.

103 City of West Torrens (SA), sub 133, p 2.

as out-of-hospital care and a focus on prevention, detection and early intervention.[104]

4.122 It is difficult to predict what the new models of care will be or how they may change demand for different health professionals. However, it is important that employment arrangements do not unnecessarily restrict workforce mobility, allowing for a smoother adjustment to newer and more appropriate models of care.

Recommendation 10

4.123 **The Australian Government amend the *Fringe Benefits Tax Assessment Act 1986* so that:**

- **local governments operating aged care facilities are able to qualify for fringe benefits tax exemptions granted to public benevolent institutions for employees involved in the aged care facility; and**
- **fringe benefits exemptions applying to public employers delivering health services in hospital-based settings also apply to public employers providing health services in other settings.**

104 Institute of Medical and Veterinary Science, sub 128, p 3; Australian College of Health Service Executives, sub 141, p 11; Australian Association of Gerontology, sub 52, p 2; Health Workforce Queensland, sub 113, p 2.