

Australia's medical workforce

- 2.1 A health workforce with an adequate supply of well-trained practitioners, including medical practitioners, underpins the delivery of high quality health care in Australia. Governments at national and state levels are instrumental in determining the community's needs for health care, and what constitutes an adequate medical workforce to meet these needs. The supply of medical practitioners (both general practitioners and specialists), and where and how they can practise is heavily influenced by government policies.
- 2.2 This Chapter presents an overview of what is known about Australia's demand for, and supply of medical practitioners, and examines some of the issues surrounding the future stability and reliability of that workforce. In that broader context, the Chapter considers Australia's past and current reliance on international medical graduates (IMGs) to fulfil the health needs of the community. The Chapter presents a brief overview of current government workforce initiatives intended to achieve equilibrium between demand and supply of medical practitioners, and address issues of geographical mal-distribution. This Chapter concludes by considering issues associated with medical workforce planning.

Medical practitioner supply

- 2.3 Assessing the adequacy of Australia's medical practitioner workforce is not straightforward, relying on estimates of underlying demand for services and judgement in relation to an appropriate level of response. Concerns regarding the supply of medical practitioners in Australia have changed over time. As noted by the Australian Medical Council (AMC):

In the last two decades, the national policy on medical workforce has swung between concerns of significant oversupply (1992), resulting in quotas on the AMC examination and points penalties on migration applications for medical practitioners, to concerns of undersupply resulting in active recruitment of overseas trained health professionals and considerations of task substitution and regulatory reform (2005).¹

2.4 As noted above, concerns about the adequacy of Australia's medical practitioner workforce emerged in the mid to late 1990s. Initially there was concern regarding an apparent mal-distribution of medical practitioners, with shortages evident in rural and remote areas of Australia. Despite measures introduced to encourage more medical practitioners to work in rural and remote locations, these shortages persisted. Furthermore, by the early 2000s evidence was emerging of medical practitioner shortages in some outer-metropolitan locations.²

2.5 Currently, although there are some suggestions that there are no shortages of medical practitioners in Australia, and that there may in fact be a surplus³, the more widely held view is that there are still too few medical practitioners to meet Australia's needs.⁴ According to a 2005 Productivity Commission report on Australia's health workforce:

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

These shortages persist despite the fact that the workforce has been growing at nearly double the rate of the population – though reductions in average hours worked in response to such factors as workforce ageing and greater feminisation of some professions, have partly offset this increase in numbers. Medical

1 Australian Medical Council (AMC), *Submission No 42*, p 19.

2 Parliament of Australia, Parliamentary Library, 'Medical practitioners: education and training in Australia', *Background Note*, July 2009, <<http://www.aph.gov.au/Library/pubs/BN/2009-10/MedicalPractitioners.pdf>> viewed 25 January 2012.

3 A Kamalakanthan & S Jackson, *The Supply of Doctors in Australia: Is There A Shortage?* Discussion Paper No 341, School of Economics, The University of Queensland, May 2006; Professor B Birrell, *Australia's New Health Crisis – Too Many Doctors*, Centre for Population and Urban Research, Monash University, September 2011, <<http://arts.monash.edu.au/cpur/--downloads/australias-new-health-crisis.pdf>> viewed 25 January 2012.

4 Australian Government Department of Health and Ageing (DoHA), *Report on the Audit of Health Workforce in Rural and Regional Australia*, April 2008, p 35. See also: Australian and New Zealand College of Anaesthetists (ANZCA), *Submission No 87*, p 20; Rural Workforce Agency, Victoria, *Submission No 91*, p 10; Government of South Australia, *Submission No 96*, p 3.

shortages also remain despite an increasing reliance on overseas trained doctors, who now make up 25 per cent of that workforce compared with 19 per cent a decade ago.⁵

2.6 In 2008, a Australian Government Department of Health and Ageing (DoHA) report on the health workforce in regional, rural and remote locations made the following observations:

- Rural and remote Australia has experienced medical workforce shortages for a considerable period, particularly in terms of general practice services and some specialist services, such as obstetrics and gynaecology.
- Numbers of GPs in proportion to the population decrease significantly with greater remoteness, with the lowest supply to 'very remote' areas, particularly in New South Wales and Western Australia.
- There is also considerable variation across jurisdictions. Northern Territory and Western Australia, as well as the Australian Capital Territory, have lower number of GPs proportional to the population.
- In recent years, the medical workforce in rural and remote Australia has increased modestly, mostly due to restrictions on Medicare provider numbers for overseas trained doctors to encourage them to work in rural and remote areas of workforce shortage.
- One-third of doctors currently working in Australia were trained overseas.
- The proportion of overseas trained doctors is significantly higher in rural and remote areas where 41% of all doctors have trained overseas.
- Although the number of GPs continues to grow, this growth does not indicate increased availability of GPs over time, as the growth in the medical workforce has not kept pace with the rate of population growth.⁶

2.7 The Australian Institute of Health and Welfare Medical Labour Force 2009 survey (published in 2011) highlighted the gulf between cities and rural areas with regard to the availability of doctors and specialists:

The supply of employed medical practitioners was highest in major cities (392 full-time equivalent medical practitioners per 100,000 population) (based on a 40-hour working week). The rate

5 Productivity Commission, *Australia's Health Workforce*, Research Report, 2005, pp xvi-xvii, <http://www.pc.gov.au/_data/assets/pdf_file/0003/9480/healthworkforce.pdf> viewed 25 January 2012.

6 DoHA, *Report on the Audit of Health Workforce in Rural and Regional Australia*, April 2008, p 35.

of employed medical practitioners per head of population was significantly lower in other remoteness areas, with outer regional having the lowest rate (206 full-time equivalent [FTE] medical practitioners per 100,000 population). The number of clinical medical specialists decreased with increasing remoteness (142 FTE per 100,000 for major cities; 24 FTE per 100,000 for remote/very remote areas).⁷

- 2.8 Furthermore, the Overseas Trained Specialist Anaesthetists Network noted that specialist shortfalls were part of a global trend as populations in developed countries continued to age:

... the [Australian] medical sector will more than ever be dependent on Overseas Trained Doctors. This is even more important in the light of an ageing 'baby-boom-generation'. This does not affect Australia alone - the shortfall in the medical workforce can be seen worldwide with a subsequent overall migration of medical practitioners and specialists. Thus Australia competes over medical specialists on a highly competitive market with medically highly developed areas (Canada, United States, Scandinavia, Central Europe etc) with most of them conducting active recruitment and integration programs.⁸

- 2.9 Over the years Commonwealth, state and territory governments have invested in various strategies to address medical workforce shortages. Arrangements that support IMGs to live and work in Australia, is one strategy that has been used to address medical workforce shortages in the short to medium term. In the longer term Australia seeks to become 'self-sufficient' with regard to its medical practitioner workforce by providing more support for education of medical practitioners (such as university places and scholarships) and by providing more training places for general practitioners.

International medical graduates or self sufficiency

- 2.10 As medical workforce shortages became apparent in the mid to late 1990s, Australia began to introduce policies to encourage IMGs to come to Australia to live and work. Since then, Australia has increasingly relied on IMGs to supplement its locally trained workforce, and IMGs make up a

7 Australian Institute of Health and Welfare (AIHW), *Medical labour force 2009*, Bulletin 89, August 2011, p 5, <<http://aihw.gov.au/publication-detail/?id=10737419680&tab=2>> viewed 25 January 2012.

8 Overseas Trained Specialist Anaesthetists Network, *Submission No 38*, p 1.

significant part of Australia's medical workforce, particularly in rural and remote Australia.⁹

2.11 While it is difficult to determine exact numbers, the submission from DoHA indicates that IMGs currently comprise approximately 39% of the medical workforce in Australia and 46% of general practitioners in rural and remote locations.¹⁰ As observed by Rural Health West, which reported that 52% of Western Australia's rural and remote workforces are IMGs, in some areas the proportion of IMGs is significantly higher.¹¹

2.12 Ideally Australia, as an economically developed nation, should have the capacity to become self-sufficient in meeting its medical practitioner workforce needs. Indeed, the World Health Organisation (WHO) global code of practice states that Member States should meet their own health human resources needs as much as possible.¹²

2.13 The Australian Doctors Trained Overseas Association explained the rationale behind the goal for WHO Member States like Australia to aim for self-sufficiency in the development of medical practitioners:

There is a moral responsibility on them to do that because, when it does not happen, the workforce from Third World countries is denuded and they come to Australia.¹³

2.14 Furthermore, as submitted by the Rural Doctors Association of Australia and others, self-sufficiency is also likely to create a far more sustainable system for the recruitment of doctors to rural and regional Australia.¹⁴

2.15 While acknowledging an expected increase in Australian medical graduates, DoHA observed that IMGs were still an integral part of Australia's health workforce, advising the Committee:

We expect that by 2013 we will have almost doubled the number of medical graduates coming on stream through our system. So,

9 See for example: DoHA, *Report on the Audit of Health Workforce in Rural and Regional Australia*, 2008, p 3; Productivity Commission, *Australia's Health Workforce*, Research Report, 2005, p 11.

10 DoHA, *Submission No 84*, p 4.

11 Rural Health West, *Submission No 75*, p 1.

12 World Health Organisation (WHO), *The WHO Global Code of Practice on the International Recruitment of Health Personnel*, para 5.4, p 7, <http://www.who.int/hrh/migration/code/code_en.pdf> viewed 25 January 2012.

13 Dr Jonathan Levy, *Official Committee Hansard*, Canberra, 25 February 2011, p 47. See also: Rural Doctors Association of Australia, *Submission No 80*, p 6; Dr Andrew Pesce, Australian Medical Association (AMA), *Official Committee Hansard*, Canberra, 25 February 2011, p 29; Dr Alasdair MacDonald, *Official Committee Hansard*, Launceston, 14 November 2011, p 17.

14 Rural Doctors Association of Australia, *Submission No 80*, p 2. See also: AMA, *Submission No 55*, p 3.

over the medium-to-longer term, we will have many more Australian graduates, but in the meantime overseas doctors are a very important part of our workforce.¹⁵

- 2.16 However, Dr Rajendra Moodley noted that even with the anticipated increase in domestic medical graduates, it would still take time for them to develop the necessary level of skill and experience and therefore a continued reliance on IMGs is likely for a period of time. As Dr Moodley observed in relation to recent medical graduates:

How is an intern going to do the job of a registrar or of a GP who has been there for many years or of a specialist?¹⁶

- 2.17 Also, while agreeing with this ultimate goal of self-sufficiency, the AMA acknowledged that it would take some time to achieve, saying:

The doctors we are training have not yet emerged to take part in looking after patients and the public and it will be some time before they do. But there is a general recognition in Australia that Australia should be walking [working] towards self-sufficiency so that we are training our own medical workforce.¹⁷

Committee comment

- 2.18 The Committee notes that views on whether Australia's medical workforce has sufficient numbers of appropriately trained and skilled practitioners have varied over the last two decades. Over that period views have changed from an understanding of oversupply, to an understanding of mal-distribution with shortages in some geographical areas or in specific medical specialties, to the current generally held view of universal medical workforce shortages.
- 2.19 Notwithstanding the initiatives promoted by all levels of government, including the provision of additional education and training places to grow the domestically trained workforce, the Committee received a range of comments in relation to the extent of the shortfall. Two key medical workforce issues were raised again and again. These were an inadequate supply of medical practitioners generally, and an uneven geographical distribution of medical practitioners, with workforce shortages remaining acute in some regional areas and particularly in rural and remote locations. Based on the weight of evidence received, the Committee

15 Ms Kerry Flanagan, DoHA, *Official Committee Hansard*, Canberra, 25 February 2011, p 2.

16 Dr Rajendra Moodley, *Official Committee Hansard*, Brisbane, 10 March 2011, p 29.

17 Dr Andrew Pesce, AMA, *Official Committee Hansard*, Canberra, 25 February 2011, p 29.

understands that IMGs are needed to address current workforce shortages and are an integral part of Australia's medical workforce. It appears that IMGs will continue to fulfil this role at least in the short to medium term.

- 2.20 While acknowledging the valuable contribution of IMGs, especially in the provision of medical services to rural and remote communities, the Committee agrees that the development of self sufficiency in producing domestically trained medical personnel should be the target that Australia works towards. Importantly, consideration should encompass the potential for foreign born doctors who have trained in Australia to contribute to meeting domestic workforce needs by providing options which facilitates their working and practising in Australia when they have graduated. In addition, maintaining a sufficiently experienced cohort of IMGs will be critical to ensure that domestically trained medical graduates receive the clinical oversight they need for continued professional development. As observed by Associate Professor Michael Steyn:

Our foreign doctors are our current teachers, let alone our current providers of care. They teach our local students, our local health workers and our local specialist trainees. So it is more than just the provision of health care.¹⁸

- 2.21 Notwithstanding the observations above, the Committee believes that self sufficiency is an achievable goal for Australia, which will need to be facilitated by appropriate medical workforce policy developed in the context of robust workforce planning models. Information on Australia's current medical workforce policy and issues associated with medical workforce planning is presented below.

Australia's medical workforce policy

- 2.22 As noted earlier, governments at national, and state and territory levels have enacted a number of measures to address shortages and uneven distribution of the medical workforce in Australia. In broad terms these measures:

- seek to grow Australia's domestically trained medical practitioner workforce;
- target recruitment of IMGs to live and work in Australia;

18 Associate Professor Michael Steyn, *Official Committee Hansard*, 10 March 2011, p 41.

- encourage medical practitioners (domestically trained and/or IMGs) to work in areas that are difficult to recruit to, either by providing incentives or by placing restrictions on where some practitioners are able to work.¹⁹

2.23 DoHA identifies its role regarding the medical workforce:

... to maximise the possibility that there is an adequate number of health professionals to meet population need, both now and into the future; that the workforce is appropriately distributed and retained to meet the community's needs; and that adequate training and education arrangements are in place to support the continued development of the workforce.²⁰

2.24 In undertaking this role, DoHA administers a range of initiatives to support development of the medical workforce. As regional, rural and remote locations are more likely to experience medical workforce shortages, many of these initiatives form part of DoHA's Rural Health Workforce Strategy. While not a comprehensive review of all programs available under DoHA's Rural Health Workforce Strategy, the following section provides an overview of those programs which specifically target recruitment and retention of IMGs or which may be accessible to IMGs.²¹

Targeted programs

2.25 DoHA's target programs include the International Recruitment Strategy which was established to increase the supply of appropriately qualified IMGs to districts of workforce shortage (DWS) throughout Australia. Under this program funding is provided to Rural Workforce Agencies (RWAs) which assist prospective IMGs to work their way through various aspects necessary for working in Australian general practice, such as visa enquiries, pathways to medical registration, medical registration and skills recognition.²²

19 DoHA, *Submission No 84*, p 3; Parliament of Australia, Parliamentary Library, 'Medical practitioners: education and training in Australia', *Background Note*, July 2009, pp 2–3, <<http://www.aph.gov.au/Library/pubs/BN/2009-10/MedicalPractitioners.pdf>> viewed 25 January 2012.

20 DoHA, *Submission No 84*, p 3.

21 More information on the programs available under DoHA's Rural Health Workforce Strategy is available on the DoctorConnect website <<http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/content/RHWS>> viewed 25 January 2012.

22 DoHA, *Submission No 84*, p 3.

- 2.26 Other targeted initiatives that aim to encourage IMGs to work in DWS locations include non-cash incentive schemes which reduce the usual 10 year period of restricted access to a Medicare provider number that applies to IMGs in Australia.²³ Specifically, Overseas Trained Doctor (OTD) scaling reduces the restriction by up to five years for IMGs who choose to work in a DWS. Alternatively, IMGs may be eligible to participate in the Five Year OTD Scheme, which also reduces the period of restricted access to a Medicare provider number for IMGs who choose to practise in areas that are difficult to recruit to.
- 2.27 The Specialist International Medical Graduate (SIMG) element of the Specialist Training Program (STP) offers training and support for IMGs seeking Fellowship with a specialist medical college. To be classified as a SIMG, IMGs must be assessed by a specialist college as partially or substantially comparable to an Australian trained specialist. The aims of the SIMG element of the STP are to provide training for SIMGs seeking to achieve Fellowship of a specialist medical college in Australia; and support the permanent entry and retention of SIMGs in Australia, in the areas they are most needed, so they can contribute on a long-term basis to the community and the medical workforce.²⁴
- 2.28 DoHA also supports the DoctorConnect website. DoctorConnect provides a range of information about incentives available to work in regional, rural and remote Australia. It also provides a starting point for IMGs and potential employers, assisting them to work their way through the various approval processes leading to entry to the Australian medical workforce.²⁵

Non-targeted programs

- 2.29 IMGs who are permanent residents of Australia may be eligible to access support through the Additional Assistance Scheme. This Additional Assistance Scheme is administered by the RWAs, and was introduced to support increased access to general practitioners for people living in regional, rural and remote communities. The Scheme assists participants by addressing any medical knowledge/clinical deficits to support their efforts in achieving Fellowship with the Royal Australian College of General Practitioners (RACGP) or Australian College of Rural and Remote Medicine (ACRRM).

23 Restriction on access to Medicare provider numbers is legislated under the *Health Insurance Act 1973*. More information on the legislative basis of the restricted access is outlined in Chapter 3 of the report, and issues of concern with these restrictions are considered in Chapter 5.

24 DoHA, *Submission No 84*, p 13.

25 DoHA, *Submission No 84*, pp 11-14.

- 2.30 The General Practice Rural Incentive Program (GPRIP) was established in 2010 to increase the number of rural medical practitioners, GPs and specialists. It does this through the provision of financial incentives grants. While IMGs may be eligible to access some components of the available incentives, eligibility may be limited for IMGs who are not permanent residents or who are still subject to the 10 year period of restricted access to a Medicare provider number.²⁶
- 2.31 IMGs may also be able to access support through distance education and intensive training through the Rural Vocational Training Scheme (RVTS). The RVTS is a vocational education and training program in general practice that provides a pathway to Fellowship of RACGP or ACRRM. Unlike the Additional Assistance Scheme, the RVTS is open to IMGs who are temporary residents, though priority is given to permanent residents.
- 2.32 The Rural Locum Relief Program is also available to IMGs who are permanent residents and is designed to provide access to Medicare benefits for temporary placements in rural general practice or Aboriginal medical services.²⁷

Other initiatives

- 2.33 In addition to the programs described above, DoHA also funds Rural Health Workforce Australia (RHWA). RHWA is responsible for managing national programs to address the shortage of doctors and other health workers in rural and remote communities, including the recruitment of IMGs.²⁸ RHWA is also the peak body for the seven Rural Workforce Agencies (RWAs) which are not-for-profit organisations funded by DoHA, as well as their respective state governments.²⁹ The RWAs are primarily responsible for recruitment and provision of professional support services for medical practitioners in their jurisdictions, with an aim to increase the number of doctors in rural and remote communities across Australia.³⁰ RHWA, through the RWAs, is responsible for implementing programs including:

- the International Recruitment Strategy;

26 Health Workforce Queensland, *Submission No 44*, p 5.

27 DoHA, *Submission No 84*, pp 11-14.

28 Rural Health Workforce Australia (RHWA), *Submission No 107*, p 2.

29 The seven Rural Workforce Agencies are: General Practice Network NT Ltd; Health Workforce Queensland; NSW Rural Doctors Network Australia; Rural Workforce Agency, Victoria; Health Recruitment Plus Tasmania; Rural Doctors Workforce Agency; and Rural Health West.

30 RHWA, *Submission No 107*, p 6.

- the five year OTD scaling scheme;
 - the Rural Vocational Training Scheme; and
 - the Rural Locum Relief Program.³¹
- 2.34 Another significant initiative is the establishment in 2001 by the then Minister for Health and Aging of General Practice Education and Training Limited (GPET). GPET, a wholly owned Commonwealth company, was established to oversee and fund regionally based vocational education and training in general practice for medical graduates. GPET operates a system of general practice education and training, delivered through 17 regional training providers (RTPs) across Australia.³² GPET manages the Australian General Practice Training (AGPT) program and the Prevocational General Practice Placements Program (PGPPP) programs.³³
- 2.35 Under the AGPT program, registrars (including IMGs who have permanent Australian residency) may undertake vocational training in accordance with the curriculum and standards relevant to their chosen college vocational training pathway. The PGPPP (also accessible to IMGs who have permanent Australian residency) is a prevocational training program that enhances junior doctors' understanding of primary health care and encourages them to take up general practice as a career.³⁴

State and territory governments

- 2.36 While it is beyond the scope of this report to provide a comprehensive overview, state and territory governments also support a range of initiatives to address medical practitioner workforce shortages by recruiting IMGs. As noted previously, state and territory governments contribute to the funding of RWAs which provide recruitment and professional support for medical practitioners, including IMGs seeking employment and registration in Australia.
- 2.37 State and territory governments are also responsible for identifying Areas of Need (AoN). Although methods of defining them vary between

31 RHWA, Rural Locum Relief Program, <<http://www.rhwa.org.au/site/index.cfm?display=163785>> viewed 25 January 2012.

32 For a complete list of programs see: General Practice Education and Training, Training Providers, <<http://www.gpet.com.au/TrainingProviders/TrainingProviderLinks/>> viewed 2 February 2012.

33 General Practice Education and Training Limited, *Submission No 119*, p 2.

34 DoHA, General Practitioners, Prevocational General Practice Placements Program, <<http://www.health.gov.au/internet/main/publishing.nsf/Content/work-pr-pgppp>> viewed 25 January 2012.

jurisdictions, essentially AoN is a location in which there is a lack of specific medical practitioners or where there are medical positions that remain unfilled even after recruitment efforts have taken place over a period of time. Importantly, AoNs are not confined to regional, rural or remote locations but also encompass metropolitan and outer metropolitan locales. To address workforce shortages, eligible IMGs are offered options to accelerate their accreditation and apply for Limited Registration to enable them to practice in AoN locations or positions while working concurrently to obtain full Australian medical registration. More information on the options and processes available to IMGs pursuing AoN position is provided in Chapter 3 of the report.

Medical Workforce Planning

- 2.38 As noted earlier, assessing medical workforce needs is complex. Over the last 30 years views of the adequacy of the medical workforce have ranged from concerns of over-supply to concerns of mal-distribution and finally workforce shortages. It appears that actions taken in the past to restrict the flow of doctors into Australia had the unintended consequence of creating a larger shortfall than desirable, which has led to the need to recruit large numbers of IMGs to meet demand. Dr Paul Mara, President of the Rural Doctors Association of Australia told the Committee:

My understanding of the workforce over the past 28 years is that you do tend to reach a flip-flop scenario so that changes occur very rapidly and the systems do not catch up with that for a period of time after it. So for many years we were seen as having an oversupply of doctors and a misdistribution in the country and then very rapidly we all of a sudden have an undersupply in both the city and the country.³⁵

- 2.39 Robust workforce planning models are crucial if Australia is to meet its current and future medical workforce needs. Effective workforce planning needs to take into account a number of factors which will influence population demands for medical services and the supply of medical practitioners to deliver these services. Factors which will influence demand for medical services and the supply of medical practitioners to deliver them include:

35 Dr Paul Mara, Rural Doctors Association of Australia, *Official Committee Hansard*, Canberra, 31 May 2011, p 2.

- demographic trends and changing population distributions;
- changes in the burden of disease, including an increased prevalence of chronic diseases associated with an ageing population;
- technological and medical advances, coupled with higher health care expectations from consumer;
- the number of Australian medical graduates and IMGs entering the workforce;
- the availability of supervised placements Australian medical graduates and IMGs;
- retirement of current medical practitioners associated with an ageing workforce; and
- changes to working patterns, including a trend to lower average weekly working hours.³⁶

2.40 Clearly medical workforce planning is a complex undertaking. As observed by the National Rural Health Alliance (NRHA):

Medical workforce numbers are affected by a complex array of factors - many of which lie outside the control of policy makers and planners. Further complexity is added by the reality that it takes approximately 13 years to train a fully qualified medical practitioner. As a result, medical workforce planning will never be an exact science.³⁷

2.41 The difficulty associated with developing robust models and assessment tools for workforce planning is amplified by substantial gaps and inconsistencies in national medical workforce data. As observed by Mrs Martina Stanley, Director of Alecto Australia:

The other issue is around [workforce] research and data. ... When you start looking at the little bit of data that we have it is actually highly unreliable because of the way that it is collected. Different bits of data, whether it is AIHW, Medicare or whatever, all use different criteria for collecting the data, so you cannot put it back together again and then use it for anything useful because basically you are comparing apples with oranges.³⁸

36 Productivity Commission, *Australia's Health Workforce*, Research Report, 2005, pp10-11.

37 National Rural Health Alliance (NRHA), *Submission No 113*, p 6.

38 Mrs Martina Stanley, Alecto Australia, *Official Committee Hansard*, Melbourne, 18 March 2011, p 34.

COAG and medical workforce planning

- 2.42 Responsibility for Australia's health workforce is shared by the Commonwealth, state and territory governments. In brief, the Australian Government is principally responsible for policy relating to, and funding of, university education for medical students. State and territory governments are largely responsible for the delivery of health services and are major employers and trainers of medical practitioners, primarily through the public hospital system. In view of this shared responsibility for health workforce planning, the Council of Australian Governments (COAG) has played a key role.
- 2.43 In 2004, COAG's Australian Health Ministers' Conference (AHMC) developed its National Health Workforce Strategic Framework.³⁹ The Framework established a 10 year plan to address Australia's health workforce needs based on the following seven principles:
- achieving and sustaining self-sufficiency in health workforce supply;
 - workforce distribution that optimises access to health care and meets the health needs of all Australians;
 - health environments being places in which people want to work;
 - ensuring the health workforce is always skilled and competent;
 - optimal use of skills and workforce adaptability;
 - recognising that health workforce policy and planning must be informed by the best available evidence and linked to the broader health system; and
 - recognising that health workforce policy involves all stakeholders working collaboratively with a commitment to the vision, principles and strategies outlined in this framework.⁴⁰
- 2.44 In 2006 COAG established the National Health Workforce Taskforce (NHWT) to undertake projects to inform the development of practical solutions on workforce innovation and reform. Specifically the NHWT was to develop health workforce strategies encompassing:

39 Australian Health Ministers' Conference, *National Health Workforce Strategic Framework*, April 2004, <<http://www.ahwo.gov.au/documents/National%20Health%20Workforce%20Strategic%20Framework/AHMC%20National%20Workforce%20Strategic%20Framework%20004.pdf>> viewed 25 January 2012.

40 Australian Health Ministers' Conference (AHMC), *National Health Workforce Strategic Framework*, April 2004, p 14. See also: Tropical Medical Training, *Submission No 114*, p 6.

- planning, research and data;
- education and training; and
- innovation and reform.⁴¹

2.45 The work of the NHWT was overseen by the Health Workforce Principal Committee (HWPC), the Australian Health Ministers' Advisory Council's principal advisor on national health workforce policy and strategic priorities. The NHWT was a time limited, project based entity which ceased operation with the establishment of Health Workforce Australia (HWA). HWA is in the process of assuming NHWT activities as part of its broader work program.

Health Workforce Australia

2.46 In late 2008, under the National Partnership Agreement on Hospital and Health Workforce Reform, COAG announced that it would establish HWA to manage and oversee major reforms to the Australian health workforce.⁴² In 2010 HWA commenced operation as a statutory authority reporting to the Australian Health Ministers' Conference (AHMC).⁴³ According to its mission statement HWA's organisational objective is:

To facilitate more effective and integrated clinical training for health professionals, provide effective and accurate information and advice to guide health workforce policy and planning, and promote, support and evaluate health workforce reform.⁴⁴

2.47 In addition to assuming the work of the former NHWT, COAG announced the following major reforms which HWA will manage and oversee:

Increasing Supply

- Improving the capacity and productivity of the health sector to provide clinical education for increased university and vocational education and training places.
- Facilitating immigration of overseas trained health professionals and continuing to develop recruitment and retention strategies.

Reforming the Workforce

41 Australia's Health Workforce Online, National Health Workforce Taskforce, <<http://www.ahwo.gov.au/nhwt.asp>> viewed 25 January 2012.

42 Health Workforce Australia (HWA), <<http://www.hwa.gov.au/>> viewed 25 January 2012.

43 See *Health Workforce Australia Act 2009*.

44 HWA, <<https://www.hwa.gov.au/about/mission-statement>> viewed 25 January 2012.

- System, funding and payment mechanisms to support new models of care and new and expanded roles.
- Redesigning roles and creating evidence based alternative scopes of practice.
- Developing strategies for aligned incentives surrounding productivity and performance of health professionals and multi-disciplinary teams.⁴⁵

2.48 Since commencing operation HWA has developed a work plan for 2011-12. In general terms, activities being undertaken as part of HWA's 2011-12 work plan are aimed at improving Australia's ability to more effectively manage medical workforce issues. The work plan identifies a number of projects to be progressed under the following four priority areas:

- information, analysis and planning - including analysis of supply and demand trends to inform decision making on a range of workforce policy and program matters;
- clinical training reform - improving and expanding access to quality clinical training for health professionals in training across the public, private and non-government sectors;
- workforce innovation and reform - encouraging the development of health workforce models which will support new models of healthcare delivery and equip health professionals and employers to meet emerging healthcare demands; and
- international health professionals - developing a coordinated national approach to the recruitment and retention of international health professionals to work in Australia's public and non-government health sectors.⁴⁶

2.49 Projects being progressed under the information, analysis and planning work program include:

- a national training plan which aims to provide a set of planning objectives for training of health professionals, including doctors, to achieve self sufficiency by 2025; and
- a national statistical resource which aims to develop a national health workforce dataset, including registration and workforce survey data from the Australian Health Practitioners Registration Authority (AHPRA). The dataset will be used to develop an improved

45 Australia's Health Workforce Online, Recent COAG Reforms, <<http://www.ahwo.gov.au/coag.asp>> viewed 25 January 2012.

46 HWA, *Annual Report 2010-11*, pp 20-32.

understanding of the health workforce. Access to more robust data will also contribute to the development and application of a National Health Workforce Planning Tool.

- 2.50 Action to address health workforce shortages under the clinical training reform work program is being progressed through:
- the Clinical Training Funding Subsidy program which aims to address health workforce shortages by providing subsidies to increase the number of clinical training places for health professional students, including medical students; and
 - the Clinical Supervision Support program which aims to enhance post-graduate supervision capacity for a number of health professions, including doctors, by offering measures to support and develop a competent clinical supervision workforce.
- 2.51 The workforce innovation and reforms work program has been informed by HWA's National Health Workforce Innovation and Reform Strategic Framework for Action 2011–2015 (the Framework). The Framework, which was developed on the basis of research and consultation is intended to:
- ... provide an overarching, national platform that will guide future health workforce policy and planning in Australia. It sets out key priority areas and five essential domains that create the foundation for an integrated, high performing workforce fit to meet Australia's health care needs.⁴⁷
- 2.52 The five domains for action under the Framework are:
- health workforce reform for more effective, efficient and accessible service delivery;
 - health workforce capacity and skills development;
 - leadership for the sustainability of the health system;
 - health workforce planning; and
 - health workforce policy, funding and regulation.⁴⁸
- 2.53 The Regional, Rural and Remote Health Workforce Innovation and Reform Strategy complements the Framework. This strategy aims to
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47 HWA, *National Health Workforce Innovation and Reform Strategic Framework for Action 2011–2015*, p 1.

48 HWA, *National Health Workforce Innovation and Reform Strategic Framework for Action 2011–2015*, p 14.

promote better use of the existing workforce and will also work to build workforce capacity to respond and adapt to the changing demands of rural and remote communities.⁴⁹

- 2.54 HWA completed an initial consultation process in late 2010 to inform the development of a National Strategy for International Recruitment (the National Strategy). The aim of the National Strategy is to provide a nationally consistent approach to the recruitment and retention of international health professionals, including doctors.
- 2.55 To complement the National Strategy's aim of developing a consistent and coordinated approach to international recruitment of health professionals, the HWA's work plan also supports a project to establish a single website portal under its International Health Professionals Website Development Project.

Committee comment

- 2.56 It is clear to the Committee that health workforce planning is crucial if governments are to implement health workforce policies which ensure that the supply and distribution of medical practitioners is appropriate to meet community healthcare needs and expectations. Current workforce policies have been influenced by the continuing need for IMGs to supplement the domestically trained medical practitioner workforce.
- 2.57 Evidence to the inquiry suggests that current workforce planning assessment tools have failed to adequately account for the range of dynamic factors which can influence supply and demand. Limitations on workforce planning models have been exacerbated by significant deficiencies in national workforce data. While the Committee acknowledges the complexities of health workforce planning, particularly in a dynamic environment, the Committee considers that there is definite scope for improvement.
- 2.58 The Committee is pleased to note that the Australian Government, through COAG, in association with its state and territory counterparts, has already taken steps to address the deficiencies in workforce planning with the establishment of HWA. Although HWA has only been in operation since 2010, the Committee is encouraged by progress made to date in relation to HWA's work plan. In particular, the Committee notes the progress on projects to improve the access to robust national health

49 HWA, *Annual Report 2010-11*, p 27.

workforce data and to develop more sophisticated workforce planning models.

- 2.59 The Committee notes that there are a number of HWA programs which aim to address medical workforce shortages by increasing education and training opportunities, with the ultimate goal of achieving health workforce self sufficiency in Australia by 2025. Although supportive of this goal in principle, the Committee has already observed that in the short to medium term Australia needs to rely on IMGs to address current medical workforce shortages. In view of this the Committee supports a national approach to recruitment and retention of IMGs currently being considered under HWA's National Strategy for International Recruitment.