



Australian Health Ministers' Conference (AHMC) Health Workforce Principal Committee

Emerging/Priority Health Workforce Issues (Attachment D)

Table	Issue	Solutions	Recommendation/Responsibility
1	Models of service delivery. Primary care (care for people living longer, more actively with chronic disease in community)	<ul style="list-style-type: none"> ○ Promote team based care ○ Referrals between professions ○ Locate close to population sectors ○ Supervised and coordinated ○ Use technology to enhance team capability ○ Encourage professions to optimise capabilities ○ Recognition of generalist practitioner 	<ul style="list-style-type: none"> ○ Train professionals to understand capability of other professions ○ Remove funding barriers ○ Incentives for working in rural sector and community
	Clinical Training <ul style="list-style-type: none"> ○ Undergrad ○ U/grad placement ○ In term placement ○ Specialist training ○ Professionals who are training now 	Link universities to professions and major provider Build quality students: <ul style="list-style-type: none"> ○ Clinical teaching ○ Clinical supervision/assessment ○ Private/public sectors ○ Simulation/technology ○ Goals/objectives ○ Clinical placements ○ Equitable access 	<ul style="list-style-type: none"> ○ Funding for private and public sector training is crucial ○ Debate needed for specialists vs. generalists ○ Build clinical training into Australian Health Care Agreement (AHCA)

	Reliable data to underpin decisions	<ul style="list-style-type: none"> ○ Commission studies within each profession to provide benchmarks ○ Demographic data with system issues 	<ul style="list-style-type: none"> ○ Ensure sufficient detail to be useful in all sectors ○ HWPC/AIHW
	Workforce Retention and Location	<ul style="list-style-type: none"> ○ Develop more re-entry courses for all professions ○ Improve flexibility in types of work ○ Improve career pathways ○ Access to up-skilling ○ Recognition of generalist practitioners 	States and Territories
	Overseas Trained Practitioners Increasing Globalisation	<ul style="list-style-type: none"> ○ Support structures ○ Need to be across all professions ○ Build greater self sufficiency 	
	“grab for rights” by one profession over another e.g. prescribing rights	<ul style="list-style-type: none"> ○ See solutions under “Models of Service Delivery (Point 1) ○ Introduce team based treatment and referrals between professions 	
	Access to health services in all communities	<ul style="list-style-type: none"> ○ Increase access to funding for all professionals e.g. Pharmaceutical Benefits Scheme (PBS), mutual rights 	

2	<p>Stronger mechanisms needed for training for health professionals in more diversified private and community settings – i.e. aged care facilities in relation to intensive care needs</p>	<ul style="list-style-type: none"> ○ Explore alternative models including alternative funding mechanisms to better utilise private/community sectors ○ Better use of simulation training methods ○ Develop training for those who train others 	<ul style="list-style-type: none"> ○ Joint health and education responsibility to develop KPIs dealing with safety, quality and performance which can be agreed by both and then underpin the placements in private and community settings. ○ KPIs could also be developed to determine appropriate and innovative models of clinical placement including the use of simulators. ○ New licensing and accreditation body should explore definition of clinical placement
	<p>What planning is in place to develop new and emerging health workforce roles and responsibilities i.e. physician assistant and utilisation of broader health workforce including Vocational and Technical Education (VTE) Sector</p>	<ul style="list-style-type: none"> ○ Development of a coordinated approach to more debate about realignment of roles into practice. In doing this a balance would need to be achieved between imposing changes and bringing these into practice with agreement of relevant professional bodies and other stakeholders ○ Universities should also be engaged in this process to ensure graduates of new courses being developed have practical skills with practical applications 	<ul style="list-style-type: none"> ○ COAG central accreditation and registration bodies ○ Professional bodies and unions ○ A pilot of expanded roles and evaluation by relevant bodies

3	Safety and Quality	<ul style="list-style-type: none"> ○ National Accreditation and Registration (NAR) ○ Competency ○ Evidence-based practice ○ Maintenance of quality – registration? ○ Inclusion of all health disciplines ○ Collaboration 	
	Sustainability <ul style="list-style-type: none"> - Finance - Scope of Practice 	Career path – job satisfaction	
	Recruitment and Retention	<ul style="list-style-type: none"> ○ Collaboration of all sectors – health and education ○ Creating job satisfaction and supporting rural community lifestyles 	
	Primary Health Care <ul style="list-style-type: none"> ○ Changing population expectations ○ Breaking down the current bio-medical model and funding arrangements ○ More capital into prevention 	More multidisciplinary approach based on client and community needs.	Move to a new paradigm of health care
	Clinical education and placements	<ul style="list-style-type: none"> ○ Exploring different models ○ Examining who is responsible ○ Creating realistic and diverse access ○ Changing the present paradigm 	
	Maldistribution of workforce and health care delivery Metro vs. rural and remote	As per number 3 Support lifestyles <ul style="list-style-type: none"> ○ Family ○ CPD 	

4	Clinical Placements <ul style="list-style-type: none"> o Number o Funding o Quality o Support 	Clarity of role delineation for responsibility for placements on establishment of single body/system to manage placements	HWPC/Taskforce
	Data Collection and Access <ul style="list-style-type: none"> o Current and future trends o Supply and demand o Participation 	Agreement of all parties to essential questions and data set to provide answers and consistency of definitions over time (integrate in new registration/accreditation system)	Taskforce
	Fragmentation between training funding and health service delivery	Integrate effort through transparent funding mechanisms conjoined with AHCAs	HWPC
	Short term output focus on long term patient care focus	Longitudinal monitoring of service outcomes of workforce development to inform curriculum development	
	Workforce not equipped to meet emerging needs and models of care (chronic disease/early intervention)	Mix of placements and training structures and better alignment of community and workforce needs with training programs including international approaches	
	Maldistribution of workforce	<ul style="list-style-type: none"> o Provision of training in areas of need to attract students o Support programs to retain workforce in areas of need 	
5	"BIG picture" workforce issues	<ul style="list-style-type: none"> o Adopting principle of looking at patient and population service needs o Changing funding arrangements to patient care packages 	All stakeholders including COAG

	More efficient use of professional time	<ul style="list-style-type: none"> ○ Expanded scope or context for existing roles and new health workforce roles ○ Amend legislation to keep pace with change 	Government and professional bodies, industrial associations, educational institutions etc
	Entrenched professional cultures	Properly managed and resourced change process including organisational change	All stakeholders
	Prevention and care for chronic disease (patients)	<ul style="list-style-type: none"> ○ Multidisciplinary patient plan and self management philosophy ○ Health worker cultural change to primary care focus 	All stakeholders
	Professional and jurisdictional barriers to new roles	National registration with assurance of maintenance of quality outcomes	All stakeholders Professional bodies Industrial relations bodies Safety & Quality (S&Q) Commission
	Quantity and quality of supervised clinical placements Funding of clinical training	<ul style="list-style-type: none"> ○ Training/accreditations for clinicians to participate in clinical education ○ Simulation models of clinical education ○ Ensure all trainees are exposed to the full range of conditions ○ Deregulated funding – attached to student not paid to facility 	<ul style="list-style-type: none"> ○ Universities ○ Government ○ Education and Health Sectors work together
6	Workforce projections linked to community needs (tension service/workforce planning)	<ul style="list-style-type: none"> ○ Good data – make public ○ Recognise planning guide rather than absolute – flexible ○ Education and Training 	<ul style="list-style-type: none"> ○ Do not lose AMWAC/AHWAC targets ○ Adequately fund clinical education and training (whole workforce) ○ Ensure delivered result for community – KPI to measure

Workforce redesign	<ul style="list-style-type: none"> ○ Determine patient/community need ○ Staffing level or design ○ Fund different service delivery models ○ Change education – undergrad 	<ul style="list-style-type: none"> ○ Professional collaboration ○ Involve community/consumers in discussions ○ Collaboration in work and training
Community expectation “need to see a doctor” Want technology.....	Community education of what is possible vs. expectations	Clarity around expectations
Recruitment and retraining in changing environment	<ul style="list-style-type: none"> ○ Different salaries in private/public sector ○ Acknowledge working conditions not just \$ (recognition, satisfaction) 	<ul style="list-style-type: none"> ○ Measure churn and manage data (CEO KPI) ○ Flexible employment ○ Who is doing it well and share
Universities providing places based on \$ not on community needs	<ul style="list-style-type: none"> ○ Use \$ as lever ○ Reduce debt on graduates ○ Funding post graduate education options ○ Consultation before introducing/ceasing courses 	Question self accreditation
Overseas Trained Professionals	Hold over to next session	
Demise of public sector while private sector flourishes	<ul style="list-style-type: none"> ○ Once turn private hospital into public hospital – efficiency ○ Support public sector to provide additional places/training 	<ul style="list-style-type: none"> ○ Tread carefully ○ Involve community (equity) ○ Keep public system “gold standard in health education and training”

7	Lack of national approach and leadership that links workforce requirements, training and standards of practice. Flexibility, role substitution, supply of health practitioners whilst maintaining patient safety.	<ul style="list-style-type: none"> ○ Workforce redesign where there is collaboration between tertiary providers, health service industry, registration bodies and other state holders across Education and Health ○ Look at competency models as per VTE Sector ○ Retention of health professionals as a priority 	<ul style="list-style-type: none"> ○ COAG create a leadership – (active) on the issue through AHMC/MCEETYA via HWPC. ○ Explore link between role design and retention particularly in allied health which can get cursory attention but is crucial
	<ul style="list-style-type: none"> ○ Distribution and access (equitable) to health services. ○ What is the benchmark for health needs in any given population? 	<ul style="list-style-type: none"> ○ Population needs based approach should be adopted ○ Lack of area based health planning that addresses health needs of a particular population 	<ul style="list-style-type: none"> ○ Move beyond OTDs model of restricting practice to certain areas to ALL health service provisions ○ Need for modelling for allied health as well as medical services in this area
	Clinical placements – insufficient placements in many professions	<ul style="list-style-type: none"> ○ Placement opportunities/models need to be diversified to reflect the changes in health workplaces ○ Best practice clinical education needs to be defined and funded and updated 	<ul style="list-style-type: none"> ○ Best practice model require ○ Consistent equitable principles for the funding and supply of clinical education not placements

	<ul style="list-style-type: none"> ○ Maintenance of professional competence ○ equity across health professions ○ where does the fund come from ○ access to CPD 	<ul style="list-style-type: none"> ○ Need to develop understanding of what changes and improves practice via CPD ○ Data collection and analysis of health complaints to help define evidence based CPD ○ Nursing may be a model to look at to develop a model of progression, accrediting of previous learnings that addresses scope of practice ○ This must be across all health professions 	A framework like the National Quality Framework (NQF) needs to be implemented across all health professions
	<ul style="list-style-type: none"> ○ Articulation between VTE Sector and tertiary sector ○ Issue of movement of health practitioners from VTE Sector training to degree level training ○ Break down barriers to full scope of practice 		
	<ul style="list-style-type: none"> ○ Funding models (restrictions) ○ Remove barriers to effective consumer outcomes 	Remove barriers to efficient practice where Medicare is hit for increased cost and the patient suffers	Improve health care dollars usage so that practitioners can treat via MBS and PBS
8	<ul style="list-style-type: none"> ○ Scope of practice change ○ Generic response to workforce change ○ Not sufficient training 	<ul style="list-style-type: none"> ○ Regulation ○ Collaboration between education and provider service ○ Substitution, evolution. Delegation ○ Supervision ○ Technology ○ Facilitation of team 	<ul style="list-style-type: none"> ○ Education of technicians reviewed ○ Uni and VTE Sector ○ CPD
	Mismatch between workforce and education drivers	<ul style="list-style-type: none"> ○ Policy alignment ○ Engagement 	Consultation processes appropriate

	<ul style="list-style-type: none"> ○ Workforce distribution ○ Country shortages (include outer suburban) 	<ul style="list-style-type: none"> ○ New roles ○ Infrastructure development/support ○ Fund placements ○ Integration of practice ○ Rural placement part of programs 	<ul style="list-style-type: none"> ○ Improved technology use ○ Student debt incentives ○ Rural/remote practice clinics
	<ul style="list-style-type: none"> ○ Impact of litigation ○ Risks to clinical practice ○ Regulation/compliance 	<ul style="list-style-type: none"> ○ Best practice guidelines 	
9	Workforce shortages	<ul style="list-style-type: none"> ○ Better marketing of health careers (undergraduate and re-entry) ○ Multidisciplinary learning/vertical integration (multidisciplinary and flexible) ○ Supportive work environment (culture) 	<ul style="list-style-type: none"> ○ Commonwealth ○ State Governments ○ Professions ○ Education Sector
	Health as a driver for education programs	<ul style="list-style-type: none"> ○ Strengthening current mechanisms (MCEETYA) to influence curricula and university places 	<ul style="list-style-type: none"> ○ AHMAC/AHMC ○ MCEETYA ○ (Ministers and Advisory Bodies)
	Clinical Placements	<ul style="list-style-type: none"> ○ Expand clinical placements into all sectors eg. Community and private sectors ○ Transparency of costs for clinical training model 	HWPC to coordinate
	Role evolution and workforce redesign	<p>Cost benefit approach based on:</p> <ul style="list-style-type: none"> ○ Patient access/community need ○ Safety and quality ○ Workforce satisfaction (see 1) 	<ul style="list-style-type: none"> ○ HWPC in conjunction with stakeholders (see 2)

	Technology supporting practice	<ul style="list-style-type: none"> ○ Use of technology as a lever for multidisciplinary approach ○ Enhancing access ○ Facilitating innovative training approaches ○ Extending care settings ○ Safety and quality 	<ul style="list-style-type: none"> ○ Health Workforce Taskforce to research and coordinate existing efforts of health and external to health – HWPC
	Patient centric workforce redesign	<ul style="list-style-type: none"> ○ Research to underpin workforce redesign will also include a better understanding of community preferences for the health system 	Community jury style approach
10	Lack of coordination between health sectors and the universities and the VTE sector	<ul style="list-style-type: none"> ○ Structured engagement to support AHMC/MCEETYA discussions that involves universities and VTE sector providers 	AHMAC/MCEETYA
	Inadequate progress in addressing the workforce implications of adequate provision of Indigenous health	<ul style="list-style-type: none"> ○ Operationalise existing successful pilot projects through awareness and realigning funding 	
	Register Training Organisations (RTO's) require an education model which supports the provision of multidisciplinary care	<ul style="list-style-type: none"> ○ Fund pilot studies to identify projects to demonstrate innovation and excellence in multidisciplinary education (driven by national accreditation and registration) 	
	Lack of structures and processes which support retention in the health workforce and return to work	<ul style="list-style-type: none"> ○ Retraining and re-entry processes need to improve ○ Workplace child care needs to improve 	
	Lack of consistency, timeliness and robustness in workforce data across all health professions	<ul style="list-style-type: none"> ○ Priority on data – collection, analysis and reporting to inform future policy 	

	Lack of capacity to support clinical training across an equitable range of settings – eg. outer urban, rural and remote and private sector	<ul style="list-style-type: none"> ○ Need better understanding of constraints to use of broader settings ○ Identify, fund and support to overcome this ○ Determination of short, medium and long term goals and targets 	
11	Supply of medical specialist in jeopardy because of lack of funded registrar positions or lack of sufficient trainees	<ul style="list-style-type: none"> ○ Funding ○ Encourage training pathways to particular specialties in shortage ○ Review training models 	<ul style="list-style-type: none"> ○ Government – funding ○ Medical Colleges ○ Universities
	Lack of quality supervised clinical placements across health disciplines	<ul style="list-style-type: none"> ○ Partnerships between governments, universities, health services ○ Provide support for students ○ Recognise clinical supervision is an additional load on staff and support them ○ Solutions may need local focus 	<ul style="list-style-type: none"> ○ Government ○ Universities ○ Health services
	Re-examine the right roles for effective patient care with a view to best use of professional skills and appropriate substitution/delegation – then look at the right funding model	<ul style="list-style-type: none"> ○ Lack of flexibility in use of workforce ○ Professional silos 	
	Maldistribution of health workforce – rural and remote shortages	<ul style="list-style-type: none"> ○ Encourage local solutions to attract health staff or support re-entry of rural non-prescribing people ○ Funding models – support telemedicine, secondary consultation, videoconferencing ○ Rural clinical and rural scholarships ○ Funding models 	<ul style="list-style-type: none"> ○ No easy solutions ○ Government ○ Universities

	Failure to make best use of available resources	<ul style="list-style-type: none"> ○ Facilitate re-entry programs ○ Facilitate access to programs for overseas trained staff ○ Make enough educational programs available for re-entry ○ Support local capacity for solutions 	<ul style="list-style-type: none"> ○ Largely federal government ○ Universities – provision of re-entry programs ○ Medical speciality colleges
	Changing models of education – graduate entry, increased time of training, age of graduates	<ul style="list-style-type: none"> ○ Ensure plenty of clinical training ○ Monitor outcomes ○ Flexible module approach at Bond University – cross discipline ○ Encourage cross discipline 	Universities
	Recognition of prior learning – people moving between health disciplines should not go back to the start	<ul style="list-style-type: none"> ○ Good processes – make them a requirement 	
	Work- life balance and greater female participation are good things but reduce availability of the workforce	<ul style="list-style-type: none"> ○ Models of service delivery ○ Role re-design ○ Best use of skills ○ Accreditation models need to be flexible 	<ul style="list-style-type: none"> ○ Government ○ Health Services
12	Role expansion: some professionals like nurse practitioners, midwives not able to work to their full scope of practice	<ul style="list-style-type: none"> ○ Allowing health professionals who are currently limited in scope to be able to work to their full scope ○ Indemnity, law reform ○ Align funding models to support the practice of all health professionals doing this ○ Innovation 	<ul style="list-style-type: none"> ○ Better support and implementation of extended roles – i.e. more positions for Nurse Practitioners (NP) in States ○ Better support for innovative models of care and scope of practice that have sound demonstrable outcomes ○ Implementation

	The importance of data. Predictive workforce modelling needs to reflect community needs	<ul style="list-style-type: none"> ○ Identify gaps in data and better analysis of existing data ○ Better use of models of care data 	<ul style="list-style-type: none"> ○ That gaps be identified and addressed ○ More analysis of existing data and linking of data
	Lack of implementation of successful innovative pilots especially in relation to models of care	<ul style="list-style-type: none"> ○ Evaluation has deemed models successful but there must be a commitment to implementation 	<ul style="list-style-type: none"> ○ A greater focus in policy development on evidence based health care (use of safety and quality criteria etc)
	Increasing clinical placements – moving training into the private sector and other settings	<ul style="list-style-type: none"> ○ Money should follow individual trainees – need to clarify funding models ○ Safety and quality issues – how can this be achieved with existing workforce shortages ○ Need to “train the trainers” to do this 	<ul style="list-style-type: none"> ○ Need well defined processes and supervision training programs; time for supervisors must be reimbursed
13	<p>Maldistribution</p> <ul style="list-style-type: none"> ○ Geographical settings ○ Mismatch of population and services 	<ul style="list-style-type: none"> ○ Root cause analysis – what, where and why ○ Flexible solutions <ul style="list-style-type: none"> ○ Location ○ Service e.g. telehealth ○ Workforce ○ Resources 	The HWPC drawing on expertise/advice from community, service providers, professional bodies

	<p>Sufficient, competent, safe workforce</p> <ul style="list-style-type: none"> ○ Supply ○ Retention 	<ul style="list-style-type: none"> ○ Professional and personal support ○ Unrealistic expectations of graduates ○ Skills articulation/ Recognised Prior Learning (RPL) ○ Better utilisation of VTE sector qualifications ○ Development of education programs collaboratively – industry, employer, professional bodies, regulators 	
	Changing health service delivery system	<ul style="list-style-type: none"> ○ Collaborative training ○ Innovative access models ○ Tailor fit of delivery systems to community needs 	Jurisdictions
	Waste, lack of cohesion and clarity in the funding and regulation of the health care delivery systems – e.g. public/private, Commonwealth/State, Medical/Health Funds, PBS/non PBS		
14	Gold standard or universal standard	Parallel systems needed at least in the short term	= accept costs Inefficiencies
	Who projects new patients demands	<ul style="list-style-type: none"> ○ We all need to work together and all take blame (or glory) 	Multi-jurisdictional approach
	Closing the gaps	<ul style="list-style-type: none"> ○ Greater efficiencies from current system ○ Recruitment and retention ○ New clinical roles ○ New models of education 	State/Commonwealth

Market forces for fast change	<ul style="list-style-type: none"> ○ Student demand vs. patient need for workforce ○ Small group vs. large groups ○ Rural vs. metro ○ Private vs. public ○ Clinicians vs. paid teachers 	Need specific incentives
Modular flexible training to blur the workforce boundaries	<ul style="list-style-type: none"> ○ Proactive approach to developing capacity – not wait until standards must be compromised by change 	<ul style="list-style-type: none"> ○ State, College and University collaboration
Change management strategy needed	<ul style="list-style-type: none"> ○ Clinical ○ Community ○ Industry <p style="text-align: center;">Expectations ↓ Education need</p>	<ul style="list-style-type: none"> ○ Increase funding to reduce the “losers” ○ Accept discomfort as normal
Do we want to reduce disparity or increase international quality – competing workforce needs	<ul style="list-style-type: none"> ○ We want a country that is fair. ○ Health for all people is more important than Nobel prize winners 	<ul style="list-style-type: none"> ○ Realistically, don’t think we are ready so need to accept inherent costs – inefficiencies of dual systems
Redefining what we need – who gets to decide? (and takes responsibilities for funding and long term outcome)	<ul style="list-style-type: none"> ○ Database of projected needs ○ (population, demographic, disease, technology, clinical models of care, consumer expectations) 	<ul style="list-style-type: none"> ○ COAG – style approach ○ Include social determinants and education strategies
Who needs to provide what service, where?	<ul style="list-style-type: none"> ○ Greater efficiencies through telehealth, transport, retrieval ○ Recruitment and retention - include HECS waivers for all professions ○ Strategic approach to role delineation of sites and workers 	

	Need to change models of education including community based clinical placements	<ul style="list-style-type: none"> ○ Unis need incentives to target training to patient need rather than student need ○ Supervisors need incentives, recognising small group learning is more expensive to deliver and impacts on workload 	<ul style="list-style-type: none"> ○ Work needed now for greater alignment of the disparate needs of academics, clinicians, employers and consumers
	Who sets the new standards?	<ul style="list-style-type: none"> ○ Clinical placements that don't meet current accreditation standards ○ Workforce no longer meets the definition of their awards 	<ul style="list-style-type: none"> ○ Employers and consumers ○ Building capacity (infrastructure, preceptor, training) for non traditional sites
	Change management strategy	<ul style="list-style-type: none"> ○ Winners and losers or increased funding overall 	<ul style="list-style-type: none"> ○ Modular and flexible training feeding into new roles and awards
15	Need for quality clinical education/placements/opportunities	<ul style="list-style-type: none"> ○ Appropriate funding for teachers and supervisors ○ Appropriate infrastructure ○ Appropriate inter-professional multi-disciplinary teaching facilities 	<ul style="list-style-type: none"> ○ Commonwealth ○ States and Territories
	Not sufficient information to make decisions for workforce based on demand trends – population, available workforce	<ul style="list-style-type: none"> ○ National modelling of workforce ○ Consider whole of workforce and not only per profession ○ Need strategic modelling and planning ○ More national consistency in definitions, data collections 	HWPC

Balance between specialisation and need for generalists	<ul style="list-style-type: none"> ○ Readjust financial incentives between specialisation and generalisation (MBS) ○ Consider number of graduates who should be working in primary care ○ Define target for each health profession 	<ul style="list-style-type: none"> ○ Commonwealth ○ States and Territories ○ Education Sector ○ Colleges
Retraining staff, health workplace environment	<ul style="list-style-type: none"> ○ Flexible career pathways required ○ Multiple entry points ○ Horizontal movement required ○ Recognition of prior learning- credit transfer ○ Positive practice culture ○ Articulation across vocational/tertiary courses 	Liaison between HWPC, HWT and Universities
Health professionals whose roles and responsibilities don't reflect what they trained for	<ul style="list-style-type: none"> ○ Review roles - who needs to do what? 	
<ul style="list-style-type: none"> ○ Competency of graduating health professionals, quality of training not provided ○ Ongoing training and competency of health professionals 	<ul style="list-style-type: none"> ○ Funding and infrastructure ○ Expansion of training settings outside teaching hospitals ○ Training institutions need to be responsive to workplace needs 	
<ul style="list-style-type: none"> ○ Burnout of health professionals providing mentoring, teaching ○ Increasing burden on clinicians to provide teaching and supervision 	<ul style="list-style-type: none"> ○ Training of supervisors/clinical facilitators ○ Funding and infrastructure 	<ul style="list-style-type: none"> ○ Professions ○ Industry ○ Education ○ Commonwealth ○ State

	Consistency of accreditation – show it is done across the workforce	<ul style="list-style-type: none"> ○ Common criteria, requirements and processes for teaching ○ Rationalising the number of accrediting bodies 	
	National registration and accreditation for the other health professions other than the nine recognised	<ul style="list-style-type: none"> ○ Bring all groups together not registered together ○ Engage with complementary medicine ○ Rationalise accreditation bodies 	
	Consider what workforce is required to meet clinical service needs – “who is the best fit”	<ul style="list-style-type: none"> ○ Training needs to be responsive to new service needs ○ Identifying what workforce is required ○ Need cooperation with stakeholders ○ Align national and local initiatives 	Need to work across all levels – all major stakeholders, not just at an intergovernmental level
	How to support and replace rural and remote health workforce	<ul style="list-style-type: none"> ○ Better resourcing of IT to support telehealth ○ Appropriate aero medical services ○ Monitoring ○ Education and training needs to be responsive 	<ul style="list-style-type: none"> ○ Commonwealth ○ State ○ HWPC
	Competency versus time based training	<ul style="list-style-type: none"> ○ Reflect number 6 in priorities 	
16	Access to quality clinical placement and supervision – ensuring supervisors have time allocated to do that role	<ul style="list-style-type: none"> ○ Raising the profile of mentoring across health professions 	Incorporate education training and workforce in to Australian Health Care Agreements
	Changing lifestyle of health professionals (generation Y)	<ul style="list-style-type: none"> ○ Cultural change in attitude towards teaching supervision i.e. protected teaching time ○ Task transfer between roles and professions 	Incorporating more flexible employment practices

	Matching of under graduate positions to clinical positions	<ul style="list-style-type: none"> ○ Provision of data to all relevant bodies ○ Consistency in data collection 	National formal mechanisms to match education and health industry need
	National registration ensuring a smooth transition to national system	<ul style="list-style-type: none"> ○ Ensure data integrity is maintained and a minimal data set agreed upon by all states 	<ul style="list-style-type: none"> ○ Planning and communication ○ More clarity about terms ○ Federal and State departments
	Non alignment of workforce to health industry need	<ul style="list-style-type: none"> ○ Measure new roles effectiveness ○ Clarity in roles and responsibilities ○ Multi-disciplinary approach ○ Role consistency between states 	Communication between education facilities, professional bodies, government and health care providers
	Assessment of overseas practitioners maintaining quality standards	<ul style="list-style-type: none"> ○ Each health professional needs registration ○ Reduction in training of o/s specialists who go straight home 	National guidelines for registration and accreditation which can be adopted by each profession
	Adoption of prevention and early intervention practice preference in treatments	<ul style="list-style-type: none"> ○ Education community based as well as professional ○ Task transferrals 	
17	Training, recruitment and retention of trained workforce (especially rural and remote, acute services)	<ul style="list-style-type: none"> ○ Indigenous health workers ○ Hospital pharmacists ○ Dental 	<ul style="list-style-type: none"> ○ Remuneration ○ Leave/Cover ○ Professional development ○ Consideration of family, spouse, children ○ Rosters ○ Admin support; red tape
	Define needs in areas i.e. collect data	<ul style="list-style-type: none"> ○ Generic needs ○ Specific needs to group/specialty 	
	Clinical and intern placements	<ul style="list-style-type: none"> ○ Identify suitable numbers of placements ○ Where they exist ○ Develop pathways where they do not 	

	Indigenous medical services	<ul style="list-style-type: none"> ○ Expansion of national registration and accreditation process to cover aboriginal health workers 	
	Scope of practice	<ul style="list-style-type: none"> ○ Deal with supervision ○ Delegation in team type environment (independent worker) ○ IT support etc to minimise non-value adding work 	Indemnity based on training and standards
	International health graduates	<ul style="list-style-type: none"> ○ Include process of assessments ○ Access to up-skilling training ○ (moral decision – less developed countries) 	
	Universities matching funding education and service needs	<ul style="list-style-type: none"> ○ Increased focus on needs and vocational training ○ Less on revenue generation 	
18	Clinical placements for medical education	<ul style="list-style-type: none"> ○ Range of training environments ○ System approach to education 	<ul style="list-style-type: none"> ○ Funding following trainees for facility, employment, service ○ State/with jurisdiction ○ Providers ○ HWPC to coordinate
	Complimentary clinical placements for nursing, midwifery, allied health etc	<ul style="list-style-type: none"> ○ Range of training environments ○ Systems approach to education 	<ul style="list-style-type: none"> ○ Funding following trainees for facility, employment, service ○ State/with jurisdiction ○ Providers ○ HWPC to coordinate
	Adhoc approach to health work force issues (inefficient/ineffective)	<ul style="list-style-type: none"> ○ Better needs data to develop workforce plans 	<ul style="list-style-type: none"> ○ States ○ Commonwealth
	Continuing professional development S&Q issue	<ul style="list-style-type: none"> ○ Compulsory ○ Resourced ○ Re-certification 	<ul style="list-style-type: none"> ○ Link to registration ○ Jurisdictions ○ Professions

	Retention of Health Workforce	<ul style="list-style-type: none"> ○ Incentives ○ Integration of care teams ○ Rostering of teams 	<ul style="list-style-type: none"> ○ Jurisdictions ○ Facilities
19	Acknowledge that issues are so extensive that we should identify and select the most important (max 4)	<ul style="list-style-type: none"> ○ Identify priority areas and address in a timely fashion 	<ul style="list-style-type: none"> ○ Government ○ Relevant stakeholders
	Establish a systemic approach to matching vocational training to undergraduate numbers	<ul style="list-style-type: none"> ○ Establish an attractive training and research environment with clinical service 	<ul style="list-style-type: none"> ○ Colleges ○ Health Services
	Greater clarity of responsibility for services between Commonwealth, State and local jurisdictions e.g. national registration, clinical training especially post PGY, avoid bottom line as sole KPI	<ul style="list-style-type: none"> ○ Improved at a strategic level – not yet at operational level ○ Communication 	<ul style="list-style-type: none"> ○ Governments ○ Health Services
	Capacity to deal with <u>identified</u> needs – workforce numbers, distribution and practical training	<ul style="list-style-type: none"> ○ Deal with new initiatives – eg screening ○ Deal with maldistribution ○ Training to follow patients 	<ul style="list-style-type: none"> ○ Government ○ Health services ○ Professions
	Research into retention rates: <ul style="list-style-type: none"> - income - career satisfaction - migration 	<ul style="list-style-type: none"> ○ Address income inconsistencies and disconnect ○ Teaching and research where appropriate ○ Document migration issues 	<ul style="list-style-type: none"> ○ Health services ○ Professions
	More effective integration of current initiatives and investment	<ul style="list-style-type: none"> ○ build on proven initiatives rather than pass buck ○ audit to identify these 	<ul style="list-style-type: none"> ○ Governments ○ Health services

20	Workforce efficiency	<ul style="list-style-type: none"> ○ Make better use of existing workforce ○ Use of IT – eg OASIS in SA – automate test results and Discharge Report ○ Substitution – optimise use of professionals ○ Use other roles that can be supervised eg. Clerks, auxiliary workers 	Macro and micro reform of workforce
	Clinical training positions and support (especially in rural and remote)	<ul style="list-style-type: none"> ○ Recognise organisations and individuals that make clinical teaching places ○ Accommodation, travel, rooms for students in regional placements 	<ul style="list-style-type: none"> ○ Make education and teaching of undergraduates a KPI for CEO/Hospital and others with incentives to do so
	Education skills of clinicians providing student support	<ul style="list-style-type: none"> ○ Increase skill capacity and recognition of health practitioners that are required to support students 	Recognition with rewards – money or other
	Generalist vs. specialist debate	<ul style="list-style-type: none"> ○ We need both, specialists need to retain generalist skills especially in smaller regional centres 	
	Supporting longevity of existing workforce	<ul style="list-style-type: none"> ○ Flexible roles and workforce conditions for other workforce 	
	Models of training and regulation	<ul style="list-style-type: none"> ○ Protected titles to “main” professions but allow competency development across professions and support RPL 	