



**Australian Health Ministers' Conference**

**NATIONAL HEALTH WORKFORCE  
STRATEGIC FRAMEWORK**

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## **ABBREVIATIONS**

ABS	Australian Bureau of Statistics
AHMAC	Australian Health Ministers' Advisory Council
AHWAC	Australian Health Workforce Advisory Committee
AHMC	Australian Health Ministers' Conference
AHWOC	Australian Health Workforce Officials' Committee
AIHW	Australian Institute of Health and Welfare
AMWAC	Australian Medical Workforce Advisory Committee
ARCPOH	Australian Research Centre For Population Oral Health
NRHA	National Rural Health Alliance
WHO	World Health Organisation

## **FOREWORD**

Australia's health workforce fulfils one of the most important roles in our country, that of providing effective, safe, quality care that improves the health and well being of the Australian community.

Health workforce is a high priority for Australian Health Ministers and in recent years there has been an ongoing investment in the coordination of national health workforce action. Yet until now there has been no national strategic framework to guide that action. This Framework has now been developed. The Framework represents Australia's first attempt to establish a comprehensive National Health Workforce Strategic Framework, and as such this is a landmark document.

The Framework is designed to guide national health workforce policy and planning and Australia's investment in its health workforce throughout the decade. It is a forward looking positive document that focuses on delivering a vision for the Australian health workforce, meeting challenges proactively and ensuring that actions are sustainable and linked to an overall direction. The Framework recognises that a collaborative, multidisciplinary approach is needed to effectively tackle health workforce issues.

The Framework has been designed against the background of current challenges – particularly health workforce shortages and maldistribution; and future challenges – where the key affecting themes are considered to be demographic change, new technologies and empowered consumers. The Framework recognises that the key medium-long term issue is the tightening national labour market.

The structural approach to the Framework has been to define a vision, guiding principles and strategies. The vision is the direction in which national health workforce effort should be focused, the principles are the underlying fundamentals that will guide health workforce strategic action in achieving the vision; and the strategies are the planned actions that will deliver the vision.

The principles are the core of the Framework and the application of the principles to health workforce policy will be critical to the Framework's success. The purpose of the principles is to provide a set of guidelines that will be applicable to all stakeholders, and applied by all stakeholders to national health workforce policy. The strategies outline likely actions that will be required to implement the vision. The strategies are deliberately broad to encompass the wide range of actions that may be undertaken by stakeholders nationally, within jurisdictions, within particular locations and within sectors of the health system.

Stakeholder cohesion and collaboration will be essential to the delivery of the vision and the implementation of the principles. It is anticipated that health workforce policy will be better coordinated across government, service settings, professional groups, consumer and carer organisations and the education, training, regulation and industrial sectors so as to maximise the nation's investment in its health workforce. The commitment of stakeholders in developing the Framework is acknowledged and appreciated.

**Australian Health Ministers 2004**

# NATIONAL HEALTH WORKFORCE STRATEGIC FRAMEWORK

## Introduction

The health workforce is the most important of all health system inputs (WHO 2000 and 2001). All health workers have a care and/or cure role, and utilise a range of skills in a diversity of settings, some of which overlap. The Australian health workforce's core business is providing effective, safe, quality care that improves the health and well being of the Australian community. More often than not this care involves a group of people working either in a team, or as seamlessly as possible.

Jurisdictions in Australia (and indeed most countries around the world) face the same challenge of having the workforce they need to provide equitable, accessible, sustainable, timely, safe health care. The issues in common include workforce shortages, maldistribution, keeping up with changing models of care, and maintaining a culture of continuous improvement and flexibility.

Health workforce is a high priority area for Australian Health Ministers and the Australian Health Ministers' Advisory Council (AHMAC). In recent years there has been an ongoing, but limited, investment in coordination of national health workforce action. This action has tended to focus on immediate priorities. While this will continue to be necessary, action also needs to be focused on establishing a national strategic direction for the future health workforce and better linking health workforce needs to emerging issues and broader health system priorities. Actions need to be based on common principles and be better coordinated across jurisdictions, service settings, professional groups, and the health and education and training sectors so as to maximise the nation's investment in its health workforce and our ability to improve the health and well being of the Australian community.

What follows is a national health workforce strategic framework for Australia. It contains:

- an overall vision of the future health workforce;
- guiding principles for health workforce policy;
- health workforce priorities that are expected to require action over the next 5-10 years; and
- strategic actions (which recognise, and respect, that jurisdictions and stakeholders have specific roles and responsibilities within the health system).

The process used in developing the framework is outlined in Appendix A.

### *Terminology and context*

In this framework the term health workforce is used in its broadest context and refers to the workforce that provides health care to the Australian people; ranging from workers with no formal qualifications providing support services in home based settings through to highly qualified specialists working in technology intensive super-acute hospital settings. It is acknowledged that the workforce is supported by volunteers and carers. More detailed background data on the size, composition and distribution of the Australian health workforce is provided in Appendix B.

Care is also considered in its broadest context and as such includes prevention, promotion, diagnosis, testing, treatment, rehabilitation and palliation.

The framework has been developed within the overall context of a population health framework that embraces health protection and promotion, disease prevention, primary care, community care, remote care and acute care. The population health framework recognises that the health and well being of the Australian people is the result of a complex interplay of biological, psychological, social, environmental and economic factors which operate at the individual, family, community, national and global level (Australian Health Ministers 2003). This approach is consistent with the approach adopted in other recent national health frameworks and plans considered and adopted by Australian Health Ministers.

### *Timeframe*

The timeframe covered by the framework is the next 10 years; so the thoughts on health workforce priorities are in the context of current and emerging issues and the suggested strategies are a necessary mix of what is currently being done and should be continued, what must happen immediately and what is likely to be required in the medium term.

It is intended that the framework can guide Australian health workforce policy, health workforce development and the prioritising of national level investment in the workforce, workforce planning and workforce data and information systems.

It is recognised that new community expectations and changing economies and environments will mean that the health needs of the Australian people, and the workforce required to meet those needs, will almost certainly change over time beyond this framework. Accordingly, the framework should be seen as an evolutionary document that will require regular updating and reassessment. In this context, reassessment will need to be considered in terms of both the evolving and changing health system and the success, or otherwise, of all stakeholders in implementing the principles and strategies set out in this framework.

### *The need for a Strategic Framework*

Over recent years, several health system trends have emerged, all of which mandate thinking more strategically about the future health workforce. These trends include:

- new and varied approaches to health service delivery and the provision of care;
- more and better technology;
- new roles for old disciplines and new disciplines;
- continuing demographic change and shift;
- increased consumer participation in health care and health care decision making;
- greater availability of accurate, timely information;
- an even greater focus on quality cost efficient service provision; and
- the continued development of the global community.

Other developments indicating the need for a national health workforce strategic framework include:

- over the next 10-20 years Australia will need to deal with an ageing population, a 'tightening' national labour pool and an increasingly global and mobile workforce;
- the need for a strengthened national approach to obtaining, retaining and using the health workforce was identified by the Australian Health Care Agreement Reference Group on Collaboration on Workforce, Education and Training;
- other countries (especially Canada and the United Kingdom), have recognised similar challenges and needs, and are undertaking strategic workforce activities to ensure that

they have a health workforce with the skills and training that will be required for the health system of the future;

- the AHWOC stocktake of jurisdictional investment in health workforce and the Australian Medical Workforce Advisory Committee (AMWAC) and Australian Health Workforce Advisory Committee (AHWAC) research projects have generated resource documents which detail workforce issues, jurisdictional investment in health workforce and workforce planning processes and data collections, which means there is now available an improved information base on which to base thinking about the future health workforce (AHWOC 2003; summarised in Appendix C and the Health Workforce Australia website at [www.healthworkforce.health.nsw.gov.au](http://www.healthworkforce.health.nsw.gov.au)); and
- in addition to AHWOC, AHWAC and AMWAC there are a number of other AHMAC committees which have developed aspects of health workforce activity, all of which should be operating in a broadly cohesive manner. A national strategic framework should ensure that this is the case. Other national level AHMAC sponsored health workforce related work is being overseen by:
  - Aboriginal and Torres Strait Islander Health Workforce Working Group;
  - Care of Older Australians Working Group;
  - Industry Training Advisory Board;
  - Medical Specialist Training Outside Teaching Hospitals Working Group;
  - National Advisory Committee on Oral Health;
  - National Health Information Group;
  - National Mental Health Working Group;
  - National Nursing and Nursing Education Taskforce;
  - National Public Health Partnership;
  - National Rural Health Policy Group; and
  - Radiation Oncology Reform Implementation Committee.

#### *Related national strategic frameworks*

As noted earlier, Australian Health Ministers and AHMAC have, over the past few years, approved and adopted a number of national strategic frameworks and action plans that are related to the Australian health workforce. The thinking, principles, strategies and recommendations contained in these frameworks and plans are supported and have been incorporated within this national health workforce strategic framework.

In 2002, the Aboriginal and Torres Strait Islander health workforce was the subject of a separate AHMAC strategic planning exercise (AHMAC 2002). The resulting framework has been adopted by AHMAC. Shortages of health workers in rural, regional and remote Australia are also well documented and strategies in this area have also been supported by a separate AHMAC endorsed strategic framework (AHMAC and NRHA 2002). The key principles and strategies from each of these frameworks are summarised in Appendix D and Appendix E. In addition, the work of the Australian Council For Safety And Quality In Health Care has some key workforce linkages. The proposed priority areas for national goals to improve safety and quality includes as one goal an effective health workforce. The goals are outlined in Appendix F. Similarly, the national mental health plan, endorsed by Health Ministers in 2003, has several workforce key directions and these are summarised in Appendix G.

## **The Changing Health System**

Health systems are always in a constant state of evolution and this means that the environment in which the health workforce works and develops is complex and ever changing.

Health systems are labour and technology intensive, geographically dispersed, and focused on trying to meet the community's diverse health care needs. At the same time, whilst the provision of health care must be safe and in line with community expectations, it must also be grounded in economic and financial reality.

The Australian health workforce is large and diverse (see Appendix B). Currently, the nursing, medical and dental workforces are ageing and working shorter hours. Combined with increasing demand for services, these key influences have meant that shortages are common and as a result the current expectation is for a continued need to expand the health workforce. Workforce distribution also remains a key concern. Beyond these immediate challenges, however, is the expectation that the nature of health care provision is likely to change markedly over the next two to three decades. This has clear implications for the health workforce and whilst the future is never certain it is able to be contemplated and the impact of already known developments considered in any thinking about the future and the setting of strategic directions.

From the workforce perspective any health policy, service delivery or technology change will have an impact on demand, productivity or practice, or a combination of all three. From the community perspective there will be other issues such as affordability, privacy and the ethics of particular actions and outcomes. As has always been the case, advances and innovations will change the treatment of disease and injury and in turn this will affect the way health care is delivered and by whom.

There have been many recent reports on the future direction of health care in Australia and worldwide; the following is an attempt to group and summarise three key themes consistently highlighted in this literature (see Department of Education, Science and Training 2003, Department of Health and Aged Care 2001, Department of Health and Human Services South Australia 2003, Department of Human Services Victoria 2003, Independent Pricing and Regulatory Tribunal 2003, Queensland Health 2002, PriceWaterhouseCoopers 1999, Romanow 2002, Usher 2002, Wanless 2002).

### **1. Demographic change in Australia**

That Australia is undergoing demographic change is well known and usually summarised as Australia having a slowly growing but ageing population. However, this summary misses the key workforce impact of demographic change. In Australia today, the national workforce grows at an annual rate of around 170,000 per year. By 2020 this is predicted to be just 12,500 per year; or put another way, for the whole of the decade 2020-2030 the workforce will grow by less than it currently grows each year (Department of Health and Aged Care 2001). So unless this outlook changes the next twenty to thirty years will see an increasing, and unprecedented, focus on obtaining (and keeping) the Australian workforce, including the health workforce. Jurisdictionally, the impact of this demographic change is expected to be greatest in New South Wales and Victoria.

This then is the supply reality the Australian health system will be facing, without even contemplating any effect from increased global competition for health practitioners. It is also worth remembering that this future supply situation starts from a base where the health workforce has grown steadily over the past twenty years, to the point where Australia now has the most health practitioners in the country it has ever had. The other stress point for the health workforce is that it is a 'bulgy' workforce, where some of the largest numbers of practitioners are in the older age cohorts, who will be proceeding through to retirement over the next 20 years.

Beyond the numbers, other issues that can be expected to focus attention will be around:

- practice (in the context of greater flexibility and the 'who can do what?' question);
- productivity (especially in the context of working more effectively and staying in the workforce longer); and
- length of initial training;

as organisations try to maximise the lifetime working contribution of the workforce.

For the health sector, the ageing of the population is expected to also affect demand by increasing the need for services and the nature of those services. There is likely to be a greater than ever emphasis on healthy ageing strategies. There is also an expectation for an increasing prevalence of chronic disease. Similarly, as part of improving the health of the population as a whole, there will be greater emphasis on promotion and prevention strategies. From the workforce perspective this has implications for the supply of health workers with particular knowledge and skills, and therefore the nature and content of training programs. There are also implications for how care may be delivered, with the attendant flow on implications to the workforce.

## 2. New technologies and health care

Advances in health technology have always been readily incorporated into the provision of health care. As noted previously these advances impact on demand, productivity and practice. The expectation for the next twenty to thirty years and beyond is that health care advances and innovations will be upon us at an astounding rate, with pressure from increasingly well informed consumers for their prompt uptake and universal application.

This is also the area where workforce implications are the most difficult to contemplate, although the overall expectation seems to be that the treatment of many diseases and injuries will change substantially influenced by:

- nanotechnology (the ability to assemble materials molecule by molecule);
- gene technologies (genetic screening and gene therapy and individual knowledge of their genetic profile);
- robotics; and
- e-technologies (impacting on the way care is delivered, the storage of information and data, and communication).

Some of the implications are clear – greater demand for services (but in many instances different types of services), the ability to provide more services and potentially even safer care, a change in the way services and care are provided with new opportunities in

diagnosis, testing, treatment and surveillance and the support of each of these processes, and an ever expanding need for training and regular skills updates throughout practitioner careers.

The other issues, perhaps not so obvious initially, are the implications technology advances will have for the management of knowledge, the use of time, and consumer expectations for successful diagnosis and treatment. It will probably mean that more than ever, practitioners, and systems, will be expected to respond totally to the individual's needs with complete effectiveness. There are also issues around affordability, systems and infrastructure development, and privacy and ethical practice.

### 3. Empowered consumers

Empowered consumers will demand to know more about the treatments proposed for them, their effectiveness and the track record of the practitioners involved in their diagnosis, testing and treatment. Track record knowledge can also be expected to extend to the facility or setting in which the service and care is being provided. All this will affect the management of knowledge and the development of procedures, protocols and guidelines for effective safe care. Again this will mean that the workforce imperative is for up to the minute knowledge and skills and therefore an education and training environment that effectively imparts, and promptly updates, this information.

Consumers are also likely to seek out the most advanced, safest, lowest cost care options.

So what are some possible 'big picture' messages for the future Australian health workforce?

Clearly, there are implications for workforce supply and having the 'right' numbers in the 'right' place at the 'right' time. This is not new, but what it will mean is that there will be a continuing need for up to date planning advice and the attendant data collections that support this planning. Beyond the planning however, there are clear implications for continuing strategies around putting in place the supply and retaining the existing workforce. However, this is all pretty much continuation of the status quo with, most probably, ever larger numbers. The more difficult issue will be that the types of healthcare workers may change and that these changes will be deeply impacted by technology. So ensuring the right practitioner mix will be crucially important and this is likely to involve a mixture of new disciplines and new roles for old disciplines. Boundaries and established professional roles will need to evolve; and new knowledge and skills be acquired, maintained and expanded. In turn, all this will place a greater focus on the length of education and training and the content of education and training programs. Getting the right mix of health workers in place will also extend to care settings and facilities. There will then be flow-on issues for the regulatory and industrial organisations.

In all this there will be issues around affordability, priorities, incentives, disincentives, 'turf', payment, and traditions. In particular, the potential for affordability to 'mug' expectations should not be underestimated.

Leadership, strategic thinking and management ability will be key skills required of all stakeholders. And, for Australia, our geography will continue to provide a special challenge, as will the priority needs of our Aboriginal and Torres Strait Islander population.

In an era of 'tightening' available workforce health care organisations may have to increasingly develop strategies to attract talented practitioners, pay to attract these individuals (or develop other innovative strategies), and search globally for these talents. Policies and programs, which to date have been universal in their design and application, may increasingly have to be tailored to the individual, fitting into the stage they are at in their career and with their work-life balance needs.

The potential changes in health education and training are equally as profound. As noted above pressure will increase to produce practitioners faster as the demand for labour increases. Similarly there is the ever constant need to maintain and update knowledge and skills. Learning is now considered in the context of life long and the delivery of that learning is shifting increasingly towards computer-based and web-based platforms. As the technology expands and the training costs increase, and the availability of traditional learning infrastructure decreases, there is an expectation that virtual learning platforms and processes will expand further.

It is also likely that regulatory arrangements will increasingly be expected to facilitate prompter workforce supply. Regulators may also be expected to better recognise and respond to the evolution of innovative solutions to work practice and work place design (or redesign) and the associated recognition of knowledge and skills and the ability to practise safely and competently.

Sections of the health workforce will continue to become more specialised as technology drives and defines new and innovative approaches to treatment and care. At the same time, however, the health workforce may also have to be more adaptable than ever as health care evolves and changes at a more rapid rate than previously with new practices and treatments evolving and the old practices and treatments they replace disappearing.

If workforce supply tightens, as anticipated (domestically and globally), the workforce may become more demanding and even more choosy about where it works, so that only employers and locations of choice may ever have an 'adequate' workforce.

Most likely, there will also be an imperative developing where everything associated with supplying, training and maintaining a health workforce needs to occur with increased speed and accuracy.

None of this is certain, but all of it is possible.

## **The Vision**

The National Health Workforce Strategic Framework contains a vision, seven principles and a range of related strategies. The vision is the direction in which national health workforce effort should be focused, the principles are the underlying fundamentals that will guide workforce strategic action in achieving that vision, and the strategies are the planned actions that will deliver the vision.

The vision has been designed as a direction setting statement based on a set of health workforce goals. The principles have been designed to form a set of fundamental approaches that can guide health workforce policy action. The principles relate to the vision of the Australian health workforce, whilst the strategies or policy action are designed to deal with the challenges, both current and emerging, that have been identified in the previous discussion.

A set of goals which underlie the vision for the Australian health workforce of the first part of the 21<sup>st</sup> century might appropriately be to ensure Australia has available a health workforce that is:

- population and health consumer focused, ie. able to deliver safe, appropriate, quality care that maximises health outcomes, improves the health and well being of the Australian community and accommodates community expectations, all within a population health framework;
- sustainable: in terms of service and financial sustainability, and ensuring there is adequate workforce supply, both now and into the future;
- distributed to achieve equitable health outcomes: to ensure equitable access to health care regardless of location;
- suitably trained and competent: ie. appropriately educated with continuing maintenance and improvement of professional competence;
- flexible and integrated: able to undertake multiple tasks, work in community and/or institution based settings and in multidisciplinary teams, but also that work-life balance is respected;
- employable: ie. optimal use can be made of available skills and new skills taught; and
- valued: ie. career satisfaction is maximised and work is undertaken within a supportive environment and culture.

And the vision that encapsulates this is:

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

## **Guiding Principles**

The guiding principles are critical to the success of the framework. The principles are the core of the framework and provide a simple set of rules, guidelines and aims which allow all stakeholders to apply them to their own circumstances with a minimum of prescription.

The principles have been constructed so as to ensure that they can be applied at either the national or jurisdictional or regional level. The use of the seven principles and related strategies should ensure sufficient scope is available to jurisdictions and regions to accommodate variations in emphasis in health workforce policy that will inevitably be necessary due to differences in priorities and circumstances in each jurisdiction. This approach is similar to that used in several other recent AHMAC strategic frameworks (see for example Australian Health Ministers 2003, AHMAC 2002, AHMAC and NRHA 2002).

The principles interlink and have been developed to focus on the key action areas that will be essential to the delivery of the vision. These can be summarised as:

- ensuring and sustaining supply (see Principle 1);
- workforce distribution that optimises access to health care and meets the health needs of all Australians (see Principle 2);
- health environments being places in which people want to work (see Principle 3);
- ensuring the health workforce is always skilled and competent (see Principle 4);
- optimal use of skills and workforce adaptability (see Principle 5);
- recognising that health workforce policy and planning must be informed by the best available evidence and linked to the broader health system (see Principle 6); and
- recognising that health workforce policy involves all stakeholders working collaboratively with a commitment to the vision, principles and strategies outlined in this framework (see Principle 7).

Therefore the key to delivery of the vision for the Australian health workforce is for all stakeholders to develop health workforce policy based on the following seven principles:

1. **Australia should focus on achieving, at a minimum, national self sufficiency in health workforce supply, whilst acknowledging it is part of a global market.**
2. **Distribution of the health workforce should optimise equitable access to health care for all Australians, and recognise the specific requirements of people and communities with greatest need.**
3. **All health care environments regardless of role, function, size or location should be places in which people want to work and develop; where the workforce is valued and supported and operates in an environment of mutual collaboration.**
4. **Cohesive action is required among the health, education, vocational training and regulatory sectors to promote an Australian health workforce that is knowledgeable, skilled, competent, engaged in life long learning and distributed to optimise equitable health outcomes.**
5. **To make optimal use of workforce skills and ensure best health outcomes, it is recognised that a complementary realignment of existing workforce roles or the creation of new roles may be necessary. Any workplace redesign will address health needs, the provision of sustainable quality care and the required competencies to meet service needs.**
6. **Health workforce policy and planning should be population and consumer focused, linked to broader health care and health systems planning and informed by the best available evidence.**
7. **Australian health workforce policy development and planning will be most effective when undertaken collaboratively involving all stakeholders. It is recognised that this will require:**
  - **cohesion among stakeholders including governments, consumers, carers, public and private service providers, professional organisations, and the education, training, regulatory, industrial and research sectors;**
  - **stakeholder commitment to the vision, principles and strategies outlined in this framework;**
  - **a nationally consistent approach;**
  - **best use of resources to respond to the strategies proposed in this framework; and**
  - **a monitoring, evaluation and reporting process.**

## Strategies

The themes within each of the guiding principles have been developed into strategies that are capable of delivering the vision for the Australian health workforce and guiding stakeholder investment in the health workforce.

In this section a range of potential strategies are outlined. The process used in summarising the strategy discussion has been to group a number of strategic actions under each principle. This is not intended as a detailed exhaustive list, and it is not based on any 'audit' of current strategic action. Some strategies build on existing actions, others are new, and some can be seen to cut across a number of the guiding principles. All are potentially relevant to all stakeholders, and many should be equally capable of application at a national, jurisdictional, regional and/or local level.

In drafting this section of the framework there were a range of differing views considered on how broad or detailed to make the strategies. Recent related AHMAC endorsed national frameworks and plans used both approaches. In the end the strategies have been kept broad and as such the discussion outlines a range of actions that stakeholders will need to consider and progressively put in place.

**Principle 1** is about ensuring and sustaining supply. Actions will have to focus on workforce intakes, recruitment and retention and may involve education, undergraduate and graduate training, use of overseas practitioners and re-entry into the workforce of health practitioners.

*Strategic directions* are:

- Align education and training supply with projected workforce requirements and health service needs to achieve long term national self sufficiency of supply;
- Reduce immediate shortages through short-term strategies including improving workforce re-entry and ethical overseas recruitment;
- Support domestic supply through a multifaceted and sustainable approach to recruitment and retention; and
- Promote retention and effective service delivery through innovative education and training models.

**Principle 2** is about workforce distribution that optimises access to health care and meets the health needs of all Australians. This may involve both incentives and disincentives to facilitate equitable distribution of workforce numbers and skills.

*Strategic directions* are:

- Explore innovative approaches to address distribution issues, including incentives and disincentives to practise in areas and sectors of greatest need and workforce shortage;
- Target training and education where the need is greatest; and

- Use innovative models of service delivery to improve access to areas of geographic and cultural need and specialties in shortage.

**Principle 3** is about ensuring health organisations are places in which people want to work. This may involve employers offering workplace flexibility to allow staff to achieve a balance in their life and work that meets their life stage needs. It is also about maximising the contribution that the workforce makes.

*Strategic directions are:*

- Explore and develop flexible working environments that reflect the changing needs and profile of the workforce;
- Explore and develop models that enable articulated, multiple career pathways to provide lifelong career opportunities in the health sector; and
- Continue and enhance initiatives aimed at promoting supportive cultures, innovation, leadership and collaboration in work environments.

**Principle 4** is about common cohesive action among stakeholders to ensure the health workforce is sufficient and always skilled and competent. This may involve both existing and new training providers identifying the needs of the workforce and providing training in a variety of locations, using a range of modalities and diverse and extended curricula. Consideration of accelerated entry to the workforce may also be necessary.

*Strategic directions are:*

- Identify a formal mechanism for the effective engagement of the health and education and training sectors such as the establishment of a National Health and Education Training Council;
- Align education and training programs with health service needs;
- Continue to develop new and innovative ways to deliver health education and training, which facilitates accelerated entry to the workforce and flexible delivery of clinical training; and
- Promote initiatives that encourage practitioners to maintain a level of skills, knowledge and competence that aligns with evolving health consumer needs and changes in service delivery.

**Principle 5** is about the optimal use of skills and workforce adaptability. This may involve a complementary realignment of existing roles or the creation of new roles. The accepted limits of existing professional roles may need to evolve; and new knowledge and skills be acquired and maintained.

*Strategic directions are:*

- Link service development with workforce development approaches and explore opportunities to maximise the flexibility of the workforce, including innovative approaches to skill mix and new workforce roles and changes to scope of practice;
- Develop workplace, professional and education and training practices that facilitate team approaches and multidisciplinary care; and
- Explore regulatory arrangements that facilitate workforce supply and innovative solutions to work design and the recognition of knowledge and skills.

**Principle 6** is about recognising that health workforce policy and planning must be informed by the best available evidence and linked to the broader health system. This will involve innovation, research, information sharing, collaboration and consultation. Ongoing evaluation and knowledge gained will be used to continually inform health workforce policy and processes.

*Strategic directions are:*

- Establish shared health workforce planning methodologies that include comprehensive workforce planning as part of any capital, service or infrastructure planning;
- Lead, encourage and support a health workforce research, planning and policy development agenda, including national supply and demand studies, to meet the population and consumer health care needs;
- Continue to develop health workforce information sharing – both data and information about potential solutions to challenges; and
- Continually improve health workforce data collections; putting in place common language, minimum data sets, and consistent collection and processing arrangements.

**Principle 7** is about recognising that health workforce policy involves all stakeholders working collaboratively with a commitment to the vision, principles and strategies outlined in the framework. This may involve jurisdictional, professional, industrial and organisational cohesion and will involve ongoing commitment to the vision, principles and strategies outlined in this framework. It will require leadership and management from all stakeholders, visionary thinking and prompt inclusive actions.

The strategic action required here is essentially recognition of this principle, and more importantly, its constant, and consistent, application to the development and implementation of Australian health workforce policy.

*Strategic directions are:*

- Develop national and jurisdictional plans to action this framework;

- Establish the monitoring, evaluation and reporting processes to support the framework; including AHWOC reporting annually on progress to AHMAC and Australian Health Ministers;
- Develop inclusive, consultative processes around the development of health workforce policy and planning that engages all stakeholders; and
- Promote discussion and awareness of health workforce issues and strategic action amongst stakeholders and the general community.

As noted earlier, Australian Health Ministers and AHMAC have, over the past few years, approved and adopted a number of national strategic frameworks and action plans that are related to the Australian health workforce. These plans have been in the areas of the Aboriginal and Torres Strait Islander health workforce (AHMAC 2002); rural, regional and remote Australia (AHMAC and NRHA 2002); safety and quality (Australian Council For Safety And Quality In Health Care 2003); and mental health (Australian Health Ministers 2003). The strategies and recommendations contained in these frameworks and plans are supported and have been incorporated within the thinking in this framework. Each of the specific recommendations from these plans would fit within one or more of the broad strategic directions outlined above; however, the specific recommendations from these plans have not been reproduced in this document. A summary of each of the plans is provided in Appendices D,E,F and G.

## Summary

The following table consolidates the foregoing discussion on principles and strategies into a simple easy to read summary.

Guiding Principle	Strategies
<p>1. Australia should focus on achieving, at a minimum, national self sufficiency in health workforce supply, whilst acknowledging it is part of a global market.</p> <p>Principle 1 is about ensuring and sustaining supply. Actions will have to focus on workforce intakes, recruitment and retention and may involve education, undergraduate and graduate training, use of overseas practitioners and re-entry into the workforce of health practitioners.</p>	<ul style="list-style-type: none"><li>• Align education and training supply with projected workforce requirements and health service needs to achieve long term national self sufficiency of supply.</li><li>• Reduce immediate shortages through short-term strategies including improving workforce re-entry and ethical overseas recruitment.</li><li>• Support domestic supply through a multifaceted and sustainable approach to recruitment and retention.</li><li>• Promote retention and effective service delivery through innovative education and training models.</li></ul>
<p>2. Distribution of the health workforce should optimise equitable access to health care for all Australians, and recognise the specific requirements of people and communities with greatest need.</p> <p>Principle 2 is about workforce distribution that optimises access to health care and meets the health needs of all Australians. This may involve both incentives and disincentives to facilitate equitable distribution of workforce numbers and skills.</p>	<ul style="list-style-type: none"><li>• Explore innovative approaches to address distribution issues, including incentives and disincentives to practise in areas and sectors of greatest need and workforce shortage.</li><li>• Target training and education where the need is greatest.</li><li>• Use innovative models of service delivery to improve access to areas of geographic and cultural need and specialties in shortage.</li></ul>

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3. All health care environments regardless of role, function, size or location should be places in which people want to work and develop; where the workforce is valued and supported and operates in an environment of mutual collaboration.

Principle 3 is about ensuring health organisations are places in which people want to work. This may involve employers offering workplace flexibility to allow staff to achieve a balance in their life and work that meets their life stage needs. It is also about maximising the contribution that the workforce makes.

4. Cohesive action is required among the health, education, vocational training and regulatory sectors to promote an Australian health workforce that is knowledgeable, skilled, competent, engaged in life long learning and distributed to optimise equitable health outcomes.

Principle 4 is about common cohesive action among stakeholders to ensure the health workforce is sufficient and always skilled and competent. This may involve both existing and new training providers identifying the needs of the workforce and providing training in a variety of locations, using a range of modalities and diverse and extended curricula. Consideration of accelerated entry to the workforce may also be necessary.

- Explore and develop flexible working environments that reflect the changing needs and profile of the workforce.
  - Explore and develop models that enable articulated, multiple career pathways to provide lifelong career opportunities in the health sector.
  - Continue and enhance initiatives aimed at promoting supportive cultures, innovation, leadership and collaboration in work environments.
  - Identify a formal mechanism for the effective engagement of the health and education and training sectors such as the establishment of a National Health and Education Training Council.
  - Align education and training programs with health service needs.
  - Continue to develop new and innovative ways to deliver health education and training, which facilitates accelerated entry to the workforce and flexible delivery of clinical training.
  - Promote initiatives that encourage practitioners to maintain a level of skills, knowledge and competence that aligns with evolving health consumer needs and changes in service delivery.
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5. To make optimal use of workforce skills and ensure best health outcomes, it is recognised that a complementary realignment of existing workforce roles or the creation of new roles may be necessary. Any workplace redesign will address health needs, the provision of sustainable quality care and the required competencies to meet service needs.

Principle 5 is about the optimal use of skills and workforce adaptability. This may involve a complementary realignment of existing roles or the creation of new roles. The accepted limits of existing professional roles may need to evolve; and new knowledge and skills be acquired and maintained.

6. Health workforce policy and planning should be population and consumer focused, linked to broader health care and health systems planning and informed by the best available evidence.

Principle 6 is about recognising that health workforce policy and planning must be informed by the best available evidence and linked to the broader health system. This will involve innovation, research, information sharing, collaboration and consultation. Ongoing evaluation and knowledge gained will be used to continually inform health workforce policy and processes.

- Link service development with workforce development approaches and explore opportunities to maximise the flexibility of the workforce, including innovative approaches to skill mix and new workforce roles and changes to scope of practice.

- Develop workplace, professional and education and training practices that facilitate team approaches and multidisciplinary care.

- Explore regulatory arrangements that facilitate workforce supply and innovative solutions to work design and the recognition of knowledge and skills.

- Establish shared health workforce planning methodologies that include comprehensive workforce planning as part of any capital, service or infrastructure planning.

- Lead, encourage and support a health workforce research, planning and policy development agenda, including national supply and demand studies, to meet the population and consumer health care needs.

- Continue to develop health workforce information sharing – both data and information about potential solutions to challenges.

- Continually improve health workforce data collections; putting in place common language, minimum data sets, and consistent collection and processing arrangements.

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7. Australian health workforce policy development and planning will be most effective when undertaken collaboratively involving all stakeholders. It is recognised that this will require:

- cohesion among stakeholders including governments, consumers, carers, public and private service providers, professional organisations, and the education, training, regulatory, industrial and research sectors;
- stakeholder commitment to the vision, principles and strategies outlined in this framework;
- a nationally consistent approach;
- best use of resources to respond to the strategies proposed in this framework; and
- a monitoring, evaluation and reporting process.

Principle 7 is about recognising that health workforce policy involves all stakeholders working collaboratively with a commitment to the vision, principles and strategies outlined in the framework. This may involve jurisdictional, professional, industrial and organisational cohesion and will involve ongoing commitment to the vision, principles and strategies outlined in this framework. It will require leadership and management from all stakeholders, visionary thinking and prompt inclusive actions.

The strategic action required here is essentially recognition of this principle, and more importantly, its constant, and consistent, application to the development and implementation of Australian health workforce policy.

- Develop national and jurisdictional plans to action this framework.
- Establish the monitoring, evaluation and reporting processes to support the framework; including AHWOC reporting annually on progress to AHMAC and Australian Health Ministers.
- Develop inclusive, consultative processes around the development of health workforce policy and planning that engages all stakeholders.
- Promote discussion and awareness of health workforce issues and strategic action amongst stakeholders and the general community.

## **Appendix A: The Process Used In Developing The National Health Workforce Strategic Framework**

Development of the National Health Workforce Strategic Framework was coordinated by the Australian Health Workforce Officials' Committee (AHWOC). The framework was prepared by an AHWOC working group, whose membership was:

Mr John Ramsay (chair)	Department of Health and Human Services, Tasmania
Ms Margaret Banks	New South Wales Department of Health
Mr Peter Carver	Department of Human Services, Victoria
Ms Justine Curnow	National Health Workforce Secretariat
Mr Julian Evans	Australian Department of Health and Ageing
Mr Paul Gavel	National Health Workforce Secretariat
Mr Mark Hathaway	Department of Health and Community Services, Northern Territory
Ms Susan Killion	Australian Capital Territory Department of Health and Community Care
Ms Bronwyn Nardi	Queensland Health
Ms Jantze Purton	New South Wales Department of Health
Ms Helen Townley	Australian Health Workforce Officials' Committee Secretariat
Ms Diana Trionfi	Australian Department of Health and Ageing
Mr Robert Wells	Australian Department of Health and Ageing

The process overseen by AHWOC for development of the framework involved the following stages:

1. presentation of a draft outline of the framework for endorsement by AHMAC in October 2003;
2. preparation of a draft framework by the AHWOC working group, based on consultation with jurisdictions;
3. using the draft framework as the basis for broader consultation with stakeholders including through a workshop held on 29 January 2004; and
4. presentation of the finalised framework to AHMAC and Australian Health Ministers for endorsement.

### National Health Workforce Strategic Framework Workshop

On 29 January 2004, a workshop was held to consider the draft national health workforce strategic framework. The workshop was attended by 160 stakeholders drawn from across the nation and covering:

- government - Australian and all jurisdictions;
- AHMAC workforce committees and AHMAC workforce related committees;
- consumers, carers and volunteers;
- Aboriginal and Torres Strait Islander organisations;
- the industrial, regulatory, education and training sectors;
- professional organisations – allied health, nursing and medical;
- health service providers; and
- health workforce academics and researchers.

The workshop was facilitated by Dr Norman Swan; and the process used was to undertake group work on the proposed vision, principles and strategies contained in a draft national strategic framework. There were 15 groups, with all groups including a mix of stakeholders.

The workshop was supportive of the draft framework, including the structure of the document and the notion of defining a vision and guiding principles and then outlining a range of strategic actions. Participants provided a range of suggested amendments to the vision and each principle. The suggested amendments were comparatively minor and none changed the intent or focus of the proposed principle. No new principle was proposed. Participants also outlined a range of strategic actions, in addition to those already included in the draft document.

### **Workshop participants:**

Ms	Judith	Abbott	Department of Human Services Victoria
Ms	Robyn	Adams	Services for Australian Rural and Remote Allied Health
Mr	Peter	Allen	Department of Human Services Victoria
Ms	Yvonne	Allinson	Society of Hospital Pharmacists of Australia
Mr	Les	Apolony	Committee of Presidents of Medical Colleges
Mr	Brody	Atterby	National Health Workforce Secretariat
Dr	Robert	Bain	Australian Medical Association
Ms	Dalys	Baker	Pharmacy Guild of Australia
Ms	Margaret	Banks	New South Wales Department of Health
Prof.	Bruce	Barracough	Australian Council for Safety and Quality in Health Care
Prof.	Jenny	Beutel	Australian Capital Territory Department of Health and Community Care
Dr	David	Boadle	Department of Health and Human Services Tasmania
Ms	Paula	Bowman	Queensland Health
Prof.	Philip	Boyce	Royal Australian and New Zealand College of Psychiatrists
Dr	Roger	Boyd	Royal Australasian College of Medical Administrators
Ms	Margaret	Brown	Health Consumers of Rural and Remote Australia Inc
Ms	Rosemary	Bryant	Royal College of Nursing Australia
Ms	Raelene	Burke	Department of Human Services South Australia
Dr	Ian	Cameron	New South Wales Rural Doctors Network
Prof.	Allan	Carmichael	University of Tasmania
Mr	Peter	Carver	Department of Human Services Victoria
Prof.	Mary	Chiarella	New South Wales Department of Health
Dr	Andrew	Child	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Ms	Kerren	Clark	Australian Physiotherapy Association
Ms	Belinda	Collins	Australian Health Information Council Secretariat
Dr	Bill	Coote	General Practice Education and Training
Ms	Ruth	Cox	Queensland Health
Ms	Sophie	Cresswell	Council of Remote Area Nurses of Australia
Ms	Justine	Curnow	National Health Workforce Secretariat
Ms	Vesna	Cvjeticanin	Care of Older Australian Working Group Secretariat

Mr	Brett	Dee	National Health Workforce Secretariat
Dr	Phillip	Della	Department of Health Western Australia
Prof.	Hugh	Dickson	Australasian Faculty of Rehabilitation Medicine
Dr	Gary	Disher	Royal Australasian College of Physicians
Prof.	Christine	Duffield	Centre for Health Services Management, University of Technology Sydney
Dr	Iain	Dunlop	Royal Australian and New Zealand College of Ophthalmologists
Mr	Alan	Eldridge	Australian Indigenous Doctors Association
Ms	Cathy	Ellis	National Health Workforce Secretariat
Mr	Stephen	Elsom	Australian and New Zealand College of Mental Health Nurses
Mr	Julian	Evans	Australian Department of Health and Ageing
Mr	Tony	Farley	New South Wales Department of Health
Mr	Michael	Fisher	Office of Aboriginal and Torres Strait Islander Health
Ms	Lesley	Fitzpatrick	General Practice Education and Training
Prof.	Ben	Freedman	Committee of Deans of Australian Medical Schools
Ms	Francine	Galloway	Department of Health and Human Services Tasmania
Dr	Paul	Gaudry	Australasian College for Emergency Medicine
Mr	Paul	Gavel	National Health Workforce Secretariat
Ms	Marilyn	Gendek	Australian Nursing Council
Mr	Kieran	Gleeson	New South Wales Department of Health
Ms	Kim	Goodluck	Northern Territory Remote Health Workforce Agency
Dr	Debra	Graves	Royal College of Pathologists of Australasia
Dr	Jane	Greacen	Rural Workforce Agency Victoria
Prof.	Jane	Hall	Centre for Health Economics and Research Development
Ms	Lois	Hamlin	Australian College of Operating Room Nurses
Dr	Mary	Harris	National Health Workforce Secretariat
Dr	David	Hillis	Royal Australasian College of Surgeons
Ms	Jo	Hoiles	Department of Human Services South Australia
Ms	Dell	Horey	Health Issues Centre
Dr	Suzanne	Huxley	Queensland Health
Mr	Jim	Hyde	Royal Australian College of Surgeons
Ms	Jill	Iliffe	Australian Nursing Federation
Mr	Brian	Jacobs	National Mental Health Working Group
Dr	Brian	Jardine	Public Service Association of New South Wales
Dr	Felicity	Jefferies	Western Australian Centre for Rural and Remote Medicine
Dr	Ian	Kammerman	Australian College of Rural and Remote Medicine
Dr	Tom	Karmel	National Centre for Vocational Education Research
Ms	Myra	Katz	National Health Workforce Secretariat
Ms	Susan	Killion	Australian Capital Territory Department of Health and Community Care
Ms	Annette	King	National Health Workforce Secretariat
Dr	Ross	King	Australian Dental Council
Ms	Sabina	Knight	Council of Remote Area Nurses of Australia
Ms	Anne	Kolbe	Royal Australasian College of Surgeons

A/Prof.	Ann	Larson	Australian Rural Health Education Network
Ms	Moira	Laverty	Australian Nursing Council
Ms	Di	Lawson	Community Services and Health Training Australia
Mr	Raymond	Lovett	Congress of Aboriginal and Torres Strait Islander Nursing
Prof.	Judy	Lumby	The College of Nursing
Mr	Paul	Mackey	Australian Private Hospitals Association
Dr	Lynne	Madden	Australasian Faculty of Public Health Medicine
Dr	Richard	Madden	Australian Institute of Health and Welfare
Dr	Mary	Mahoney	Royal Australian College of General Practitioners
Dr	John	Matthews	Australian Dental Association
A/Prof.	Lindy	McAllister	Speech Pathology Association of Australia
Ms	Sue	McAlpin	National Rural Health Alliance
A/Prof.	Brian	McCaughan	Australian Medical Council
Ms	Noela	McDonald	Australian Department of Health and Ageing
Ms	Kirsty	McEwin	New South Wales Rural Doctors Network
Dr	Joe	McGirr	Greater Murray Area Health Service
Ms	Lisa	McGlynn	Australian Department of Health and Ageing
Mr	Russell	McGowan	Consumers Health Forum
Ms	Kate	Mertens	New South Wales Department of Health
Ms	Katrina	Milbourne	Australian Capital Territory Department of Health and Community Care
Mr	Chris	Mitchell	Queensland Rural Medical Support Agency
Dr	Robin	Mortimer	Royal Australasian College of Physicians
Ms	Belinda	Moyes	Department of Human Services Victoria
Ms	Karen	Murphy	Australian Capital Territory Department of Health and Community Care
Mr	Matthew	Murphy	Australian Department of Health and Ageing
Ms	Bronwyn	Nardi	Queensland Health
Ms	Sue	Norrie	Queensland Health
Prof.	Pauline	Nugent	Deakin University
Ms	Elizabeth	O'Brien	National Health Workforce Secretariat
Mr	Chris	O'Connell	National Aboriginal Community Controlled Health Organisation
Ms	Lin	Oke	Health Professions Council of Australia
Dr	Sue	Page	Rural Doctors Association of Australia
Mr	Frank	Payne	Pharmaceutical Society of Australia
Ms	Judith	Perrin	Australian Confederation of Paediatric and Child Health Nurses
Ms	Monica	Persson	Audiological Society of Australia Inc
Prof.	Lester	Peters	Royal Australian and New Zealand College of Radiologists
Prof.	Garry	Phillips	Australian and New Zealand College of Anaesthetists
Mr	John	Pitsonis	Australian Private Hospitals Association
Ms	Lise	Pittman	Department of Human Services Victoria
Ms	Prue	Power	Australian Healthcare Association
Mr	John	Price	Australasian Podiatry Council
Mr	Neil	Purdy	Department of Health Western Australia
Ms	Jantze	Purton	New South Wales Department of Health

Mr	John	Ramsay	Department of Health and Human Services Tasmania; Chair AHWOC and AHWAC
Dr	David	Reynolds	Royal Adelaide Hospital
Mr	Greg	Rickard	Department of Health and Community Services Northern Territory
Ms	Patricia	Ridoutt	New South Wales Department of Health
Ms	Amanda	Rischbieth	Australian College of Critical Care Nurses
Prof.	Don	Roberton	Royal Australasian College of Physicians
Dr	Peter	Roeser	Confederation of the Post Graduate Medical Education Councils
Dr	Jill	Sewell	National Institute of Clinical Studies
Prof.	Chris	Selby-Smith	Monash University
Mr	Peter	Slattery	Australian Institute of Radiography
Ms	Lyndie	Spurr	Australian Council of Community Nursing Services
Ms	Margaret	Starr	New South Wales Department of Health
Dr	Kay	Stevens	Royal Australian and New Zealand College of Psychiatrists
Ms	Fiona	Stoker	Department of Health and Human Services Tasmania
Mr	David	Stokes	Australian Psychological Society
Dr	Karen	Sumner	Rural Doctors Workforce Agency South Australia
Mr	Don	Swinbourne	Royal Australian and New Zealand College of Radiologists
Dr	Ken	Tallis	Australian Institute of Health and Welfare
Ms	Glenice	Taylor	Australian Institute of Health and Welfare
Ms	Debra	Thoms	Department of Health and Human Services SA
Mr	Patrick	Tobin	Catholic Health Australia
Dr	Lloyd	Toft	Australian Medical Council
Ms	Helen	Townley	Australian Health Workforce Officials Committee Secretariat
Dr	Peter	Trye	Department of Human Services Victoria
Mr	Glenn	Tyrrell	Health Services Union
Ms	Jayne	Walker	Association for Australian Rural Nurses
A/Prof.	Merrilyn	Walton	University of Sydney
Ms	Charmaine	Weeks	Australian Resource Centre for Healthcare Innovations
Mr	Robert	Wells	Australian Department of Health and Ageing
Dr	Craig	White	Austin Health Melbourne
Ms	Vera	Whitehouse	Department of Health and Community Services Northern Territory
Ms	Linda	Williams	Australian College of Critical Care Nurses
Dr	Richard	Willis	Australian and New Zealand College of Anaesthetists
Ms	Rachel	Yates	Australian Divisions of General Practice
Dr	Jeannette	Young	Princess Alexandra Hospital; chair AMWAC

The following organisations were invited to participate but unable to attend:

- Australian Rural and Remote Workforce Agencies Group  
(although a number of state agencies were present);
- Australasian College of Dermatologists;
- Australasian Faculty of Occupational Medicine;
- Australian Medical Association Council for Doctors In Training  
(although the Australian Medical Association was present);
- Joint Faculty of Intensive Care Medicine; and
- National Advisory Committee on Oral Health  
(although a number of participating dental organisations were present).

## **Appendix B: The Australian Health Workforce**

The following overview of the Australian health workforce is based on the 2001 Australian census (AIHW and ABS 2003). The 2001 census data provides the most timely and comprehensive overview of the whole health care workforce. This information has been supplemented with more specific data on the medical and nursing workforces from the Australian Institute of Health and Welfare labour force survey series.

The data highlight the diversity of the Australian health workforce; ranging from workers with no formal qualifications providing support services in home based settings through to highly qualified specialists working in technology intensive super-acute hospital settings (Department of Human Services 2003).

In 2001, there were 798,295 people employed in health and community services industries, of whom 538,783 (67.4%) worked in health or community services occupations (see Table 1). The occupations are classified using the Australian Bureau of Statistics (ABS) Australian Standard Classification of Occupations, which includes 76 different health occupations (see AIHW and ABS 2003).

In 2001, the largest health and community services occupational groups were nursing workers (244,405), medical workers (51,859) and child and youth services workers (101,715). Between the 1996 and the 2001 census, the number of employed people in health and community services occupations increased by 14.7%. For the key health occupations the main increases between the 1996 and 2001 census were medical practitioners (12.6%), medical imaging workers (25.0%), dentists (11.0%), nurses (5.4%), pharmacists (13.0%) and allied health workers (26.6%).

Other points of note, when comparing the 1996 and the 2001 health workforce, were:

- a 10.0% decrease in the number of workers in hospitals and nursing homes; and
- an increase of 9,084 (6.0%) registered nurses, but a 4,946 (21.4%) decrease in enrolled nurses and a larger number of lower paid carers and aids (up by 8,488 or 20.3%).

Workers in the health occupations were predominantly female (74%) and a relatively large proportion worked part time (34%).

In terms of workforce distribution:

- the supply of health workers decreased with increasing remoteness, ranging from 3,005 per 100,000 population in major cities to 1,498 per 100,000 in remote areas;
- the central regions of capital cities had the highest apparent supply of health practitioners, which probably reflects the centralisation of hospitals and health services in the inner city areas; and
- some of the rapidly growing areas on the outskirts of all five major capital cities had the lowest supply of practitioners of any region within their respective states.

**Table 1: Employed person in health and community services industries, by occupation, Australia, 1996 and 2001**

Occupation	1996	2001	Difference	% difference
<b>Health and community services</b>				
Allied and complementary health professionals	41,857	50,401	8,544	20.4
Ambulance/dental/Aboriginal and Torres Strait Islander health workers/inspectors	11,150	15,510	4,360	39.1
Carers and aides – health	41,734	50,222	8,488	20.3
Carers and aides – community services	83,703	102,526	18,823	22.5
Dental assistants/personal care consultants	14,052	17,524	3,472	24.7
Enrolled nurses	23,140	18,194	- 4,946	- 21.4
Health education professionals	6,579	4,273	- 2,306	- 35.1
Medical professionals	41,447	46,073	4,626	11.2
Natural and physical science/engineering professionals	7,525	9,500	1,975	26.2
Natural and physical science/engineering associate professionals	8,318	12,943	4,625	55.6
Registered nurses	152,652	161,736	9,084	6.0
Social welfare professionals	34,443	45,529	8,086	23.5
Welfare associate professionals	8,575	12,129	3,554	41.4
<i>Total</i>	<i>469,672</i>	<i>538,783</i>	<i>69,111</i>	<i>14.7</i>
<b>Other occupations</b>				
Business/computing professionals	11,590	13,551	1,961	16.9
Business/computing associate professionals	16,059	23,203	7,144	44.5
Elementary clerical and sales	6,360	7,164	804	12.6
Food labourers	16,494	14,727	- 1,767	- 10.7
Food tradespersons	7,261	6,642	- 619	- 8.5
Guards/porters/housekeepers	7,261	8,314	1,053	14.5
Hospitality/accommodation/sales professional	8,366	7,776	- 590	- 7.1
Intermediate clerical/sales and service	75,086	85,548	10,462	13.9
Labourers and cleaners	34,195	26,530	- 7,665	- 22.4
Managers	24,260	26,722	2,462	10.1
Mechanical/building/electrical tradespersons	11,217	8,902	- 2,315	-20.6
Plant and machine operators/drivers	6,694	6,524	- 17-	- 2.5
Secretaries and personal assistants/advanced clerical	16,140	14,166	- 1,974	- 12.2
Not stated	5,481	4,872	- 609	- 11.1
<i>Total</i>	<i>246,464</i>	<i>254,641</i>	<i>8,177</i>	<i>3.3</i>
<b>Total</b>	<b>721,639</b>	<b>798,201</b>	<b>76,562</b>	<b>10.6</b>

Note: total includes those whose occupation was not stated or could not be identified; details of the health workers included in each of the ABS occupation categories is provided in the explanatory notes of the report AIHW and ABS 2003, pp. 121-129.

Source: ABS Census 1996 and 2001 from AIHW and ABS 2003

Yet, despite the increase in the size of the Australian health workforce, there are some other important trends, and these trends highlight the challenges facing health workforce policy. In particular the nursing, medical and dental workforces are ageing and working shorter hours. Combined with increasing demand for services, these key influences have meant that shortages are common and as a result the expectation is for a continued need to expand the health workforce. Workforce distribution also remains a key concern (AHWAC 2003, AMWAC 2003).

Of the 14 non-information and communications technology professions on the Australian Government Department of Employment and Workplace Relations national skill shortage list, 12 are health professions. Current nursing shortages on the register are listed as:

- general nursing  
(aged care, cardiothoracic, community, critical care, emergency, indigenous, neonatal, neurological, oncology, operating theatre, paediatric, palliative, perioperative, renal);
- midwifery
- mental health; and
- enrolled nurses.

Current allied health workforces on the register are:

- physiotherapy;
- pharmacist (hospital/retail);
- occupational therapist;
- speech pathologist;
- diagnostic radiographer;
- radiation therapist;
- sonographer; and
- nuclear medicine technologist.

In medicine, of the 24 medical workforces examined in detail by the Australian Medical Workforce Advisory Committee, in all but one, paediatrics, existing or emerging shortages have been highlighted. Key areas of shortage are:

- orthopaedic surgery;
- ear nose and throat surgery;
- obstetrics;
- pathology;
- radiology;
- oncology;
- psychiatry;
- geriatric medicine; and
- general practice.

Workforce distribution also remains a key concern, with shortages magnified in rural and remote and disadvantaged areas.

Of the recommended AMWAC training program intake increases, around 90% are in place. The need to increase medical workforce supply is being driven by continued growth in the demand for medical services and on the supply side by the ageing workforce, changes in

participation (as measured by hours worked per week) and the increase in female participation (AMWAC 2003).

In nursing, several national level analyses of future nurse workforce supply have all concluded there is a need to increase supply, and as a consequence university nursing placements, with the modeling work undertaken for the National Review of Nurse Education and Training projecting a shortfall of 40,000 nurses by 2010 (Department of Education, Science and Training and Department of Health and Ageing 2002). The need to increase supply is being driven by increased demand, an ageing workforce, a decline in the full time equivalent nursing workforce, the expanding role of the nurse and the consequence of the static or declining nurse undergraduate commencements and completions throughout the 1990s.

In dentistry, the Australian Research Centre For Population Oral Health projects that an additional 120 undergraduate dental places per annum are required to 2010 (ARCPOH 2003). A recent review of the pharmacy workforce estimated that the current shortage of pharmacists will increase from 2,000 to 3,000 by 2010 and that additional university pharmacy intakes will be necessary to correct this situation (Health Care Intelligence 2003).

There are some chronic needs and deficiencies that cut across these professional listings, the most notable is in the Aboriginal and Torres Strait Islander health workforce (AHMAC 2002). Shortages of health workers in rural, regional and remote Australia are also well documented (AHMAC 2002).

## **Appendix C: Stocktake Of Jurisdictional Investment In Health Workforce Issues**

Existing jurisdictional actions to deal with the current workforce challenges are summarised in the AHWOC stocktake of jurisdictional investment in health workforce. The stocktake project is the first attempt to comprehensively document jurisdictional investment in health workforce policy and planning within the Australian health sector, including current health workforce projects in this area. To date there has been no single point where information about jurisdictional health workforce policy and planning activity could be obtained on a national basis.

As a result, it was considered that collecting this information would provide a useful resource for people working on health workforce issues. It was anticipated that the stocktake information would assist in cross-jurisdictional learning, help avoid duplication and lead to new opportunities for collaboration, both multi-jurisdictional and national.

The project used a survey form to seek information from jurisdictions about their health workforce policy and planning activity and was administered in early 2003. The project report summarises and discusses the information collected through the survey.

The report demonstrates that there is considerable investment in health workforce policy across Australia, including implementation of a number of innovative health workforce strategies to address current shortages. Alongside this, at the national and state/territory levels, strategies to manage future health workforce shortages are being considered in strategic planning and rethinking about future workforce skill mix requirements.

There are many differences among jurisdictions, but also similarities in terms of the issues that require attention. For example, the structural arrangements for health workforce policy and planning vary among jurisdictions, but jurisdictions are grappling with similar matters in relation to the limitations and lack of comparability of health workforce data.

The stocktake report contains information on:

- *Australia's health system and national health workforce structures;*
- *jurisdictional structures for health workforce policy and planning;*
- *approaches to supply and demand analysis of the health workforce;*
- *education liaison mechanisms (medical, nursing, dental, allied health, vocational);*
- *health workforce projects and initiatives; and*
- *workforce data and terminology.*

The report is available from the Health Workforce Australia website at [www.healthworkforce.health.nsw.gov.au](http://www.healthworkforce.health.nsw.gov.au)

## **Appendix D: Summary of the Aboriginal And Torres Strait Islander Health Workforce Strategic Framework**

### *Aim*

To transform and consolidate the workforce in Aboriginal and Torres Strait Islander health to achieve a competent health workforce with appropriate clinical, management, community development and cultural skills to address the health needs of Aboriginal and Torres Strait Islander peoples supported by appropriate training, supply, recruitment and retention strategies.

### *Principles*

- Cultural respect: ensuring that the cultural diversity, rights, views, values and expectations of Aboriginal and Torres Strait Islander peoples are respected in the delivery of culturally appropriate health services.
- A holistic approach: recognising that improvement of the Aboriginal and Torres Strait Islander health status must include attention to physical, spiritual, cultural, emotional and social well-being, community capacity and governance.
- Health sector responsibility: improving the health of Aboriginal and Torres Strait Islander individuals and communities is a core responsibility and a high priority for the whole of the health sector. Making all services responsive to the needs Aboriginal and Torres Strait Islander people will provide greater choice in the services they are able to use.
- Community control of primary health care services: supporting the aboriginal community controlled health sector in recognition of its demonstrated effectiveness in providing appropriate and accessible health services to a range of aboriginal communities and its role as a major provider within the comprehensive primary health care context. Supporting community decision-making, participation and control as a fundamental component of the health system that ensure health services for Aboriginal and Torres Strait Islander peoples are provided in a holistic and culturally sensitive way.
- Working together: combining the efforts of the government, non-government and private organisations within and outside the health sector, and in partnership with the Aboriginal and Torres Strait Islander health sector, provides the best opportunity to improve the broader determinations of health.
- Localised decision making: health authorities developing decision making capacity to local Aboriginal and Torres Strait communities to define their health needs and priorities and arrange for them to be met in a culturally appropriate way in collaboration with Aboriginal and Torres Strait Islander specific and mainstream health services.
- Building the capacity of health services and communities: strengthening health services and building communities expertise to respond to health needs and take responsibility for health outcomes. This includes effectively equipping staff with appropriate cultural knowledge and clinical expertise, building physical, human and intellectual infrastructure, fostering leadership, governance and financial management.

- Accountability for health outcomes: recognising that accountability is reciprocal and includes accountability for health outcomes and effective use of funds by community controlled and mainstream services to governments and communities. Governments are accountable for effective resource application through long-term funding and meaningful planning and service development in genuine partnership with communities.

### *Objectives*

The framework sets out five strategic objectives to transform and consolidate the workforce. The objectives are listed below, more detail on specific strategies for each objective is provided in the framework report.

#### Objective 1

Increase number of Aboriginal and Torres Strait Islander people working across all the health profession

This objective recognises the need for a substantial increase in the number of Aboriginal and Torres Strait Islander people with professional qualifications across all health professions.

#### Objective 2

Improve the clarity of Aboriginal and Torres Strait Islander health workers as a key component of the health workforce, and improve vocational education and training sector for training for Aboriginal and Torres Strait Islander Health Workers

This objective recognises the importance of Aboriginal and Torres Strait Islander health workers as a key component of the workforce and seeks to improve the clarity of roles, regulation and recognition of these workers. This objective seeks to improve vocational education and training sector support for training Aboriginal and Torres Strait Islander health workers. This objective also recognizes the link between the training of Aboriginal and Torres Strait islander health workers and the clarity and recognition of their roles in the health workforce.

#### Objective 3

Address the role and development needs of other health workforce groups contributing to aboriginal and Torres Strait Islander health

This objective recognises that there is a range of health workforce groups, in addition to medical practitioners, nurses and Aboriginal and Torres Strait Islander health workers, that need to be specifically recognized for their contribution to Aboriginal and Torres Strait islander people's health. This group includes, but is not limited to, dentists and other allied health staff, public health professionals, social and emotional well being workers, alcohol and substance misuse workers and the specialist medical workforce. Other workforce groups that contribute to the health of Aboriginal and Torres Strait Islander peoples include Indigenous Australian environmental health workers, health service managers, researchers and a range of others.

#### Objective 4

Improve the effectiveness of training, recruitment and retention measures targeting both non-Indigenous Australian and Indigenous Australian health staff working within Aboriginal primary health services

This objective recognises the need to improve the effectiveness of measures for the training, recruitment and retention of non-Indigenous Australians and Indigenous Australian staff working within Aboriginal primary health services. It emphasises the need to review the effectiveness of accountability arrangements for mainstream workforce initiatives in supporting the recruitment and retention of health professionals in Aboriginal primary health services. It also recognizes that particular strategies may be appropriate for preparing and supporting health professionals to work in the Aboriginal primary health sector.

#### Objective 5

Include clear accountability for government programs to quantify and achieve these objectives and support for Aboriginal and Torres Strait Islander organisations and people to drive the process

This objective recognises that this framework should include accountability through quantifiable targets tied to the objectives. The objective also recognises that there should be support for Aboriginal and Torres Strait Islander peoples to drive the process of achieving the framework's objectives.

#### *Strategies summary*

The framework has a number of strategies under each objective. Implementation of the framework is being overseen by the AHMAC Aboriginal and Torres Strait Islander Health Workforce Working Group. The following is a summary of these strategies (note more detail is available on each strategy in the framework report):

- increase the number of Aboriginal and Torres Strait Islander students in health degree courses;
- mentoring of students, use of scholarships, on campus support
- influence education and training curricula development to incorporate Indigenous Australia health and culture;
- target Aboriginal and Torres Strait Islander secondary students to encourage their entry to health degree courses;
- put in place incentives to ensure the number of Aboriginal and Torres Strait Islander graduates from degree courses is consistent with the need to increase the Aboriginal and Torres Strait Islander health workforce to align with the Indigenous Australian proportion of population;
- improve information, especially about the issues that affect the decisions of Aboriginal and Torres Strait Islander people to enter the health workforce;
- Australia/State/Territory governments respond to the Australian Indigenous Doctors' Association and the Congress of Aboriginal and Torres Strait Islander Nurses priorities;
- greater clarity of the scope of practice of Aboriginal Health Workers;
- development of an Aboriginal Health Worker vocational system to support comprehensive primary health care practice roles;
- develop national competency standards for Aboriginal Health Workers;
- ensure funding is available for the training of Aboriginal Health Workers;

- examine the feasibility of registration for Aboriginal health Workers;
- establish Aboriginal Health Worker associations in each State/Territory and nationally;
- identify current and unmet needs for specific allied health professionals in Aboriginal primary health services;
- develop strategies to address the need for an increase number of specific allied health professionals in Aboriginal and Torres Strait islander primary health care;
- improve the Aboriginal and Torres Strait Islander health content in the existing Master of Public Health courses;
- consider specific training to develop a quality Aboriginal mental health workforce; men's women's and sexual health workers; dental workforce; and alcohol and substance misuse workers;
- adopt a strategy to promote health service management options for Indigenous Australian health, for both Indigenous Australian and non-Indigenous Australian managers;
- work with Deans of medicine, nursing and allied health sciences schools to develop strategies to increase the focus of training of health professionals to prepare for work in multidisciplinary teams in integrated, coordinated services with special emphasis on the continuum of care;
- review the impact of mainstream health workforce programs on the supply, training, recruitment and retention of health professionals with Aboriginal primary health services;
- implement a standard short course in cultural respect for health personnel about to work in an Indigenous Australian service or community;
- develop a methodology for nationally consistent formulation of indicative workforce ratios as a planning tool in the allocation and targeting of resources;
- establish national standards for data collection for the Indigenous Australian health workforce and a strategy for data management; and
- develop performance indicators against which implementation of the framework can be monitored and reported.

## **Appendix E: Summary of Healthy Horizons: A Framework For Improving The Health Of Rural, Regional and Remote Australians**

The purpose of *Healthy Horizons* is to provide a banner under which Australian, State and Territory governments develop strategies and allocate resources to improve the health and well being of people in rural, regional and remote Australia.

### *Vision*

The vision for the health of rural, regional and remote Australians is that:

“People in rural, regional and remote Australia will be as healthy as other Australians and have the skills and capacity to maintain healthy communities.”

The vision will be achieved when:

- there is improvement in the health of rural, regional and remote Australians when compared with other Australians;
- people in rural, regional and remote Australia have access to appropriate levels of health care; and
- areas of high need in rural, regional and remote Australia have access to adequate resources.

### *Principles*

#### Primary health care

The primary health care approach is supported as it provides the opportunity to keep people healthy within the community setting and to intervene at the earliest possible stage to support and maintain good health

#### Public health

Public health forms the basic of improvements in health outcomes and is essentially about activities and programs directed towards prevention. In recent years the term ‘population health’ has been used as a way to more clearly describe prevention at the population level and encompassing broader determinants of health.

The public health approach is important as a basis for a range of actions, such as deciding the location and number of services, informing and educating people about changes needed in their services to meet changing health priorities, and fostering innovation in service delivery and facilities to achieve optimum health outcomes.

#### Capability of communities

Social capability and the physical capacity to plan and implement local programs are required for communities to improve and maintain their health.

#### Community participation

Community participation by individuals, communities and special groups in determining their health priorities should be pursued as a basis for successful programs and services to maintain and improve their health

## Access

Ensuring appropriate access to comprehensive health services that are culturally sensitive is fundamental for all people in rural, regional and remote Australia.

## Sustainability

The ability to sustain good health and a system of care is a necessary part of sustaining rural, regional and remote communities.

## Partnerships and collaboration

The establishment of effective partnerships in the delivery of services and collaboration for the benefit of communities are essential ingredients in successful implementation of health improvement programs.

## Safety and quality

There will be no compromise on the safety and quality of health services provided to people living in rural, regional and remote Australia. Safety and quality are paramount in the development and implementation of health services and programs.

## Goals

*Healthy Horizons* includes 7 goals. The goals guide the direction of effort, while the principles are designed to inform and influence the manner in which the goals are pursued.

Goal 1: Improve the highest health priorities first

There are seven national health priority areas that reflect the burden of disease and illness in Australia: mental health, diabetes, cardiovascular health, arthritis and musculoskeletal conditions, injury prevention and control, cancer control and asthma.

Goal 2: Improve the health of Aboriginal and Torres Strait Islander peoples living in rural, regional and remote Australia

Aboriginal and Torres Strait Islander Australians, in general, are the least healthy of all Australians and have a significantly lower level of access to appropriate health care than non-Indigenous Australians

Goal 3: Undertake research and provide better information to rural, regional and remote Australians

Good information is critical to making good decisions. Information needs to be in a form relevant to the user and to reflect their circumstances.

Goal 4: Develop flexible and coordinated services

The principle of local solutions to local problems informed and supported by participation from health professionals, community representatives, research and evidence is an important basis for developing flexible services. Networked health and community services and models based on local conditions also allow opportunities for improved access to a broader range of services.

## Goal 5: Maintain a skilled and responsive health workforce

One of the major obstacles to improving the health of rural, regional and remote communities is the difficulty experienced in attracting and retaining a competent and highly skilled workforce. Skilled health professionals in sufficient numbers are required. A workforce planning approach is vital to ensure agencies have the right mix of people and skills, and within this framework the following actions are required:

- continue action to remove legal and professional barriers to practice for health professionals in rural, regional and remote Australia to promote flexible practice;
- governments consider the additional costs associated with education and training in rural and remote areas;
- implement Aboriginal and Torres Strait Islander education and employment strategies
- provide cultural awareness training to skill the health workforce to ensure cultural respect;
- undertake workforce analysis of supply and demand for allied health workers across regional and rural communities;
- continue to address the need to reduce professional isolation, provide peer support, locum support and increased educational opportunities;
- ensure there is ongoing reform to achieve resolution of the medical indemnity issues facing the medical workforce; and
- continue to increase the number of students across all health disciplines undertaking rural preparation courses and choosing careers in rural, regional and remote areas (local programs to encourage secondary students to take up health careers, sponsorship of rural students, supporting rural student clubs and programs that introduce tertiary students to rural, regional and remote practices).

## Goal 6: Develop needs-based flexible funding arrangements for rural, regional and remote Australia

Significant progress is being made in reforming traditional funding arrangements that act as barriers to the development of innovative models of health and community service delivery.

## Goal 7: Achieving recognition of rural, regional and remote health as an important component of the Australian health system

Australians in rural, regional and remote areas have a legitimate reason to call for a fair proportion of health system resources in light of poorer health status in many areas and poorer access to services.

## **Appendix F: Proposed Priority Areas For National Goals To Improve Health Safety And Quality**

Proposed priority areas for national goals to improve safety and quality (extract from Australian Council For Safety And Quality In Health Care 2003).

*Measurable patient care improvements* – reducing patient harm in areas such as serious adverse events, health care associated infections, medication errors, inappropriate use of blood, patient falls and pressure ulcers.

*Effective health workforce* – ensuring appropriate education and training in areas of patient safety and quality improvement and appropriate supervision of all health care professionals, with a strong focus on supporting multidisciplinary approaches to patient care.

*Information technology* – using information technology to assist in the uptake of best available evidence in routine health care practice, to improve continuity of care and simplify health care processes.

*Active consumer involvement* – supporting more informed decision making for consumers and consumer involvement on health care improvement.

*Redesign of systems and processes in health* – promoting a culture of safety and greater openness in the health care system and adopting evidence-based best practice as part of routine health care delivery.

*Knowing what works and what doesn't* – developing a health service research agenda and conducting feasibility testing and aggregate level reporting on performance and outcomes.

*Measurement and reporting systems* – improving processes for measurement for local quality improvement and aggregate level reporting on performance and outcomes.

*Governance responsibilities* – achieving greater clarity about agreed responsibilities among clinicians, managers and funders for better care, patient safety and taking action to address system failings, particularly in relation to action following investigation of serious adverse events.

*Consistency of the legislation and regulatory framework* – creating greater consistency to underpin health care safety and quality areas such as medical equipment and devices, professional regulations, reporting of deaths and action on coroners' findings.

## **Appendix G: National Mental Health Plan 2003-2008 Workforce Key Directions**

### *Aims*

The aims of the National Mental Health Strategy are:

- to promote the mental health of the Australian community;
- to, where possible, prevent the development of mental disorder;
- to reduce the impact of mental disorder on individuals, families and the community; and
- to ensure the rights of people with mental disorder.

### *Principles and key directions*

The national mental health plan includes 11 principles and 34 key outcomes. One of the principles is that investment in workforce is essential.

The workforce outcomes in the plan are:

- Improved attitudes, values, knowledge and skills of the mental health workforce

Key directions are promotion of best practice through the National Practice Standards for the Mental Health Workforce, guide and support clinical supervision and mentoring, structure continuing education and curricula development, support and strengthen the role of consumers and carers working in the mental health system, and further development of training for all professionals providing mental health care.

- Improved supply and distribution of the mental health workforce

Key directions are initiatives to retain the mental health workforce; enhance the role of general practitioners and allied health professionals in providing mental health care; provide incentives to work in the public sector; plan workforce supply; increase the proportion of Aboriginal and Torres Strait Islander mental health workers; and strengthen initiatives to enhance the recruitment, retention, status, skills and numbers of the mental health nursing workforce.

- Improved workforce environment

Key directions are improve occupational health and safety, and communication infrastructure and for the mental health workforce, and improve support for general practitioners and other primary care mental health providers, especially in rural and remote areas.

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