Tasmanian Strategic Health Workforce Framework

Delivering Future Care

Discussion Paper

Developed by the
Education and Training Unit & Nursing and Midwifery Unit
Strategic Control, Workforce and Regulation

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Executive Summary

The creation of a Tasmanian Strategic Health Workforce Framework is integral to ensuring the future of Tasmania’s health and human services. Australian public health and human services face unprecedented challenges to service delivery due to a changing environment that includes an ageing population, significant increases in chronic disease and co-morbidity, rapid changes in technology and increasing community expectations.

In 2012, the report Health Workforce 2025 Doctors, Nurses and Midwives was released, providing Australia’s first major, long-term, national projections for these professions. The report showed that unless there were significant changes in workforce design and service delivery models that Australia would not be able to meet the health care needs of our population.

Tasmania’s challenge is significant. The Tasmanian population is older than the rest of the nation, we have higher rates of chronic disease and patterns of socio-economic disadvantage that impact upon health status. Addressing these issues and improving health outcomes is a key priority. The ageing population is also reflected in the levels of workforce participation, highlighting the need for workforce analysis and planning as well as innovative strategies to expand skills and maintain labour market participation.

Significant changes will be required to workforce numbers, distribution, education pathways, models of care, and skills in order to secure a sustainable, affordable workforce, equipped to meet the health service needs of Tasmanians into the future.

The need for workforce reform in our State is examined within this Discussion Paper in relation to five major drivers: improving health outcomes; impending workforce shortages; geographical distribution of populations and access to services; the future affordability of health care; and the increasing specialisation of healthcare professionals.

Department of Health and Human Services
- Key Priority Areas

The Department of Health and Human Services (DHHS) is committed to the provision of quality patient/client centered care. Five key strategic priorities have been developed to improve the health and wellbeing of patients, clients and the Tasmanian community through a sustainable, high quality and safe health and human services system.

Priorities are:

- Promoting health and wellbeing and intervening early when needed through developing and delivering prevention, promotion and early intervention activities
- Planning and forecasting the delivery of sustainable health and human services guided by evidence-based policy
- Engaging with and embracing national and state reform agendas to improve our services. Become recognised as both a first adopter and demonstration site for reform
- Building the Department’s system management capacity. Working with service delivery areas to improve service quality, safety and the performance capability of both the Department and service delivery areas
- Enabling our workforce to be properly educated, trained and developed, motivated and appropriately supported to give of its best.
Vision

The Tasmanian Strategic Health Workforce Framework 2013 - 2018 will be a key enabler to address challenges and ensure a culture and working environment within the public health system where doctors, nurses, midwives and allied health professionals are respected and supported to provide high quality patient/client centered care.

The Tasmanian Strategic Health Workforce Framework 2013 – 2018 will ensure alignment with the Commonwealth, Health Workforce Australia and the education sector in the training, recruiting and retention of doctors, nurses, midwives and allied health professionals to adequately respond to future needs.

In this changing health environment, it is recognised that it is not possible to develop a framework for the next twelve years that will adequately respond to needs. This first Strategic Health Workforce Framework 2013-2018, will focus on the next five years taking into account Health Workforce data for 2025. The Strategic Health Workforce Framework will be an overarching document that sets the platforms for an iterative approach to establishing the direction for a future health workforce to deliver a high quality, sustainable, responsive and integrated health system to meet the future needs of the Tasmanian community.

The Purpose of this Paper

This Discussion Paper is an opportunity for you to provide input into the Tasmanian Strategic Health Workforce Framework 2013– 2018 and how to develop and support our health professionals to provide excellent care for patients.

The paper presents a summary of the major themes that have arisen from national health reform, national policy directions, key workforce challenges and the enablers for change that will influence Tasmania’s future health care system health and service delivery.

Throughout this paper there are a number of discussion points with key questions designed as a platform for further discussion and consultation. Feedback will be used to maximise future health workforce reform and funding bids to support innovation. A summary of discussion points are provided on pages 8-9.

Valuing People’s Experiences and Feedback

Input from staff is vital to the development of a Workforce Framework within the DHHS. This paper will be circulated widely and feedback may be submitted electronically through the DHHS website or through participation in regional consultative workshops. Feedback gathered during the consultation process will be used to form the foundation of the Workforce Framework.

To ensure the Workforce Framework is relevant to Tasmanian workforce needs, input will also be obtained from working groups representing professional groups, and forums focusing on inter-professional practice and new models of care to meet emerging health care needs.

Underpinning the development of the Workforce Framework is the focus on clients/patients and ways to improve access to quality health care. The Tasmanian Strategic Health Workforce Framework 2013–2018 will be a key enabler to achieving this.
How to Respond to this Paper

You are invited to consider the discussion points raised in this Paper and provide written comment.

There is no set format and comments/submissions do not need to be formal documents. However, referencing to the relevant sections of the paper will assist with the compilation of the feedback.

Where possible, please submit your feedback electronically.

Comments or submissions should be marked Tasmania’s Strategic Health Workforce Framework and sent to:

Post: Clinical Professor Fiona Stoker
Chief Nurse and Midwifery Officer and
Director of Education and Training
Chair of the Tasmanian Clinical Education Network
Department of Health and Human Services
GPO Box 125
Hobart TAS 7001

Email: workforce@dhhs.tas.gov.au

Comments/submissions should be lodged by close of business, Friday, 6 September 2013 and receipt will be acknowledged via email.

It is not intended to publish the comments and submissions, but a list of individuals and organisations that respond to this paper may be publicised. If you do not wish to be identified in any public document this should be noted clearly on your submission and in this case, your comments/submission will be attributed anonymously.

Comments and submissions, together with further data analysis and consultation will be taken into account in the development of the Tasmanian Strategic Health Workforce Framework 2013 - 2018.
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<td>Discussion Point</td>
<td>Workforce Reform – The Context</td>
<td>Given the Tasmanian healthcare context, how should service delivery models be shaped for the future?</td>
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<td>Do you have examples of innovative models that may have applicability elsewhere in Tasmania?</td>
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<td>What types of skills would be required in these models?</td>
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<td>What key aspects of service redesign do you think would have the greatest impact for your area and service delivery? What implications would these have for workforce redesign?</td>
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<td>Discussion Point</td>
<td>National Health Workforce Innovation and Reform</td>
<td>Can you provide examples of successful collaborative care arrangements? Are there opportunities to improve collaborative practice within your area that could be used more broadly?</td>
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<td>What mechanisms and support are needed to better enhance greater collaborative practice within and across Tasmania’s health and human services areas?</td>
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<td>Given Tasmanian health care needs and pressures on the acute system, what should emerging models of care look like in your area?</td>
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<td>Can you identify potential areas for extended scope of practice? If so, what would this look like and how would this help to improve service delivery?</td>
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<td>Would the development of an overarching skills or competency framework assist your area to undertake workforce redesign and innovation in your area?</td>
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<td>How would increasing the generalist workforce provide expanded opportunities for your service?</td>
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<td>What strategies do you think would be most effective in developing a generalist workforce?</td>
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<td>How can we better work across health care settings to improve patient/client centred care and ensure critical services are provided?</td>
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<td>Are there specific technological advances that could be implemented to improve the way we work? If so, how will this make the workforce more efficient, impact service delivery and improve health outcomes?</td>
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<td>Do you have examples of innovative and interdisciplinary practice that could be applied more broadly across Tasmania?</td>
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<td>Are there other roles you would like to see developed in other professional areas?</td>
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<td>Are there specific of collaborative practice areas where Allied Health Professionals could improve health outcomes and reduce demand on the acute care sector?</td>
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<td>Do you have examples of expanded scopes of practice or generalist approaches that could be considered for piloting in Tasmania?</td>
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<td>Three</td>
<td>Distribution, Attraction and Retention</td>
<td>Do you have examples of innovative models of service delivery that have worked well in rural and remote regions?</td>
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<td>What type of educational preparation and support should underpin these models?</td>
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<td>Do you have examples of attraction and recruitment strategies that could be used more broadly?</td>
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<td>Do you have examples of flexible working arrangements and strategies that could be applied effectively to improve service delivery in rural and remote areas?</td>
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<td>Do you have effective strategies for attracting and retaining staff in rural and remote areas? What do these look like and what support is required?</td>
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<td>How can we improve our training pathways for rural and remote areas?</td>
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<td>If you work in a rural or remote area have you accessed education, training or a peer support network via telehealth? If yes, how can this experience be enhanced?</td>
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<td>What strategies could be used to improve locum/agency workforce?</td>
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<td>Ageing Workforce</td>
<td>Do you have examples of strategies that have worked well to support older workers in the workforce?</td>
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<td>Five</td>
<td>Capacity Building - Education and Training</td>
<td>How can we better develop and support the Vocational Education and Training sector career pathways?</td>
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<td>What are the elements that should be included in clinical education?</td>
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<td>What opportunities do you see for building the capacity of the workforce to include a stronger preventive focus and work in health promoting ways?</td>
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<td>How could your area contribute to closing the gap in Aboriginal and Torres Strait Islander health? What information and skills would you need?</td>
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<td>Do you have an example of a successful cultural change strategy or program that has increased the capacity of staff to work in different ways?</td>
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<td>How can we further build capacity for education and training to address future workforce need?</td>
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<td>What other key areas of focus should be included in the TCEN Work Plan?</td>
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<td>Is there potential for inter-professional learning within your area? If so, what does this look like and what is required to support this?</td>
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<td>Can you identify any mechanisms that could be used to further assist in the engagement of new graduates in the short-term?</td>
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<td>Would an interactive program for newly qualified health professionals and support staff, such as Flying Start, assist with workforce integration in your area? How could greater use of technology assist with this?</td>
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<td>Do you have examples of strategies to enhance career pathways that could be more broadly implemented?</td>
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<td>How can we more effectively provide mentoring and support?</td>
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<td>What are the barriers to the development of staff?</td>
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<td>Clinical Leadership</td>
<td>How can we create a culture that values the role of leader, supervisor/preceptor and educator?</td>
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<td>What are the barriers to providing supervision support, and what can be used to address these barriers?</td>
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1. Workforce Reform – The Context

1. The Australian health care system is regarded as one of the best in the world with government-guaranteed universal access to public health care, mid-range spending on health as a percentage of Gross Domestic Product (GDP) compared to other OECD (Organisation for Economic Co-operation and Development) countries, and health care delivery through a mixed public and private system with good health outcomes compared to numerous other countries. However, increases in chronic disease and preventable diseases, an ageing population, new treatments becoming available and rising health care costs are placing a strain on Australia’s public sector system.

2. To ensure sustainability into the future, the Commonwealth and States and Territories, are implementing a very broad program of reform across the public health sector to improve the health outcomes for all Australians and ensure the sustainability of the system. These include governance and organizational changes, innovation in the health system to improve access and health status, workforce redesign and changes in the funding system.

3. To attract, retain and expand the health workforce so it can meet Australia’s health care needs, Health Workforce Australia (HWA) was established to lead and support Australia’s critical health workforce planning, training and reform priorities. In 2012, Health Workforce 2025 Doctors, Nurses and Midwives was released providing Australia’s first major, long-term, national projections for these professions. Currently, forty (40) allied health professional and other occupations are being examined.

Projected Workforce Shortages

4. The projections from the Health Workforce 2025 report on Doctors, Nurses and Midwives were modeled on the future supply of health care professionals against future demand; basing the demand projections on current utilisation rates including admissions, demographic and disease trends, and using the current service delivery models.

5. Without reform Australia is looking at a shortage of over 112,000 professionals in these categories – the majority being nurses (109,000). The study of dentists and allied health professionals is yet to be concluded but shortages in dentistry are already evident, as well as shortages of key allied health professionals in rural areas.

6. Both the HWA 2025 study and the Review of Australian Government Health Workforce Programs concluded that it is not possible or affordable to address this shortage by training alone. Service redesign accompanied by workforce change is also required. In addition to education and training

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3 Council of Australian Governments (2011) National Healthcare Agreement
5 Health Workforce Australia (2012) HW2025 Doctors, Nurses and Midwives Volumes 1,2,3.
6 Ibid
7 Mason, J. (2013) Review of Australian Government Health Workforce Programs
initiatives, measures are required to improve retention, address workforce distribution, better
manage and reduce the demand on services; and enable health care professionals to work at the full
extent of their scope of practice through the use of technology, role redesign, and the development of
varied skills.

7. A recent Environmental Scan undertaken through the Community Services Health Industry Skills
Council has identified community services and health as Australia’s largest industry grouping,
employing nine (9) per cent of the workforce. Industry employment is projected to grow by at least
35 per cent over the next ten years. Health expenditure has increased by $53 billion from $77.5
billion in 2000-01 to $130.3 billion in 2010-11.

8. This paper has been developed as a first step in the development of a Workforce Framework and
toolkit to assist local areas in the development of workforce plans. Feedback from the paper will also
assist inform the Department on key areas and gaps with regard to the health reform agenda. The
paper will be disseminated through the Department of Health and Human Services (DHHS) and each
Tasmanian Health Organisation (THO) via the internet and several key workshop/forums will be held
as consultative mechanisms to maximise feedback.

Tasmania’s Health Status

9. Tasmania faces serious health challenges in comparison to those experienced nationally. The
Tasmanian population increased from 476,481 to 495,354 between in 2006- 2011. Some health
indicators have improved; Tasmanians are living longer, but they still have lower than average health
outcomes in terms of life expectancy at birth, potentially avoidable deaths, and mortality rates.

10. While the gap between the health status of indigenous and non-indigenous Tasmanians has decreased,
the health outcomes of the indigenous members of our community remain significantly lower.
Aboriginal people have a lower life expectancy than all other Australians, 64.8 years for Aboriginal
women and 59.4 years for Aboriginal men. These ages are approximately 16-17 years less than the
overall life expectancy of the Australian population.

11. Tasmania has the oldest population of any state or territory with 16% of people over 65 years of age.
By 2025 it will reach 23% and expected to double in 40 years’ time. The Tasmanian median age of 40
years is 2.6 years more than the national median. While this seems small it translates to approximately
500 more cases of cancer a year than if Tasmania was at the national median age (State of Public
Health 2013). Cancer of all types is the leading cause of death in Tasmania with colorectal cancer
being the second most common.

12. Tasmania has higher rates of chronic disease than almost all other States and Territories with
increasing rates of cancer, diabetes, respiratory disease, mental health conditions, arthritis, heart
disease and stroke. For example, AusDIAB data show that approximately 8% of the adult population
have type 2 Diabetes. However, only 4.6% of people are aware they have diabetes. Diabetes
amongst the younger population is on the increase, and the higher risk rates of the Tasmanian
population related to alcohol consumption, smoking, poor nutrition, obesity and low physical activity

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9 Australian Bureau Of Statistics Census (2010) Health and Welfare of Australia’s Aboriginal and Torres Strait Islander Peoples
are cause for concern.

13. The health picture reflects patterns associated with rural regions, socio-economic disadvantage as well as the age of the population. Average income and educational levels are below that of most other States with 31% of Tasmanian households relying on income support including aged, disability and sole parents support. Tasmania has the highest percentage of families headed by a sole parent (17%) of any other State or Territory, and also has the highest disability prevalence rate at 22% of our population.

14. Between 5-10% of Tasmanians lack food security. Industry partnerships to address food security along with innovative social housing initiatives are in place to reduce the cycles of disadvantage that contribute so strongly to long term health outcomes13.

15. The Disability and Community Services arm of DHHS has service delivery partnerships with the community service sector to actively decrease risk factors and improve outcomes via a range of services to children, young people, and families. For example, risk factors associated with family functioning, parenting and mental health including post-natal depression is high on the agenda of child, youth and family services. Amongst known risks is the loss of family and community networks which can occur for individuals, or impact an entire cultural community as occurred for members of the Stolen Generations14.

16. Clearly Tasmania is facing a significant challenge to improve outcomes, reduce demand, create new models of care and achieve financial sustainability. This will not be possible without an engaged workforce with the knowledge, skills and capability to make the difference.

Tasmania’s Reform – Service Delivery and Funding

17. In line with the reform agenda, Tasmania’s DHHS was restructured with Parliament passing enabling legislation to underpin THO s and their Boards of Directors. The responsibilities of the DHHS agency have been separated so that:

- The DHHS ‘Department’ is the funder of services and system manager, being responsible for policy, planning, setting the terms of service performance, and the interface with government
- DHHS Operational Units deliver agreed services - Population Health, Ambulance, Disability, Housing and Community Services, and Children and Youth Services.
- THOs are responsible for providing public sector hospital and community health services.

18. The Commonwealth established the Tasmanian Medicare Local Organisation (MLO) to improve access to, and coordination of, primary health services. The THOs and MLOs are responsible for leading and delivering their service activities in ways that are responsive to the community. This includes ensuring that hospital and primary health services work well together for patients/clients.

19. The introduction of Activity Based Funding (ABF) has implications for the way that Tasmania’s resources are allocated. The Commission on the Delivery of Health Services in Tasmania 2012 noted that Tasmania had higher than average costs per hospital separation.

20. The Commission noted that the Commonwealth Grants Commission (CGC) had assessed that in recognition of Tasmania’s current health and service provision factors, the island state needed to spend 11.6% more than the national average on admitted patient services. However Tasmania is

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spending 34% more.

21. The CGC also assessed that the Tasmania public sector needs to spend 19% more than the national average on community based and ambulatory health care services. However, spending is 40% less than the national average15.

Service Delivery Reform

22. While it is not possible or safe, to provide every type of service in every locality, the design of services is focused around meeting community needs by providing timely, accessible high quality services across a comprehensive range of health care settings. Principles of social inclusion also drive service design to address health inequities and ensure services are appropriate; examples include rural and remote communities, the Aboriginal community and people with complex health care needs.

23. The current imbalance between Tasmanian public sector spending for admitted and non-admitted services and the increasing burden of chronic disease and comorbidities has implications for the design of services and models of care as well as the numbers and skill mix of health workers required.

24. There are a number of proven initiatives that work in conjunction with acute care services, to reduce avoidable hospital admissions and readmissions by interdisciplinry programs. The New South Wales (NSW) Chronic Care Program (Connecting Care), Victorian Hospital Admission Risk Program (HARP), and Hospital in the Home Services (HITH) are examples along with focused effort by hospitals to identify and reduce factors that can unnecessarily add to a patient’s length of stay.

25. There is also emerging evidence that a patient centered ‘Medical Home’ program with a collaborative practice approach can deliver improved outcomes. A ‘Medical Home’ is based on defined collaborative partnerships between a General Practitioner (GP) and patient, and other service providers including medical specialists, hospital, community nursing, allied health and broader service providers. The Commonwealth has recently flagged interest in working with the Royal Australian College of General Practitioners (RACGP), Medicare Locals and THOs to explore evidence based approaches to this model16.

26. Service redesign may be triggered by new technology, or by increasing volumes, access barriers, escalating costs, service imbalances, or workforce shortages. The latter may include services dependent upon a sole practitioner or where a small but critical workforce in danger of decline.

27. Increasingly, reviews of service delivery models will consider workforce redesign in order to respond to changing demands, new evidence, or where health practitioners or managers see opportunities for improved models and use of highly specialised and general skills. The Community Health Industry Skills Council Review17 highlights the importance of reviewing the utilisation of skills amongst a workforce in the light of educational and technological advances. Enabling the best possible use of the skills and competencies of our workforce will be an increasingly important factor in achieving a sustainable service while maintaining the quality of patient care.

Q1 Given the Tasmanian healthcare context, how should service delivery models be shaped for the future?

16 Mason, J. (2013) Review of Australian Health Workforce Programs
Q2 Do you have examples of innovative models that may have applicability elsewhere in Tasmania?

Q3 What types of skills would be required in these models?

Q4 What key aspects of service redesign do you think would have the greatest impact for your area and service delivery? What implications would these have for workforce redesign?
2. National Health Workforce Innovation and Reform

New Ways of Working

28. The National Health Workforce Innovation and Reform Strategic Framework provides an overarching, national platform to guide future health workforce policy and planning in Australia. Two key aspects are focused on:
   - supporting the development of more adaptable and efficient roles within service delivery models that will better address population health needs
   - ensuring the workforce is equipped with the requisite competencies to support team-based and collaborative models of care\(^\text{18}\).

Collaborative Practice

29. The World Health Organisation (WHO) has identified that collaborative practice in healthcare occurs when multiple health workers from different professional backgrounds provide comprehensive services by working with clients/patients, their families, carers and communities to deliver the highest quality of care across settings. This practice includes both clinical and non-clinical health-related work, such as diagnosis, treatment, surveillance, health communications and management\(^\text{19}\).

30. There is a growing understanding of the positive benefits when health professionals work collaboratively to deliver care. The interconnectivity between health professionals, who bring a range of varied knowledge and expertise, contributes to better patient care and outcomes as well as improved health service efficiency.

31. The focus on primary and preventative care and the increase in the number of patients with chronic illnesses and co-morbidities, signals the need for inclusion of interdisciplinary workforce models. The Tasmanian Strategic Health Workforce Framework 2013 – 2018 will enable comprehensive profiling of future workforce requirements.

32. Institutional support strategies are required to develop collaborative practice\(^\text{20}\). Institutional mechanisms can shape the way people work collaboratively, creating synergy instead of fragmentation. Staff participating in collaborative practice requires clear governance models, structured protocols, and shared operating procedures.

33. Collaborative practice is effective when there are opportunities for shared decision-making. This enables health workers to decide on common goals and patient management plans, balance their individual and shared tasks, and negotiate shared resources. Structured information systems and processes, effective communication strategies, strong conflict resolution policies and regular dialogue among team and community members play an important role in establishing a good working culture.

\(^\text{18}\) National Health Workforce (2011) Innovation and Reform Strategic Framework for Action 2011-2105


http://www.who.int/hrh/nursing_midwifery/en/


http://www.who.int/hrh/nursing_midwifery/en/
34. The use of technology, space design, and the built environment can significantly enhance or detract from collaborative practice in an inter-professional clinic or networked service. In some cases, effective space design has included input and recommendations from the community and patients, as well as members of the health-care team.

35. There are a number of collaborative practice examples in Tasmania including Nurse Practitioner Collaborative Practice agreements, and formal Shared Care arrangements between general practitioners, rural community nurses, midwives and regional hospital birthing services.

**Q5** Can you provide examples of successful collaborative care arrangements? Are there opportunities for improved collaborative practice within your area that could be used more broadly?

**Q6** What mechanisms and support are needed to better enhance greater collaborative practice within and across Tasmania’s health and human services areas?

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**Discussion Point: Collaborative Practice**

Are there any opportunities for improved collaborative practice within your area and across the sectors?

What mechanism and support is needed to better enhance greater collaborative practice within and across Tasmania’s health, human and education sectors?

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**Changing Scopes of Practice**

36. Australia is well advanced in its program to ensure national consistency in the standards of health practitioners in all states and territories through accreditation of all programs of education leading to a qualification as a health care provider, registration of professionals, definitions of scopes of practice and competency standards.\(^{21}\)

37. A scope of practice describes those activities that a health practitioner is educated, competent and legally authorised to perform. The scope is influenced by the needs of consumers; the settings in which they practice and the policies of employers. It is important that health care workers are enabled to work to the maximum of their scope as they continuously review their practice, learn and develop.

38. The HWA are funding a number of pilot programs to expand existing scopes of practice to enable health service professionals to redesign their services and provide improvements to patient/client services care on a collaborative practice basis. The projects are also identifying legislative or industrial

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barriers that impact on the ability to progress solutions.

**Expanding Scopes of Practice (ESoP) Program**

39. HWA have funded a specific program to improve productivity, recruitment, retention and ultimately to improve accessibility and health services to patients. Currently, the program consists of four sub-projects to Expanding Scope of Practice (ESoP):22:

- Physiotherapists in the Emergency Department
- Nursing in the Emergency Department
- Extending the Role of Paramedics
- Advanced Practice in Endoscopy Nursing.

40. **ESoP Nurses in Emergency Departments (ED):** Projects are being piloted across eight (8) sites in NSW and Victoria in response to the high volumes of patients presenting to emergency departments. In these projects, experienced ED Registered Nurses who meet specified competency standards are initiating and managing a range of patient care assessment and treatment protocols developed in a collaborative practice model.

The aim is to:

- identify and implement models of expanded work that demonstrate improved productivity by decreasing waiting times for patients in emergency departments
- allow increased medical time for more acutely ill patients
- develop guidelines and training to support take-up of these roles across Australia.

41. **ESoP Physiotherapists in Emergency Departments:** Senior physiotherapists are assessing and managing patients presenting to the ED with acute low back pain and peripheral musculoskeletal injuries.

Outcomes include:

- increased availability of ED medical staff to manage higher acuity patients in a timely manner while delivering quality care for people presenting with peripheral musculoskeletal injuries and low back pain
- the innovation has also resulted in improved ED ability to meet access targets
- provided a career path for skilled musculoskeletal physiotherapists and assisted with retention.

42. **Extended Care Paramedic:** Pilot projects enable extended care paramedics to treat patients at home, where appropriate, reducing visits to emergency departments as well as patient transfers between facilities. A trial in Tasmania has demonstrated outcomes that include less disruption for patients, increased support for patients to remain at home including their residential care home, and less time transporting vulnerable patients between home and medical facilities.

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43. **ESoP for the Nurse Endoscopist:** $2.6 Million has been provided to Victoria and Queensland Health for development and implementation. Nine hospitals are participating including the Alfred, Austen, Monash Medical Centre and Logan hospitals plus five (5) other implementing hospitals. Evidence is showing that the provision of a nurse endoscopist as part of a collaborative service, improves patient access, helps reduce waiting times, and increases patient satisfaction.

44. Drawing on just one example from above, the nurse endoscopist program could assist in meeting the high demand and waiting times for endoscopy services in Tasmania. The leading cause of death in Tasmania is cancer of all types and Tasmania has the second highest incident and mortality rates of Australian States and Territories\(^23\). Bowel cancer is the second most common cause of death of males, and third most common cause of death of females\(^24\).

45. Extended scopes of practice can be enhanced by the Medicare Benefits Schedule (MBS)\(^25\) and Pharmaceutical Benefits Scheme (PBS)\(^26\). For example, Nurse Practitioners (NP) and Eligible Midwives (EM) prescribe authorised medications and order diagnostic investigations. Nurse practitioners and midwives in the private sector have access to limited items in the MBS and PBS.

46. In general practice, the role of practice nurses is supported by the MBS Practice Nurse items. This allows more effective use of the skills of the practice nurse and the general practitioner.

47. A range of Allied Health Providers (AHP) can access the MBS system on referral. AHP MBS numbers have greatly increased access to practitioners who are key to the improved management of chronic disease, injury, rehabilitation and mental health disorders.

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**Q7** Reviews of roles open up numerous questions; for example, can we better utilise the skills of pharmacists within their scope and with collaborative care models? What impacts could this have on improving services?

**Q8** Given Tasmanian health care needs and pressures on the acute system what should emerging models of care look like in your area?

**Q9** Can you identify potential areas for extended scope of practice? If so, what would this look like and how would this help to improve service delivery?

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\(^24\) Menzies Research Institute Tasmania (2008) *Cancer in Tasmania – A Snap Shot*


The Health Professionals Prescribing Pathway Project

48. The Health Professionals Prescribing Pathway is aligned with the work to expand scope of practice and ensure timely and safe access to care. Health Workforce Australia (HWA) seeking to deliver:

- a national approach to prescribing by health professionals, other than doctors, that covers important concepts such as prescribing models, competency attainment, registration and endorsement, and safety, quality and practice issues
- an implementation plan for a national prescribing pathway that includes a hierarchy of authorisation for:
  - full prescribing rights within scope
  - protocol prescribing (within the parameters of protocols or standing orders)
  - specific authorization such as currently exists for non-medical authorised immunisers (e.g. Nurses, Aboriginal and Torres Strait Islander Health Practitioners).

Skills Acquisition and Competence

49. Multi-disciplinary teams frequently share a core set of common skills. Utilising shared competencies to reduce duplication and increase service capability depends on the models of care, the systems that support team operations, and the ability to determine what actions are required and who will provide them.

50. HWA is identifying and articulating skills that are shared across the health workforce in the delivery of healthcare services, such as taking a patient’s history. By understanding the skills and competencies collectively available, it becomes possible to make better use existing skills to enhance service delivery and to include core skills in educational programs.

51. The National Common Health Competency Resource: is primarily being developed as a tool to inform and support flexible approaches to workforce design on the basis of skill mix. The resource will also support inter-professional models of care by maximizing skill utilisation and assist people with planning continuous professional development. HWA is seeking feedback via the link in the footnote below²⁷.

52. The Broken Hill Primary Schools Program: This innovative program provides interdisciplinary allied health training and service provision. New knowledge and skills are applied in a service delivery model that is creating sustainable services for Broken Hill. The program has increased the rate of screening, assessment, intervention and referral for children with issues ranging across speech and language, motor skills, nutrition and obesity²⁸.

53. Specialist Mental Health Services for Older Persons Program (SMHSOP): An innovative approach to ensure services for a vulnerable group saw the establishment of a sustainable scholarship system for clinicians from any professional background. The program will build capacity through supporting advanced study leading to a professionally recognised qualification with the NSW Institute of Psychiatry. Twenty interdisciplinary staff have received the scholarship over the past 5 years. with

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²⁸ Mason, J. (2013) Review of Australian Government Workforce Programs, Chapter 3
demonstrated service benefits to the clients.  

Q10 Would the development of an overarching skills or competency framework assist your area to undertake workforce redesign and innovation in your area?

Generalist/Specialist Mix

54. Findings from the HWA analysis of the medical workforce show a decline in specialist training of generalists in favour of a marked increase in subspecialty training. This trend has impacted on the distribution of the workforce with a marked maldistribution of the medical workforce between metropolitan areas and regional areas such as Tasmania and a significant impact on service delivery.

55. The term ‘generalist medical practitioner’ refers to GPs, rural generalists and other general specialists, such as general surgeons, pathologists and physicians who retain a broad scope of practice. The Australian Medical Association strongly endorses the HWA 2025 findings on the need to enhance the medical workforce with doctors who specialise as generalists with improved training programs and career pathways, and greater recognition and support for the important work provided by generalists across the health system. Initiatives to strengthen rural medical training and exposure of interns and registrars to other settings implemented in association with the Australian Medical Council, the Medical Board of Australia, Colleges and other key stakeholders.

56. The Australian General Practice Training (AGPT) program provides vocational training for medical practitioners wishing to specialise in general practice. It is designed to prepare registrars to be assessed for Fellowship of the Australian College of Rural and Remote Medicine (FACRRM) and/or Fellowship of the Royal Australian College of General Practitioners (FRACGP). Both fellowships lead to registration as a specialist General Practitioner. In Tasmania, a General Practice Training Tasmania (GPTT) coordinates GP Registrar Training with the aim of meeting population and accredited quality training needs.

57. Currently, the Pre-vocational General Practice Placement Program (PGPPP) operates on a 13 week rotation basis for interns employed in a regional or tertiary hospital. A program is underway to pilot a Community Based Intern Education program through the AGPT by locating interns for a year in accredited general practices and providing rotations to hospitals as well as community health services. University of Melbourne Commercial is currently scoping this program and, subject to the findings of the feasibility study, will commence intern placements in early 2014.

58. The recognition of non-vocationally recognised GP’s is a separate subject with complex MBS funding arrangements that sees patients who attend these doctors further out of pocket due to lower rebates. Pathways to support non-vocationally recognised GP’s is not the subject of this paper but the issue is noted as an important component of retaining experienced GP’s in rural and socio-economically disadvantaged areas and ensuring equity in access for the communities they service.

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29 Health Workforce Australia Inventory Of Innovation [http://www.hwainventory.net.au/](http://www.hwainventory.net.au/)
30 HWA2025 Medical Specialties Volume 3
31 Australian Medical Association (2012) Position Statement on Fostering Generalism in the Medical Workforce
32 Mason, J. Review of Australian Government Workforce Programs, Chapter 3
34 Mason, J. (2013) Review of Australian Government Health Workforce Programs
59. The Mason Review\textsuperscript{35} of Australian Government Health Workforce Programs has recommended strongly that programs to develop nursing and allied health rural generalists also be prioritised. There are a number of programs that could be considered for trial or implementation into Tasmania for example:

- the Western Australian Government offers Country Nurse Programs including an ‘Ocean to Outback Program’ for Graduate RN and EN’s as well as a ‘Country to Coast’ Program for RNs with more than 2 years’ experience to undertake a structured rotational program across rural and remote hospitals and services. The Country Nurse Program links to a formal Post Graduate Certificate Program and qualifications in rural and remote nursing for those interested in specialty practice and further development towards advanced practice.

60. The Australian Rural Health Education Network (AHREN) has also proposed a new program of clinical training for final year dental students\textsuperscript{36}.

61. The Australian Primary Health Care Research Institute\textsuperscript{37} identifies three policy areas for consideration in enhancing generalist care delivery:

- increase the importance and status of primary health care generalist workforce through career pathway development and remuneration
- enhance the educational content and settings that strengthen a generalist primary health care workforce. This includes how curricula can be expanded to increase focus on chronic disease management\textsuperscript{38}
- build and transfer evidence about strategies that strengthen generalism in the primary health care team.

Q11 How would increasing the generalist workforce provide expanded opportunities for your service?

Q12 What strategies do you think would be most effective in developing a generalist workforce?

Q13 How can we better work across health care settings to improve patient/client centred care and ensure critical services are provided?

Q14 Are there specific technological advances that could be implemented to improve the way we work? If so, how will this make the workforce more efficient, impact service delivery and improve health outcomes?

\textsuperscript{35} Ibid

\textsuperscript{36} Australian Rural Health education Network (2010) A Bright Future for Rural Health


\textsuperscript{38} Commonwealth of Australia (2008) "Towards a National Primary Health Care Strategy": A Discussion Paper
Discussion Point: Workforce Reform - delivery of service to expanded health care settings

What could service delivery models, or models of care look like in your area and what roles would be required?

What key aspects of workforce redesign do you think will have the greatest impact for your area and service delivery?

Would the development of an overarching competency framework assist workforce redesign and innovation in your area?

How can we better work across health care settings to improve patient/client centred care and ensure critical services are provided?

Are there specific technological advances that could be implemented to improve the way we work?

If so, how will this make the workforce more efficient, impact service delivery and improve health outcomes?
Increasing the Utilisation of Other Roles

Nurse Practitioner

62. A nurse practitioner (NP) is a Registered Nurse who is educated and endorsed to function autonomously and collaboratively in an advanced and extended clinical role. The NP role includes assessment, planning, diagnosis, management, referrals, prescribing medications and ordering diagnostic investigations within their specialty area of practice. NPs have completed a Nursing and Midwifery Board-approved Nurse Practitioner qualification at Master’s level. Post Graduate specialist qualifications and advanced practice for a minimum of three (3) years are pre-requisites of entry into a NP Masters Program. The Master’s program includes a period of internship and NP’s must meet National Competency Standards to achieve and maintain Registration endorsement as an NP39.

63. Tasmania has a small number of NPs working in the public sector in practice collaboratives with key medical staff and interdisciplinary staff. NPs work across the acute and community sector, functioning in specialties such as in Diabetes, Cardiac Rehabilitation, Aged Care, Aged Mental Health, and Emergency Care. In addition the State has a number of qualified NP’s in Wound Care, Burns and Women’s Health who are not yet employed in funded NP roles. Tasmania has also received Commonwealth funding for the development of an NP position for Palliative Care.

Eligible Midwives

64. Eligible Midwives are a class of midwives endorsed as qualified to prescribe Schedule 2, 3, 4 and 8 medicines required for midwifery practice across pregnancy, labour, birth and post natal care, in accordance with relevant State legislation. To be endorsed for scheduled medicines, a midwife must be able to demonstrate successful completion of an accredited and approved program of study determined by the Nursing and Midwifery Board of Australia. The program develops midwives’ knowledge and skills in prescribing, and ability to meet competency standards to maternity care to women and their infants.

Physician Assistants

65. Physician Assistants are members of the medical profession who are educated in a Medical School to work in collaboration and under supervision of a registered medical practitioner. Physician Assistants are generalists and can work in any field of medicine. Physician Assistants do not replace other professions, but work collaboratively within existing multidisciplinary teams. Physicians Assistants must have completed at least five (5) years of practical experience in any health profession to be granted entry into the two (2) year Master’s program.

66. There have been two pilot studies conducted in Australia recently, one in South Australia and the other in Queensland and these studies have demonstrated acceptance by nursing and allied health professionals, and by consumers of health care.

39 Nursing and Midwifery Board of Australia ( April 2011) Endorsement of a Nurse Practitioner Registration Standard
Perioperative Nurse - Surgeons Assistant

67. The Royal Hobart Hospital employs a Peri-Operative Nurse Surgeons Assistant – an RN with extensive experience who has undertaken post graduate qualifications as a Surgeons Assistant\(^40\). The Perioperative Nurse Surgeon’s Assistant (PNSA) is an expanded practice role that enables the perioperative registered nurse, in collaboration with, and at the direction of the surgeon, to provide a continuum of care for patients undergoing surgical procedures. The role encompasses preoperative patient assessment, intra-operative assistance and patient care, immediate postoperative care, patient and family education, and discharge planning.

Enrolled Nurses

68. Enrolled Nurses are regulated by the Nursing and Midwifery Board of Australia and they work under the delegation of Registered Nurses. The EN entry level education preparation has been raised from Certificate IV to Diploma of Nursing level. The preparation provides enrolled nurses with a broader range of knowledge and skills, and they are authorised to administer medicines and IV fluids (without additives) if they have completed Nursing and Midwifery Board approved programs of study\(^41\).

69. Whilst these changes impact positively on the enrolled nurse’s capacity to contribute to health care provision, there has been little change to the overall number of enrolled nurses within DHHS workforce. In 2003, enrolled nurses represented 11.7% of the DHHS nursing workforce, currently they are 12.32%. DHHS employs 32% of the Enrolled Nurse workforce in Tasmanians, with the majority of the remaining 68% working in residential aged care and private hospitals.

Allied Health Professionals

70. Allied Health Professionals collectively make up 18% of the national health care workforce. They are looked at separately in this section due to the diversity of the roles and the need to better understand their potential to make significant contributions to improving population health status, and reducing demand upon the acute care sector.

71. The allied health workforce is made up of health professionals, technical or scientific officers, and other roles. Currently, the public sector health workforce employs a diverse range across all sectors. These may include (but are not limited to) Audiologists, Dentists, Dietitians, Health Promotion Officers, Exercise Physiologists, Music Therapists, Occupational Therapists, Medical Imaging Professionals, Radiation Therapy Professionals, Orthoptists, Orthotist/Prosthetists, Pharmacists, Podiatrists, Perfusionists, Psychologists, Social Workers, and Speech Pathologists.

72. The majority of allied health professionals have a minimum of 4 years university training and utilise higher degrees to support advanced practice or endorsement for specialised areas of practice e.g. psychology.

73. Allied health professionals provide direct care, including diagnosis, treatment and rehabilitation, often autonomously and across the full range of the health care sector\(^42\). As the health workforce expands and diversifies, the contribution of the allied health professions needs to be better understood and utilised\(^43\). Their roles in acute care, chronic disease management, aged care, disability, mental health,

\(^{40}\) Australian College of Operating Room Nurses \(\text{http://www.acorn.org.au/careers.html}\)

\(^{41}\) Nursing and Midwifery Board of Australia Board of Australia (April 2013 ) Fact Sheet Enrolled Nurses and medicine administration

\(^{42}\) Australian Health Professionals Association (2012) \(\text{http://www.ahpa.com.au/}\)

\(^{43}\) Mason. J. (2013) Review of Australian Government Health Workforce Programs
child youth and family services and acute care should be identified and opportunities for enhanced roles considered

Q15 Do you have examples of innovative and interdisciplinary practice that could be applied more broadly across Tasmania?

Q16 Are there other roles you would like to see developed in other professional areas?

Q17 Are there specific or collaborative practice areas where Allied Health Practitioners could improve health outcomes and reduce demand on the acute care sector?

Q18 Do you have examples of expanded scopes of practice or generalist approaches that could be considered for piloting in Tasmania?

Q19 ENs qualify at the Diploma level. How can we maximise the skills of Enrolled Nurses within your area to support your team to work to its full capacity?

**Assistant Roles**

74. Assistant roles provide an entry point into the healthcare workforce that can provide an entry point into a health career. Greater use of assistants may also improve retention of skilled health professionals in rural and regional areas, enabling them to deliver services that more closely align with their level of competence.

75. Allied health assistants work under the supervision and delegation of allied health professionals. The introduction of vocational qualifications for allied health assistants and discipline specific allied health assistants enables allied health professionals to deliver services to a larger number of people as well as to communities in order for people to have access to essential services closer to home.

76. Assistants in Nursing (AIN) provide care under the supervision and delegation of Registered Nurses and may share common skills with other assistants who work primarily with nurses such as Carers and Extended Care Assistants who work in sub-acute settings and mental health.

77. An AIN trial at the Royal Hobart Hospital is in progress in two acute care units with participants recruited from undergraduate Bachelor and Diploma of Nursing students, and staff with a Certificate III in Health Services Assistance HLT32507 (Acute Care). The purpose of the trial is to introduce a new entry level role into the acute care sector within the nurses/midwives career pathway; and contribute to patient outcomes.
78. Other Specialist Assistant roles are extensive and include (but are not limited to):
   - Pharmacy Technicians
   - Rural Health Workers
   - Health Promotion Assistant role
   - Cultural special needs groups Workers – eg Refugee communities

**Creation of New Roles**

79. With the explosion of technologies and rapid growth in the evidence base of contemporary health care, there is a need to examine the traditional ways we have provided services. The increasing expertise of the medical, nursing, midwifery and allied health workforce needs to be utilized as effectively as possible to meet the steep curve in health service demand.

80. It is clear from the projections that an expansion in the current health care workforce is required. As part of this, new roles will be required to meet the acute care needs of the community and the needs of people with impacted by disability and multiple chronic diseases. A number of these roles might not be readily self-evident.

81. For example, Health Informatics Professionals and vocationally prepared technicians are employed in some sectors. Health information management is central to the provision of effective and efficient health care, with information and communication technologies being increasingly utilized in hospital and community settings including virtual clinics, video consulting, use of technology by patients/clients for self-management, and remote health monitoring and coaching.

82. The Health Care Workforce has readily adapted and evolved over the past 50 years, and will do so again. As previously noted, HWA is currently mapping the skills and competencies of the professional workforce. Other tools may also assist in assessing the skills and tasks required for service provision.

**Q20** How would the introduction of more assistants in the workforce provide greater flexibility for your area? How would this be implemented?

**Q21** Can you see the potential for new roles in your area to support your team to provide services?

**Calderdale Framework**

The Calderdale Framework is a tool that has been developed to assist with the implementation of Assistant roles within the United Kingdom. The Framework provides a structured process for analysing and

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44 Anderson, G. (2011) For 50 Years OECD Countries Have Continually Adapted To Changing Burdens Of Disease; The Latest Challenge Is People With Multiple Chronic Conditions [Link]

45 University Department of Rural Health, Tasmania Health Informatics [Link]
determining skills that can be shared between professions, delegated to other professional staff, or tasks that can be delegated to assistant staff. The system is applicable across a broad range of clinical and professional service.

83. The Calderdale Framework has been critically reviewed by the Journal of Multidisciplinary Healthcare and is the subject of a randomised trial research project in the Emergency Department at Mackay Base Hospital, Queensland.

84. The Framework follows a seven staged approach to workforce redesign and includes identification of tasks and competencies.

**Q22** How would a skills/task delegation framework assist in the introduction of new roles within your area and allow existing workforce to work to their full scope of practice?

**Q23** What areas would be suited to piloting a skills/task delegation framework?

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**Discussion Point: Workforce design/redesign**

What should emerging models of care look like and what roles will be required?

How would the introduction of more assistants in the workforce (such as Assistants in Nursing) provide greater flexibility to your area? How would this be implemented?

How would a task delegation framework assist in the introduction of new roles within your area and allow existing workforce to work to their full scope of practice?

What areas would be better suited to piloting a task delegation framework? If so, what would this look like and how would this help to improve service delivery?

Can you identify potential areas for extended scope of practice within your specific area?

If so, what would that look like?

How would the better utilization of the Enrolled Nurses within your area assist your team to work to its full capacity?

How would increasing a generalist workforce assist health provision and expand opportunities for your service?

What strategies do you think would be most effective in developing a generalist workforce?

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3. Distribution, Attraction and Retention

85. Across Australia the health workforce and the community services sector together are growing faster than the all industries rate but the rural and remote sectors are facing significant skills shortages.

86. The Australian Standard Geographical Classification Remoteness Areas (ASGC-RA)\(^7\) system was implemented from July 1 2010 by the Department of Health and Ageing. The Remoteness Areas (RA) categories are defined in terms of remoteness - the physical distance of a location from the nearest Urban Centre (access to goods and services) based on population size. There are five categories: RA1 Major Cities; RA2 Inner Regional; RA3 Outer Regional; RA4 Remote; RA5 Very Remote. A map showing the RA categories and Districts of Workforce Shortage (GPs) in Tasmania is included below\(^8\).

![ASGC Remoteness Areas](image)

**Figure 1: RA Categories and Districts of Workforce Shortage (GPs)**

87. Analysis of workforce data, using the RA classification, indicates that regional and remote areas have a

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\(^7\) Commonwealth Government Australian Standard Geographical Classification


lower health workforce to population ratio compared to metropolitan facilities. Geographical maldistribution of the health workforce is evident across health professions across Tasmania, particularly the Medical and Allied Health professions.

88. In many allied health professions, the majority of the workforce provides services in the private sector. While there may be an adequate supply of new entrants to the workforce, there are numerous locations in Tasmania where communities rely solely on publicly funded allied health professionals for care. This is particularly relevant in some outer regional areas, most small rural locations and remote communities.

89. The nursing workforce supply in remote areas has responded to initiatives such as the improved accommodation on Bass Strait Islands and introduction of a rotational model between Flinders and Cape Barren Islands. However, in common with other mining areas in Australia, recruitment of staff to the West Coast remains difficult.

90. Tasmanian maternity services are provided by a mix of public and private providers across the entire continuum of care i.e. ante-natal, birth, and the post natal period for women and babies. Agreements exist on the types of services provided locally, and those that are referred or transferred to larger regional centres, or to the tertiary service at Royal Hobart Hospital.

91. The level of service provided is determined by the role delineation framework. In Tasmania, this is currently based on gestation of the pregnancy and additionally influenced by the complexities identified for the individual woman and baby.

92. The inclusion of multidisciplinary maternity care in the Australian Governments Medical Services Outreach Assistance Program (MSOAP) has been of significant benefit to Tasmanian rural and remote communities. The visiting service consists of a stable multi-disciplinary team ensuring continuity of care for the woman, and also a stable relationship with local service providers including GP’s, community midwives and community nurses.

93. The National Maternity Plan\(^*\) established under the auspices of the Australian Health Ministers Advisory Committee (AHMAC) provides a national strategy, including the development of a service capability framework, to guide and further improve maternity services in the context of the wide ranging changes in the health care landscape.

94. In relation to workforce considerations, the plan includes strategies to develop and support a rural and remote workforce along with work to facilitate a culture of interdisciplinary collaboration in maternity care. This includes mapping and development of a Core Competencies and Educational framework\(^*\) for Primary Maternity Services and National Guidance for Collaborative Maternity Care\(^*\).

95. In common with the nursing, medical and allied health workforce, it is critical that the Midwifery workforce works to its full scope, as part of a team that effectively recognises and utilises skills and knowledge to provide a high quality and comprehensive program of care to rural and remote women and their families.

96. MSOAP meets the medical, allied health and targeted specialist nursing needs of rural and remote communities. However, not all programs can offer consistent staff. While these services are of value to the community, the visiting individual health professionals are drawn from a larger team and can

\(^*\) Australian Health Ministers (2010) National Maternity Services Plan
\(^*\) National Health Workforce Taskforce (2010) Core Competencies and Educational Framework for Primary Maternity Services in Australia
\(^*\) National Health and Medical Research Council (2010) National Guidance on Collaborative Maternity Care
vary. As such they may be unable to provide the levels of community engagement necessary to improve longer term health care outcomes or continuity of care a more stable presence can provide52.

97. To fill health care professional gaps, rural and remote communities can be heavily reliant on international health professionals (IHPS), short-term placements, visiting staff, and the student/trainee workforce. As discussed previously, offering innovative training opportunities and expanded scopes can have benefits of service provision to rural and remote communities as well as increasing the potential for attracting people to rural and remote practice.

98. There is considerable effort in every state and territory, to develop models of care, service delivery methods and workforce roles that better meet the unique needs and address the different circumstances faced by rural and remote individuals and communities.

99. Examples include efforts to reduce the impact of distance through the increasing use of information and communication technology (telehealth and eHealth)53, and promoting and supporting the role of generalist practitioners across all health professions.

100. Alternative staffing models under consideration across Australia include enhanced linkages between rural and urban services with practitioners serving in both settings with appropriate levels of support and infrastructure.

101. Additionally, the opportunity to support over-worked rural medical practitioners with a team that includes a Nurse Practitioner or RN and AHP working in an extended scope may appeal to nurses or allied health practitioners who enjoy the autonomy of rural practice and the richness of a varied team based environment.

102. A particular priority is the development of a workforce that has the capacity to work across the continuum of care with skills in chronic disease management and mental health. Improving the skills of generalists of all professions in rural and remote areas in assessing, and managing mental health risks and problems has had proven outcomes for communities and role satisfaction of staff 54.

103. Workers in health, law enforcement, emergency services, child protection and education, need to collaborate more frequently in remote communities which can be a source of stress or a source of professional enrichment and job satisfaction.

**Q24** Do you have examples of innovative models of service delivery that have worked well in rural and remote regions?

**Q25** What types of educational preparation and support should underpin these models?


54 Ellis, IK and Philip, T. (2010) Improving the skills of rural and remote generalists to manage mental health emergencies, Rural and Remote Health, 10, (3) pp. 1503. ISSN 1445-6354 [Refereed Article]
Attraction and Retention

104. Health professionals, like other professional workforces, are attracted to areas for diverse reasons, including viable social and economic infrastructure, at different points in time of their life. The benefits of a small stable community can be an attraction to many professionals.

105. The ability to recognise attraction factors and leaving influencers assists in developing strategies for recruitment and retention. It is essential that prospective staff have continuing development opportunities that match changing professional, family and lifestyle requirements.

106. Many rural incentives for health practitioners are focused on financial provisions. However, there is increasing evidence that there are a diverse range of factors that will attract and retain staff in rural and remote areas as well as working in areas of disadvantage as shown in the figure below\(^5\). The reputation of the organisation can be a key to attracting and retaining staff\(^6\).

\[\text{Figure 2: Rural Incentives to Attract Health Practitioners}\]


Factors affecting health worker motivation and retention

107. The Senate Community Affairs Reference Committee\textsuperscript{57} found that models focusing purely on financial compensation for hardship can be stigmatising and miss numerous other factors that need to be provided including:

- training and professional development opportunities
- options for career development
- strategies to assist with high workloads including on call hours
- opportunities for spouses and children including social and recreational strategies
- peer and professional support
- a reliable locum and relief system
- appropriate remuneration and recognition
- provision of adequate housing/childcare.

108. The Services for Australian Rural and Remote Allied Health (SARRAH) network effectively offers a communication network to support Allied Health Practitioners across rural and remote Australia. SARRAH notes that employers who provide AHPs with assistance and support to link with the social networks of their community, have better retention rates\textsuperscript{58}.

109. Providing training and financial support to people who originate from a rural or remote community can be a strategy to encourage local retention of students to qualify and return for the benefit of their community. Additional incentives are available to medical graduates who can apply for a generous scholarship in return for a bonded service obligation but these are not in place for nursing and allied health professionals from rural and remote areas who may be interested in returning home to practice.

110. Strategies to provide incentives for recruitment and retention in rural and remote areas have included bonded medical scholarships, declaration of districts of workforce shortage for General Practitioners, financial and other incentive arrangements such as rural and remote allowances which also apply to the nursing and midwifery workforce.

111. WHO\textsuperscript{59} has made a number of evidence based global policy recommendations to increase access to health workers in rural and remote areas through improved retention. A brief summary of the extensive recommendations includes strategies such as:

- targeted admission policies to enroll students from rural and remote areas in education and training for health care, provision of scholarships with agreements of terms of service
- revision of undergraduate and post graduate curricula to include rural health topics, specific design of continuing education and professional development programs for rural and remote health workers, and improving accessibility to education
- enhanced scopes of practice to increase autonomy and job satisfaction

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\textsuperscript{57} Senate Community Affairs Reference Committee (2012) The factors affecting the supply of health services and medical professionals in rural areas

\textsuperscript{58} Services for Australian Rural and Remote Health (SARRAH) http://www.sarrah.org.au/site/index.cfm

• introduction of different types of health workers with appropriate training and regulation to increase the number of health workers in rural and remote areas
• provision of Personal and Professional Support that address Living conditions, enhanced career options and pathways and professional networks and systems of support.

Alternative Considerations for Recruitment

112. School programs that can engage students with work experience coupled with vocational training may be useful in areas where traditional employment opportunities are declining.

113. Rural and remote regions with difficulty recruiting to permanent positions may consider targeted recruitment initiatives which package a training pathway with a career at the end of the training and guaranteed employment.

114. Similarly, more focus is required to extend the skills of our existing workforce in order to improve retention of staff and prevent premature loss of knowledge and skill.

115. Research indicates that exposure to a location or specialty influences future choice of practice – this is the premise of the current postgraduate medical education system which provides rural exposure. Programs are coordinated and structured to match training with employment opportunities. Similarly Allied Health training programs are also delivered or coordinated through the University Department of Rural Health.

116. To assist with access to education in rural areas, the DHHS has been funded by the Commonwealth to develop Rural Inter-professional Clinical Education and Training Centres (RICETCs) to provide interactive learning hubs and accommodation for undergraduate students at Queenstown, Oatlands, Smithton, St Helens and Deloraine.

117. HWA have also funded Simulated Learning Environments including mobile simulation units in the North and North West Tasmania as well as equipment for Southern Tasmania. A Principal Educator and three Regional Coordinators have also been engaged as part of this project to develop relevant education programs.

Q26 Do you have examples of attraction and recruitment strategies that could be used more broadly?

Q27 Do you have examples of flexible working arrangements and strategies that could be applied effectively to improve service delivery in rural and remote areas?

Q28 Do you have examples of effective strategies for attracting and retaining staff in rural and remote areas? What do these look like and what support is required?

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60 NSW Health (2011) Securing a stable medical workforce for rural communities: A discussion paper
Q29 How can we improve our training pathways for rural and remote areas?

Q30 If you work in a rural or remote area have you accessed education, training or a peer support network via telehealth? If yes – how can this experience be enhanced?

Locums

118. Rural areas rely heavily on locums and agency staff. This also impacts on the facility being considered a suitable teaching facility. Strategies to address this have included establishing a relationship with locum providers to allow for more stable cover, and greater engagement of locums to supervise and train.61, 62

119. There may be a need to review attraction strategies to encourage long term locums to consider permanent employment. This may provide greater opportunities for inter-professional supervision of trainees to enable experienced staff from other professions to supervise also needs to be considered. This is particularly important for small rural facilities which rely on locum and visiting workforce. This workforce is usually not available at all times to provide supervision for trainees.

Q31 What strategies could be used to improve the locum/agency workforce?

Discussion Point : Workforce Distribution

Do you have examples of attraction and retention strategies that could be used more broadly?

Do you have examples of innovation models of service delivery that have worked well in rural and remote regions?

Do you have examples of flexible working arrangements and strategies that could be effectively applied to improve service delivery in rural and remote areas?

Do you have examples of effective talent management strategies for attracting and retaining rural and remote areas? What do these look like and what support is required?

How can we improve our training pathways for rural and remote areas?

What strategies could be used to improve the locum/agency workforce?

62 NSW Health (2011) Securing a stable medical workforce for rural communities – A discussion paper
4. Ageing Workforce

120. Tasmania has an ageing workforce with the majority of employees between 45–64 years (Source: ABS, Population Estimates by Age and Sex, Regions of Australia, 2009, Cat No 3235.0, 2009). AIHW statistics highlight age as a prevalent feature in the nursing and midwifery workforce with the peak age group 50-54 years.

121. The following graph provides a clear picture of the change in the demographic of the nursing and midwifery workforce.

![Nurses – age cohort comparison](image)

122. There are a number of benefits in retaining older workers including workplace stability, retention of industry knowledge and experience as well as key enablers for future succession planning and mentoring.

123. There are also factors associated with an ageing workforce that may pose certain challenges. These include age-related degeneration or ‘wear and tear’; long-term physical conditions associated with older age including arthritis, osteoporosis and cardiovascular disease; work-related sprains and falls.

124. Reducing the risk of hazards and reviewing work and job design is essential if DHHS is to minimise its projected workforce losses. Factors to consider include: fitness for work (are employees able to undertake the inherent duties of the work assigned to them); job design and task demands (repetition or heavy manual handling) work environment (noise, lighting and surfaces); physical capacity (muscular strength and fatigue); eyesight in relation to printed material or computer use.

125. Key strategies for supporting an ageing workforce may include:

- creating an age-inclusive culture – promoting a culture that understands and supports age diversity
- health, safety and wellbeing – understanding the physical and psycho-social factors associated with the job; undertaking regular workplace risk assessments; reviewing employee fitness for

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63 Government of Western Australia, Department of Commerce (2010) Understanding the safety and health needs of your workplace: Older Workers and safety

Last Version Updated 18 July 2013 at 1600 Version 0.11
work; reviewing shift structures and patterns of work; integrating health promotion and prevention strategies into the workplace, such as health screenings

- training and development – discussing career intentions and engaging training and career plans into performance development

- flexible work arrangements – consideration of flexible working hours; part-time work or job sharing.

126. The Tasmanian Government has a responsibility to consider age-related factors in providing a safe workplace. Addressing health, physical activity and safety of all employees has been shown to maintain better health and reduce the impact of risk factors to employees64.

127. Changes can benefit the entire workforce. Flexible, diverse and inclusive work arrangements have been shown to increase productivity, retention and decrease knowledge loss in an organisation.

Q32 Do you have examples of strategies that have worked well to support older workers in the workforce?

Discussion Point 4: Ageing Workforce

Do you have examples of strategies that have worked well to support older workers in the workforce?
5. Capacity Building - Education and Training

Capacity Building

128. The Health Workforce 2025 Report findings highlight that without significant changes to our current models of care, future shortages of health professional occupations within in Australia will be at crisis point. This is further compounded by the predicted increase in demand for health services. Currently a large percentage of health and community health workers are drawn from the undergraduate and post graduate education. Greater investment is required in the Vocational Education and Training (VET) Sector to support and increase the range of workers with a broader range of skills, targeting different age cohorts with multiple entry points. This would enable the population to move in and out of careers increasing workforce flexibility.

Q33 How can we better develop and support Vocational Education and Training Sector career pathways?

129. As the Health Workforce Australia 2025 Report highlights, Australia faces a future shortage of health professionals within some professions based on the current models of care and distribution. It also faces training bottlenecks, with the number of students in some disciplines exceeding the number of clinical training places available. Health Workforce Australia launched the Clinical Training Funding Program in 2010, with funding available for the 2011-2013 period. This Program is designed to expand the clinical training capacity of the health workforce in Australia.

130. The Department and associated service delivery organisations have obligations to meet existing and emerging reporting requirements to both the Tasmanian and Commonwealth Governments and other established bodies through a range of Service Agreements. This includes meeting existing national agreements for clinical education and training.

131. In spite of the significant change in the burden of disease and the associated change in how health care is delivered, most clinical education remains hospital centric. Health professionals continue to receive a large portion of their clinical training in hospitals. With the growing prevalence of chronic disease and the growing prevalence of people with multiple chronic diseases, the upcoming challenge will be to redesign curricula to meet these needs.

132. This may include:

- greater support for regional training schemes and primary health care clinical training places
- exploring models of funding that promote the importance of the teaching role, like part time academic positions and practice based teachers, to increase the status of teaching within the professions themselves
- supporting innovative learning (e.g. simulated learning) and greater e-learning options for busy health professionals
- accelerating entry to the workplace without compromising quality or standards (e.g. Fast-
tracking or streamlining training)

- considering how multi-skilled health workers could be supported through an enhanced focus on interdisciplinary learning.

**Q34** What are the elements that should be included in clinical education?

### Aboriginal and Torres Strait Islander Health Workforce

133. Based on information from the 2011 Census, the ABS estimates that there were 669,736 Indigenous people living in Australia in 2011 [1]. As can be seen in the details below Tasmania has the largest proportion of Indigenous population at 4.7%

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Indigenous population (number)</th>
<th>Proportion of Australian Indigenous population (%)</th>
<th>Proportion of jurisdiction population (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td>208,364</td>
<td>31.1</td>
<td>2.9</td>
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<tr>
<td>Vic</td>
<td>47,327</td>
<td>7.1</td>
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<td>Qld</td>
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<tr>
<td>WA</td>
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<tr>
<td>SA</td>
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<td>2.3</td>
</tr>
<tr>
<td>Tas</td>
<td>24,155</td>
<td>3.6</td>
<td>4.7</td>
</tr>
<tr>
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</tr>
<tr>
<td><strong>Australia</strong></td>
<td><strong>669,736</strong></td>
<td><strong>100.0</strong></td>
<td><strong>3.</strong></td>
</tr>
</tbody>
</table>

Source: ABS, 2012 [1]

Notes:

1. Preliminary estimates are subject to revision; population projections are expected to be finalised by 2014
2. Australian population includes Jervis Bay Territory, the Cocos (Keeling) Islands, and Christmas Island
3. Proportions of jurisdiction population have used total population figures estimated from demographic information for June 2011

In 2011, 90% of Indigenous people identified as Aboriginal, 6% identified as Torres Strait Islanders, and 4% identified as both Aboriginal and Torres Strait Islander.
134. The Commonwealth provides funding to support the organisations below to mentor, support and encourage Aboriginal and Torres Strait Islander doctors, nurses, allied health professionals and health Workers to work in health. It also promotes a national approach to education, training and up-skilling of Aboriginal Health Workers directly aimed at increasing Indigenous health workforce capacity.

- Australian Indigenous Doctors' Association (AIDA) (external) - advocates improvements in Indigenous health in Australia and encourages Aboriginal and Torres Strait Islander people to work in medicine.
- Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN) (external) - promotes the recruitment and retention of Indigenous peoples in nursing.
- National Aboriginal and Torres Strait Islander Health Worker Association (NATSIHWA) (external) - provides a range of communication resources to assist members keep up-to-date with developments in their profession.
- Indigenous Allied Health Australia (IAHA) (external) - aim is to further develop a stronger Aboriginal and Torres Strait Islander allied health workforce and continue to encourage more Aboriginal and Torres Strait Islander Australians to take up careers as allied health professionals.
- Leaders in Indigenous Medical Education (LIME) (external) - a network to ensure the quality and effectiveness of teaching and learning of Indigenous health in medical education and curricula as well as best practice in the recruitment and retention of Indigenous medical students.
- Aboriginal and Torres Strait Islander Health Registered Training Organisation National Network (ATSIHRTONNN) (external) - a network of Aboriginal and/or Torres Strait Islander Community Controlled Registered Training Organisations (RTOs).

135. Given Tasmania’s high percentage of Indigenous population at the jurisdictional level, emphasis is required in the following areas:

- improving workforce data reporting and analysis to determine gaps and needs for this population group.
- engaging with the Aboriginal and Torres Strait Islander Health Worker Working Group and other key state and national bodies to assist in the development of workforce strategies.
- working with the education sector to increase pathways and linkages to the health workforce for Aboriginal and Torres Strait Islanders to work specifically with their communities and also to create pathways to employment as health professionals in all service delivery sectors across Tasmania.
- developing a broader understanding of Aboriginal and Torres Strait Islander culture and cultural competency within the mainstream health workforce to improve understanding of cultural needs and sensitivity for Aboriginal people to assist in Closing the Gap\textsuperscript{64}.

\textbf{Q35} How could your area contribute to closing the gap in Aboriginal and Torres Strait Islander health? What information and skills would you need?

\textsuperscript{64} Department of Families, Housing, Community Services and Indigenous Affairs (2013) Closing the Gap, The Indigenous Reform Agenda

Building Capacity – Prevention and Health Promotion

136. Tasmania’s challenge is to meet the health care needs of our population now and into the future. To achieve this, a cultural change is needed that that not only supports inter-professional practice, but also integrates health promotion into professional practice and across all service areas.

137. Tasmanian is a signatory to the National Partnership Agreement on Preventive Health (NPAPH). Initially announced by the Council of Australian Government (COAG) in November 2008, and refined in 2012, the NPAPH was extended to June 2018 as a supplement to the National Health Care Agreement. In a groundbreaking move, the Australian National Preventive Health Agency was established along with a funded translational research program.

138. The Tasmanian framework for implementing the agreement includes eight (8) principles of practice outlined in Working in Health Promoting Ways: A Strategic Framework for DHHS 2009-12. Cultural change for the purposes of this framework is about accepting the value of working in health promoting ways and enhancing the skills and knowledge of all professionals to:

- utilise and apply evidence
- create programs and services that address the determinants of health
- address health inequities
- work in partnerships
- work across the continuum and engage with clients to promote health and wellbeing at every opportunity
- seek to create environments that support health.
- Ensure community participation including engaging with clients and community in a meaningful way.

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67 Department of Health and Ageing National Partnership Agreement on Preventive Health

68 National Health Promotion Agency

139. The Australian health system at both a state and national level is shifting its focus to include a much stronger preventative focus including the active promoting health and wellbeing. Cultural change is about developing the skills and competencies of the health workforce in prevention and promotion as well as their capacity to participate in multidisciplinary and integrated care.

Q36 What opportunities do you see for building the capacity of the workforce to include a stronger preventive focus and work in health promoting ways?

Q37 Do you have an example of a successful cultural change strategy or program that has increased the capacity of staff to work in different ways?

Health Workforce Australia Funded Projects

140. HWA delivers a national, coordinated approach to health workforce reform in six critical areas:

- Building capacity by delivering more fit-for purpose workforce, more quickly and efficiently
- Boosting productivity and maximising the utility of the workforce
- Improving distribution to get the workforce into the places and specialties that are needed.
- Building the evidence for national health workforce reform and innovation through planning research and evaluation
- Providing leadership to inform and influence national health workforce policy and program decisions
- Working in collaboration with key stakeholders to deliver targeted programs to drive reform.

141. HWA has funded the Department of Health and Human Services to deliver a range of key projects aimed at building capacity for education and training of undergraduate students.

142. Projects for which DHHS has been successful in receiving funding include:

- Rural Inter-professional Clinical Education Centres – provision of accommodation and learning hubs at rural sites within Tasmania at Smithton, Queenstown, St Helens, Deloraine and Oatlands (Commonwealth funded prior to the establishment of HWA)
- Clinical Supervision Support Program - mapping supervision and identifying potential support programs for piloting
- Clinical Training Funding Program - the establishment of an IT System for Clinical Placements and infrastructure for Oral Health in North and South Tasmania
- Integrated Regional Clinical Training Networks - the establishment of the Tasmanian Clinical Education Network
- Simulation Learning Environments - purchase of simulation equipment including two mobile simulation units for the North and North West Tasmania, simulation equipment for Southern Tasmania, plus the development of a Simulation Learning Environment Education Program.
143. It is anticipated that these projects will expand the capacity for education and training through increased access, simulation and support for vocational education and training and undergraduate students across all health professions in Tasmania.

144. Following on from this, Health Workforce Australia are currently developing policy responses to key priorities and directions to address identified workforce shortages and health workforce reform more broadly.

Q38 How can we further build capacity for education and training to address future workforce need?

Tasmanian Clinical Education Network

145. Integrated Regional Clinical Training Networks (IRCTNs) is one component of the Commonwealth investment under the COAG National Partnership Agreement on Hospital and Health Workforce Reform.

146. The Tasmanian Clinical Education Network (TCEN), Tasmania’s Integrated Regional Training Network funded through Health Workforce Australia, will play a key role in planning clinical education and training requirements within Tasmania. The TCEN includes representation from all public and non-government health, aged care, primary care and community services organisation within Tasmania who are involved in the delivery of health professional clinical training, as well as higher education providers wishing to place health professional students and trainees within Tasmania.

147. The TCEN has developed a program of work activity to:

- Promote access to clinical training placements within Tasmania
- Facilitate systematic reporting of clinical training activity
- Build relationships and collaborations between education and clinical training providers
- Facilitate forward planning and deployment of training requirements and placement opportunities
- Match supply and demand for clinical placements and recommend distribution
- Support education and service providers in the management of clinical training placements including at the local level
- Support and engage with education and clinical training providers on other key national workforce reform issues consistent with the National Partnership Agreement.

Q39 What other key areas of focus should be included in the TCEN Work Plan activity?

Inter-professional Education

148. Health professionals, need to work together effectively to take care of clients/patients, particularly with the increases in patients with co-morbidities. Training and educational programs have been developed as a possible way to improve how professionals work together to take care of
clients/patients70. Inter-professional Education (IPE) occurs when learners from two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes71.

149. IPE aims to encourage different professionals to meet and interact in learning to improve collaborative practice and the health care of patients/clients, and therefore has more potential for enhancing collaborative practice than a program of multi-professional education (where professionals share their learning experiences but do not interact with one another, such as a joint lecture) or uni-professional education (where professionals learn in isolation from one another)”72.

150. Effective Inter-professional education relies on curricula that link learning activities, expected outcomes and an assessment of what has been learned. Research indicates that Inter-professional education is more effective when principles of adult learning are used, learning methods reflect the real world practice experiences of students, and interaction occurs between students73.

151. A range of mechanisms shape effective Inter-professional education and collaborative practice. These include:

- supportive management practices
- identifying and supporting champions
- the resolve to change the culture and attitudes of health workers
- a willingness to update, renew and revise existing curricula
- appropriate legislation that eliminates barriers to collaborative practice74.

Q40 Is there potential for Inter-professional learning within you area? If so what does this look like and what is required to support this?

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71 Canadian Interprofessional Health Collaborative (CIHC) [http://www.cihc.ca/](http://www.cihc.ca/)


74 Ibid
Transition to Practice

152. It is clear that one of the key challenges for graduates of all health professions is transitioning to the workforce and this is a critical factor in implementing the changes needed so that the workforce can appropriately address the challenges of rising demand for health care services.

153. Nursing has long recognised the benefits of providing additional support to new graduates as they consolidate their skills and knowledge, build their confidence, and are inducted into the workplace and organisational culture where they first practice.

154. Transitions Programs are not are not a regulatory requirement for nursing registration. The programs and positions enable graduates to orientate to the complex organisational systems of their new environment and consolidate their knowledge and skills as a beginning practitioner. A supported and positive experience in a transition program also contributes to retention.

155. The current ‘oversupply’ of new graduates is part of the solution to the future deficit – and every effort must be made to recruit as many new graduates into transition to practice positions. Additionally, support extended to those nurses who are not immediately employed, will assist in maintaining professional engagement until positions become available.

156. The Nursing and Midwifery Graduate Jobs portal\textsuperscript{75} is a national strategy that has been developed through HWA to support the employment of nursing graduates across Australia. The Nursing and Midwifery Office is currently developing a graduate nurse strategy that will be available for consultation.

157. Although the scenarios projected in the Health Workforce 2025 report postulate significant shortages of nurses and smaller shortages of doctors, in the short term there are difficulties in placing all medical graduates in internships. It must be remembered that unlike nursing graduates medical graduates must complete their intern year in order to register.

158. Initiatives involving all jurisdictions are being progressed to optimise the distribution of medical interns and maximise their opportunities for employment where they will gain the skills needed for emerging areas of need. These include work on national intern allocation mechanisms\textsuperscript{76}.

159. It is really important that graduates in the near future remain engaged in their profession despite short term oversupply and mal-distribution because their involvement will be needed as the combination of population ageing and retirements from the ageing workforce create opportunities.

Q41 Can you identify any mechanisms that could be used to further assist in the engagement of new graduates in the short term?

160. A program developed in the United Kingdom is Flying Start\textsuperscript{77} - an interactive web based program that provides a national development program for all newly qualified nurses, midwives and allied health professionals in NHS England. It has been designed to increase the confidence and competence of newly qualified health professionals.

\textsuperscript{75} Health Workforce Australia, Nursing and Midwifery Graduate Jobs \url{http://www.nmgi.org.au/}

\textsuperscript{76} Confederation of Postgraduate Medical Education Councils, National Intern Allocation Working Party \url{http://www.cpmecc.org.au/Page/national-intern-allocation-working-party}

\textsuperscript{77} National Health Service, Education for Scotland, Flying Start \url{http://www.flyingstart.scot.nhs.uk/}
161. The resource has been developed to complement professional support practices such as supervision and mentoring. A period of support during the transition is legitimate, necessary and valued by the organisation and allows for recognition of learning and transferability. This program has been piloted in Queensland across a range of disciplines with positive results.

162. Flying Start provides:

- a clear message to newly qualified practitioners and managers
- flexibility of program which allows for individual and context applicability
- help to manage expectations and legitimises the need for a period of transition from student to registered nurse, midwife or AHP
- learner directed and context specific application of learning
- access to up to date learning material, national policies and useful

163. More information can be found at [http://www.flyingstart.scot.nhs.uk/](http://www.flyingstart.scot.nhs.uk/)

**Q42** Would an interactive program for newly qualified health professionals and support staff, such as Flying Start, assist workforce integration in your area? How could greater use of technology assist with this?
Discussion Point: Building Capacity – Clinical Education and Training

How can we better develop and support Vocational Education and Training Sector career pathways?

What are the elements that should be included in clinical education?

What opportunities do you see for building the capacity of the workforce to include a stronger preventive focus and work in health promoting ways?

How could your area contribute to closing the gap in Aboriginal and Torres Strait Islander health? What information and skills would you need?

How can we further build capacity for education and training to address future workforce need?

What other key areas of focus should be included in the TCEN Work Plan activity?

Is there potential for inter-professional learning within you area? If so what does this look like and what is required to support this?

What mechanisms can be used to further assist in the engagement of new graduates in the short term?
Career Planning and Support

164. The factors involved in career decision making are varied. The Tasmanian Government has identified as part of the Health Professional Workforce Plan the need to develop strategies to enhance career pathways for doctors, nurses, midwives and all allied health groups to assist with attraction and retention.

165. The need for career advice during undergraduate education is well recognised within the Medical and Nursing professions. In a survey undertaken across Allied Health students in South Australia, 97% of respondents indicated support for the inclusion of specific information and sessions on career options, with over half indicating that formal career advice should be provided every year[^78]. Adopting such an approach would provide an opportunity to not only inform undergraduate students of the range of careers available but provide realistic and timely advice on where there is likely to be under and over supply.

**Q43** Do you have examples of strategies to enhance career pathways that could be more broadly implemented?

Mentoring and Support

166. Pastoral care mentoring and support for the health student/trainee across the training continuum, in regards to promoting career options for both geographical settings and for specialty choice is important. A recurring theme within the medical training environment is the decline of pastoral care to support the student/trainee as they navigate through the training and employment choices available to them.

167. The use of career frameworks or matrices, such as the United Kingdom’s National Health Service (NHS) Career Framework would provide advice to both potential and existing workers on the range of career options available across a range of professions. Advice includes key competencies, capabilities and the education required to undertake different roles. The Career Framework information is a way of improving career development and job satisfaction, by encouraging individuals to learn new skills and take on extra responsibilities that enable them to progress within an organisation.

**Q44** How can we more effectively provide mentoring and support?

[^78]: Williams, M. (2006) The Nature of Career Advice Provided to Undergraduate Allied Health Sciences Students at the University of South Australia Internet Journal of Allied Health Sciences and Practice Vol 4 No 4
Performance Management

168. The Tasmanian Government State Service Act 2000 outlines specific requirements that apply to and support the recognition of employee performance, and identify a structure for the management of performance.

169. The purpose of encouraging effective performance management throughout the state service is to ensure that employees know what is required and how they are expected to contribute to unit and team operational goals. Performance management is designed to promote an environment of open communication that provides ongoing constructive feedback and support in order to achieve better performance outcomes and specific requirements.

170. Equally important is the provision of a work environment that encourages career development and learning that is directed at continually improving performance as well as supporting the development of work environments that are productive, satisfying and aimed at attracting and retaining quality employees.79.

171. The effectiveness of the performance management system depends on several key factors. The Performance Management System needs to be based on clear, measurable and sustainable employee performance outcomes and related specifically to the job requirements. Both managers and staff can use a performance management system to shape skill and career development based on those skills and capabilities of employees that are identified over time.80.

Q45 What are the barriers to development of staff?

Discussion Point: Career Planning and Support

Do you have examples of strategies to enhance career pathways that could be more broadly implemented?

How can we more effectively provide mentoring and support?

What are the barriers to staff development?

80 Ibid
6. Clinical Leadership

172. The Australian health system needs strong leadership at all levels in organisations if it is to be sustainable and responsive to the health needs of Australians now and into the future. For workforce reform to be a success, we need leaders who are well placed to lead the transition of systems and staff and manage the expectations of consumers and the community.

173. The development of leadership capability to support and sustain reform in the health system has therefore been identified as a key component of the HWA innovation and reform strategy. As part of the Leadership for Sustainable Change Program, the “Health LEADS – Australian Health Leadership Framework” has been developed in consultation with health and education sectors\(^81\).

Leading Culture

174. Perhaps the greatest barrier to the increased involvement of clinicians in shaping the future of patient care lies in the historical beliefs of clinicians themselves about the value of leadership and management. One way to address this issue is to be far more systematic about gathering stories, told authentically and compellingly by those who participated, or observed, that highlight the value of great clinical leadership. Clinical leaders of all types, both in formal management and in frontline roles, organisations can create a stronger bank of role models and also spark a sense of possibility\(^83\).

Q46 How can we create a culture that values the role of leader, supervisor/preceptor and educator?

Leadership Development

175. Any effort to encourage clinical leadership has to include support for professional development. However, the best starting point is not to create or commission a training course. Health care organisations must first define what they want from their clinical leaders, what skills and attitudes they want to encourage, whether there are differences across professions or roles, and where the need to develop leadership is greatest. Efforts can then be targeted to where they can have the greatest impact\(^83\). The UK National Health Service has created a Leadership Framework that comprises seven domains that describe the leadership behaviours, knowledge, skills or attitudes expected\(^84\).

176. For clinicians, development programs with real work at their heart can help enormously in demonstrating how patients benefit when clinicians lead the improvement of services. A leadership program involving a dozen UK hospitals and both clinical and nonclinical staff focused on redesigning pathways for patients with stroke and hip fractures. The program, positioned as a quality-improvement effort rather than a training or development course, had a remarkable impact on lengths of stay, mortality rates, and costs—all of which fell by up to 30 percent. It also created enthusiasm for leading service-improvement efforts more generally, with enduring benefits after the formal program had ended\(^85\).


\(^{84}\) Ibid

\(^{85}\) National Health Service, Leadership Academy Leadership Framework \(\text{http://www.leadershipacademy.nhs.uk/discover/leadership-framework/}\)

177. The DHHS has an existing Management and Leadership Program that seeks to increase the capabilities of our managers and leaders, to ‘shape our workforce to be capable of meeting changing needs and future requirements’ (Strategic Direction 5).

178. This includes a Graduate Recruitment program (commenced June 2009); a program for middle and front-line managers (April 2010), a University pathway (July 2010); and a range of short-courses and workplace activities for medical, nursing, allied health and management professionals.

179. All DHHS development activities expand the core themes of:
   - Leading Self: self-awareness, self-development, leadership development
   - Leading Others: people management, building teams and networks, negotiation skills
   - Strategic Focus: strategic thinking/planning/acting, change management, political awareness
   - Achieving Results: resource/financial management, performance management, time management
   - Quality and Governance: service improvement, consumer engagement, client-centred care.

180. The Foundation Program provides managers with an understanding of management and leadership issues within health and human service settings, to support their further development as managers and leaders.

181. The development of a Clinical Leadership Program that includes the key elements outlined below, will provide improved health outcomes for all Tasmanians.

Support and Supervision

182. Research showing that the development of staff is linked to an organisation’s success in recruiting and retaining staff also suggests new healthcare graduates experience stress during the early phase of initial employment. Students reportedly often feel unprepared and unsupported in making the transition from student to confident practitioner. Structured support and a positive learning environment during this phase can make a difference to the confidence of the individual and contribute to, and improve, ongoing recruitment and retention86.

183. The role of senior clinicians in supporting and training the future workforce is important, and should not go unrecognised. As discussed in the Education and Training section of this paper, the training system for health professionals is reliant on supporting new graduates in consolidating their theoretical knowledge in the workplace, and in many instances accreditation is reliant on periods of supervised “internship”.

184. The development of the proposed clinical leadership framework such as below would assist improve health outcomes for Tasmanians.

Q47 What are the barriers to providing supervision support, and what can be used to address these barriers?

Discussion Point 7: Clinical Leadership for Sustainability

How can we create a culture that values the role of leader, supervisor/preceptor and educator?

What are the barriers to providing supervision support, and what can be used to address these barriers?

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86 District Health Boards New Zealand (2010) Allied Health New Graduate Toolkit
Technical Report

Key Drivers - National Context

1. Australia is regarded as having one of the best health systems in the world with government-guaranteed universal access to public health care, mid-range spending on health as a percentage of Gross Domestic Product (GDP) compared to other OECD (Organisation for Economic Co-operation and Development) countries, and efficient health care delivery through a mixed public and private system with good health outcomes. However, a larger older population and a comparatively smaller working age population can put a strain on publicly funded health and social services.

2. The chronic disease burden associated with an ageing population, the need to close the gap in health outcomes for indigenous Australians, increasing demand pressures and fragmentation between health services due to differences in national, state and territory funding and governance arrangements has resulted in calls for reform and renewal of the Australian health care system.

National Workforce Reform

3. In February 2008 the Commonwealth Government formally approved the establishment of the National Health and Hospitals Reform Commission, responsible for developing a long-term health reform plan for Australia. The final report detailed the actions to be taken across the three reform goals of:
   - tackling the major access and equity issues that affect people now
   - redesigning the health system to meet emerging challenges
   - creating an agile and self-improving health system for future generations.

4. The reform goals, from the workforce perspective, are reflected in five domains of the subsequent National Health Workforce Innovation and Reform Strategic Framework for Action 2011-2015. The aims of this framework are to attract and retain a highly valued workforce and to expand the size and nature of the future workforce to meet current and emerging demands. The five domains which provide guidance for workforce reform at the state and National level are:
   - Health workforce reform for more effective, efficient and accessible service delivery
   - Health workforce capacity and skills development
   - Leadership for the sustainability of the health system
   - Health workforce planning
   - Health workforce policy, funding and regulation

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91 National Health Workforce Innovation and Reform Strategic Framework for Action 2011-2015
Health Workforce 2025

5. Health Workforce 2025 Doctors, Nurses and Midwives (Health Workforce 2025) is the first major, long-term study of the national health workforce in Australia to 2025 and the publication of volume three in November 2012 concludes the current series.

6. The following high demand scenario information is from Health Workforce 2025, Figures 10 and 11, and Tables 14 and 15. This modeling shows that nationally, high demand scenarios outstrip the projected supply of both doctors and nurses into the future, unless significant change occurs to enable the workforce to meet the growing need for health care services. Modeling is not yet available for allied health professions. These scenario projections are based on a number of assumptions outlined in the report and are only recorded at the national (not jurisdictional) level.

Figure 10: High demand, supply and demand projections, all doctors, 2009 to 2025

Table 14: Parameters for high demand projections, all doctors, selected years

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<th>Headcount</th>
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<th>2016</th>
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<td>Permanent migration</td>
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<td>Temporary migration</td>
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<tr>
<td>Exits (%)</td>
<td>3%</td>
<td>4%</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Demand</td>
<td>72,276</td>
<td>83,970</td>
<td>100,019</td>
<td>115,758</td>
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<td>-2,160</td>
<td>-6,333</td>
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</table>
7. Projections from Health Workforce 2025 highlight the need for essential, coordinated, long-term reforms by governments. Significant changes are likely to be required to workforce numbers, policy and practice to secure a sustainable, affordable workforce that is able to meet the Tasmanian need for health services into the future.

8. For example, the report indicates that the number of medical specialists is increasing, but this workforce is not evenly distributed.

9. That is, there are not enough general practitioners and some medical specialists practising in regional and rural Australia, some medical specialties are more popular than others from a career perspective, and there is a growing trend towards specialisation and sub-specialisation, which is resulting in a shortage of generalists.

10. Health Workforce 2025 Volume 3 indicates the specialties that will be in shortest supply by 2025 if reform does not take place are obstetrics and gynaecology, ophthalmology, anatomical pathology, psychiatry, diagnostic radiology and radiation oncology.

11. Psychiatry and radiation oncology are particularly at risk as already there are not enough specialists in these fields.

12. The supply of cardiology, gastroenterology and hepatology, neurology and surgical specialties is currently adequate, but projections show there will be more of these specialists coming through the training pipeline than needed.

13. Health Workforce 2025 also identifies some specialties reliance on international medical graduates – particularly in the fields of general practice, psychiatry and obstetrics/gynaecology.
Policy Response to HWA 2025

14. The Standing Council on Health (SCoH) has approved nine Health Workforce reform policy responses to Health Workforce 202592.

1. **Responding to the projected nursing workforce imbalance**
   During the next two years, evidence that helps inform a comprehensive national approach to tackle the 109,000 projected nursing shortfall by 2025 will be analysed and a mapping of its national uptake developed. In the first phase, studies into nursing retention and productivity will be undertaken. The next phase will focus on studying the skill mix and training of nurses.

2. **Progressing workforce redesign**
   SCoH agreed to support an ongoing implementation program of nationally coordinated workforce redesign, change management and adoption to enable progressive evidence-based workforce reforms. During the next 18 months, an evaluation of outcomes of current workforce redesign programs will be reported.

3. **Aligning training and workforce need**
   Rolling annual national training plans and strategies for major health professions will be developed to improve the alignment between changing health system workforce requirements, the higher education and training sector’s activities and broader workforce distribution programs.

4. **National Medical Training Advisory Network**
   The establishment of a National Medical Training Advisory Network (NMTAN) to advise governments, the professions, employers, colleges and universities on enhanced planning and coordination of medical training, from professional entry through to vocational training, in line with the training requirements identified for the medical workforce.

5. **Driving efficient and effective training**
   The reduction of unnecessary variation in the clinical training requirements of universities and higher education providers across each profession. The aim of this is to promote national consistency of core clinical training levels and recommend maximum training durations that attract publicly funded support.

6. **Addressing industrial barriers and enablers to workforce reform**
   The identification of barriers and enablers to workforce reform within a range of health professional industrial agreements will assist employers and government to identify opportunities for reform and increased productivity, and how these could be maximised.
   A set of goals, principles and conditions to facilitate productivity and reform can be developed. These could then be potentially used by those involved in developing industrial agreements to support greater national consistency in strategies to boost workforce productivity and retention.

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92 Health Workforce Australia. (November 2012) Health Workforce Insights
7. **Addressing legislative barriers and enablers to workforce reform**

   An analysis of relevant Commonwealth, State and Territory legislation to identify barriers and enablers to the flexible use of the workforce, optimal distribution, removal of unnecessary profession-specific demarcation and restrictions on health professionals working to their full scope of practice. The initial focus will be on the State and Territory Drugs and Poisons and Radiation Safety legislation.

8. **Streamlining clinical training funding**

   The Commonwealth and jurisdictions will consider current approaches to clinical training funding in the public, non-government and private sectors, supported by the establishment of efficient training pathways.

9. **Considerations for achieving national self-sufficiency**

   An analysis of the implications of differing levels of self-sufficiency in the health workforce and the interaction with other policy priorities including workforce distribution. The aim is to address the issue that Australia is one of the least self-sufficient nations in the OECD group in terms of the proportion of its workforce sourced through its domestic training and workforce development efforts.

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**Health Workforce Australia**

15. Health Workforce Australia (HWA) delivers a national, coordinated approach to health workforce reform in six critical areas:

   - Building capacity by delivering more fit-for-purpose workforce, more quickly and efficiently
   - Boosting productivity and maximising the utility of the workforce
   - Improving distribution to get the workforce into the places and specialties that are needed
   - Building the evidence for national health workforce reform and innovation through planning, research and evaluation
   - Providing leadership to inform and influence national health workforce policy and program decisions
   - Working in collaboration with key stakeholders to deliver targeted programs to drive reform.

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**Integrated Clinical Training Networks**

16. The Integrated Regional Clinical Training Networks (IRCTNs) are one of a range of programs that HWA are delivering to assist in the implementation of workforce reform agenda in accordance with the National Partnership Agreement on Hospital and Health Workforce Reform.

17. IRCTNs will play a pivotal role in facilitating, identifying and aligning health professional clinical training placements across the higher education and training sectors at a regional or local level. IRCTNs will support collaboration between higher education and training with government and non-government clinical training providers to accommodate increasing health professional student numbers.

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93 Health Workforce Australia. (November 2012) Health Workforce Insights
18. The Tasmanian Clinical Education Network (TCEN) is Tasmania’s response to IRCTNs. The intention of the TCEN is to include all public and non-government health, aged care, primary care and community services organisation within Tasmania involved in the delivery of health professional clinical training, as well as higher education providers wishing to place health profession students and trainees within Tasmania.

19. The TCEN has developed a program of work activity to:
   - Promote access to clinical training placements within Tasmania.
   - Facilitate systematic reporting of clinical training activity.
   - Build relationships and collaborations between education and clinical training providers.
   - Facilitate forward planning and deployment of training requirements and placement opportunities.
   - Match supply and demand for clinical placements and recommend distribution.
   - Support education and service providers in the management of clinical training placements including at the local level.
   - Support and engage with education and clinical training providers on other key national workforce reform issues consistent with the National Partnership Agreement.

Funding

20. Influencing payment models is a medium to long-term challenge that involves agreement nationally. It has been identified by Health Workforce Australia as a key priority as part the National Health Workforce Reform and Innovation Strategic Framework.

21. For DHHS, Activity Based Funding (ABF) is one of the factors influencing the move to a Purchaser/Provider model. With this model the Purchasing Commissioner Unit focuses on assessment of needs, evaluation of cost alternatives, and service planning (the Purchaser function), aiming to increase the efficiency and effectiveness of resources for Tasmanian Health Organisations and other health service provision areas (the Provider function).

22. Further information on these arrangements can be found in the fact sheets regarding the Purchasing Commissioner\(^\text{94}\) and the New Governance Framework\(^\text{95}\).

23. ABF changes the way that services are provided through public hospitals and moves away from the previous block funding approach. ABF funding is based primarily on a nationally-uniform, efficient cost set through the Independent Hospitals Pricing Authority (IHPA). This change was initiated by the Council of Australian Governments (COAG) in their March 2008 commitment to a new reform framework including financial reforms\(^\text{96}\). This came into effect through the December 2008 National Partnership on Hospital and Health Workforce Reform and the National Health Reform Agreement of August 2011\(^\text{97}\).

24. ABF began in July 2012 and has implications for the way that hospitals, - and health services that interact with hospitals - manage their resources including staffing levels and distribution of skills.

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\(^{94}\) DHHS Purchasing Commissioner Fact Sheet accessed 18 January 2013  
\(^{95}\) DHHS New Governance Framework Fact Sheet accessed 18 January 2013  
\(^{97}\) Council of Australian Governments National Health Reform Agreement August 2011 accessed 20 December 2012
Efforts to achieve the efficient price for a procedure may either drive beneficial changes with regard to workforce composition and distribution; or drive changes which have beneficial cost impacts in the short term but have negative impacts on sustainability of workforce supply and longer term service delivery.

25. It is possible that workforce issues may impact on ability to achieve the efficient price set by IHPA, thus affecting revenue streams and wider decisions about service provision. Transition to ABF is anticipated by 2018 for teaching, training and research and classification systems to support are currently being designed98. This may also have an impact on the workforce by shaping decisions about student placements and investment in teaching of all sorts, as well as affecting research programs.

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98 Independent Hospital Pricing Authority Frequently Asked Questions accessed 21 December 2012
8. Key Drivers - Tasmanian Context

The Tasmanian Strategic Health Workforce Framework 2013 - 2018

26. The Tasmanian Government outlined its vision for health in the Tasmanian Strategic Health Framework and one of the key commitments was a ten year Health Workforce Plan. In line with the Government’s commitment the Tasmanian Strategic Health Framework 2013 - 2018 will ensure Tasmania’s health and human services trains, recruits and retains the health workforce through working with the Commonwealth, Health Workforce Australia, colleges and education providers. It will also consider new models of care involving interdisciplinary teams undertaking varied roles.

27. The Tasmanian Strategic Health Framework 2013-2018 will be implemented against a complex background and changing environment. The Framework will consider patient/client needs that are shifting from an acute to a chronic model and which are placing a greater emphasis on the need for effective primary and preventative health care. There is also a continued need to focus on prevention strategies where there is inequity in health outcome, such as that which occurs in Aboriginal and rural and remote communities.


29. In the 1960s the health care systems in many countries were focused on treating infectious diseases, although acute illness was already the predominant reason why most people sought medical care. During the past 50 years, health care systems have gradually transformed themselves to focus on treating acute illnesses. Currently, the predominant reason why people seek medical care is chronic disease. This is leading to a need to respond to the increasing costs and prevalence of chronic conditions. The challenge now is the prevalence, cost and poor outcomes associated with people with multiple chronic conditions99.

30. Tasmanians are ageing at a rate faster than the rest of the nation. Tasmania has the oldest population of all the states and territories with a median age of 39.6 years. Over the next 40 years the number of Tasmanians aged 65 years and over is expected to more than double while the number aged 80 years and over is expected to more than treble100. Nationally, at 30 June 2008, 13.2% of the population were aged 65 and over compared to Tasmania with 15.0% of its population aged 65 years and over.

31. The ageing population is also reflected in the levels of workforce participation, highlighting the need for workforce analysis and planning as well as innovative strategies to expand skills and maintain labour market participation.

32. The Tasmanian public service workforce is ageing with 55.09 per cent over the age of 45 in 2010. During the coming decade those workers aged over 45 will progress to the retirement age of 55 as will those in the 35 to 44 year age group, thus highlighting the challenges in maintaining workforce capability101.

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99 Anderson, G. (2011) For 50 Years OECD Countries Have Continually Adapted To Changing Burdens Of Disease; The Latest Challenge Is People With Multiple Chronic Conditions – Anderson 2011

100 Council of Australian Governments National Partnership Agreement 2009 Sub-acute plan Tasmania 2009-2013

33. At August 2010, 20.65% of the Tasmanian public service was over the age of 55. This raises the potential for up to one fifth of the workforce to leave by choosing to retire which may impact on the capacity for service delivery and public sector management. One scenario using 2010 data has a possible 9000 plus employees, or almost a third of the workforce, leaving the service upon retiring at age 62.102.

34. As can be seen from the national projections above, Tasmania will struggle to meet the forecast growth required in the health workforce based on current health service patterns and models of care. This is because the differential growth in age groups in the population in general will mean that the working age population will not keep pace with the increased demand for service.

35. Growth in people entering the workforce from school and post-secondary education (15 to 29 years) is projected to be much lower than general population growth.

**Burden of Disease**

36. With the ageing population, rise in chronic disease and increasing pressure on the acute system it is likely that people will be inappropriately forced into acute and residential care as a result of their care needs not being able to be met in the community.

37. Health care needs within the community have shifted from an acute model to one of chronic and complex care emphasising the need for effective primary and preventative health care.

38. Prevalence of risk factors for chronic disease is steadily increasing. The incidence of people in Tasmania who are overweight or obese is 63.9%, higher than the national average of 61.4% and contributing to the increasing national trend.103

39. The 2011 Australian Bureau of Statistics Health Survey for 2011 reports Tasmanian rates of obesity, smoking, and alcohol consumption are all higher than the national average.104 Fostering professional and community alliances to improve health outcomes with increased focus on health promotion and preventative health will be key to meeting our increased service demand.

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102 Ibid
Developing the Capacity for Planning at a Local Level

40. As noted earlier, given the differential growth in age groups in the population, the available pool of workers is growing more slowly than the growth of the aged in the population. This means there will be greater competition for scarce workforce resources for all industry sectors. Workforce redesign, role substitution and training more workers will not be enough to address the expected future health needs of the community. Workforce planning will need to be at the forefront of all health service planning activities.

41. With the implementation of Tasmanian Health Organisations (THOs) and Medicare Locals (MLOs) comes responsibility for a broad range of human resource-related functions, including local workforce planning and workforce strategy, recruitment, and skills development (supported by the Health Education and Training Institute). It will be necessary for the THOs and MLs to have the skills and capacity to undertake this role. The THOs and MLOs will need to ensure that collaboration of service, budget and workforce planning is occurring within their organisations.

Funding Model

42. Australia’s health payment/fee for service model sees health as a series of transactions as opposed to outcomes. There is much debate about whether this model is conducive to effective long term management of chronic conditions. Critics believe the model provides perverse incentives to maximise the number of presentations, whereas a successful long term management system should ideally result in a reduction in the number of primary and acute presentations. Whilst consideration of other options for payments is beyond the scope of this Discussion Paper and the Tasmanian Strategic Health Framework 2013 - 2018, careful consideration of the impact of payment arrangements is required and should include attention to unexpected outcomes, many of which influence career choices and work practices.

43. The Australian Health Practitioners Regulation Agency data provides the current number of registered health professionals within Tasmania and is represented in the graph below.

Registered Tasmanian Health Professionals
2012

- Nurse, 7570, 61%
- Nurse and midwife, 723, 6%
- Optometrist, 84, 1%
- Osteopath, 38, 0%
- Pharmacist, 628, 5%
- Physiotherapist, 394, 3%
- Podiatrist, 90, 1%
- Psychologist, 524, 4%
- Chiropractor, 45, 0%
- Dental practitioner, 336, 3%

Midwife, 9, 0%

Medical practitioner, 2048, 16%
44. As highlighted by Health Workforce 2025 (discussed previously), on a national level, the medical specialties with greatest shortage\textsuperscript{105} are general practice, general medicine, medical oncology, radiation oncology and psychiatry. Among the factors affecting these specialties is relative lack of uptake and popularity amongst the Australian trained workforce. Some specialties therefore rely heavily on the international medical graduate workforce, have an ageing workforce and have high attrition rates.

45. Underlying reasons for this include:

46. Patient mix – general medicine, geriatric medicine and general surgery are usually faced with patients with complex and multiple co-morbidities.

47. Funding model – the Australian health funding model is skewed towards remunerating procedural specialties at a higher rate. Whilst effort has been made to balance the payment system and remove some of the ‘perverse’ incentives, further work is necessary in this area.

48. Inability to “cure” – the increasing use of allied health and nursing in clinical care has resulted in medical care being targeted towards patients with higher acuity. Whilst this is a desired workforce outcome, the inverse effect of an increasing acute patient mix is that the medical workforce is largely grappling with patients with such chronic morbidities that “cure” is not an option.

49. Many younger doctors tend to shy away from professions where they cannot “cure” a patient. This requires a rethinking of the current medical model for training and service delivery to enable a wider focus beyond short term treatment options to long term management of care.

Tasmania’s Medical Workforce

50. Tasmania’s headcount of medical practitioners per 100 000 population is higher (at 366) than for the nation (331), including for primary care clinicians. However when workload is taken into account and presented in the tables showing full-time workload equivalent, this situation is reversed.

51. From the available data, and estimated resident population, the General Practitioner full-time workload equivalent for Tasmania is 85.15 in comparison to the national average of 92.23, and reflects the part time nature of this workforce.

52. Other tables show that Tasmania continues to provide more medical graduates and advance trainee posts than its population share.

Tasmania’s Nursing and Midwifery Workforce

53. The number (headcount) of Registered and Enrolled Nurses practicing in Tasmania is higher in total per capita than the national average, but the average working hours are lower. Differences between states in the numbers of nurses working in the nominated areas of practice may reflect different models of care rather than over or undersupply.

54. The overall full time equivalent (FTE) distribution per 100 000 population of Enrolled and Registered Nurses declined nationally between 2007 and 2011 (0.73 per cent). This decline as a little more in Tasmania (at 1.12 per cent). Tasmania’s number of nurses per 100 000 population however, was 14 per cent higher than the national average in 2011 according to the data cited (Australian Institute of Health and Welfare (AIHW) labour force surveys 2007-2009 and re-registration data 2011).

\textsuperscript{105} Health Workforce Australia (2012) Health Workforce 2025, Volume 3 – Medical Specialties


Last Version Updated 18 July 2013 at 1600 Version 0.11
55. The report advises that care should be applied when comparing 2011 data and previous years because of changes to methodology of data collection and treatment.

56. The 2011 AIHW statistics shows that the peak age group for registered nurses and midwives has increased. In 2011 this was 50-54 years of age.

57. The number of midwives per capita in Tasmania is approximately 80 per cent of the national average. This may be affected by the ageing population structure of the state, in addition to other factors.

58. Tasmania’s birthing population is evenly dispersed geographically across the north and the south of the state. The Council of Obstetric and Paediatric Mortality and Morbidity Annual Report 2010 reported that 3117 babies were born in the south while 1974 were born in the north/northwest; total births for 2010 (6137) represents a decrease in all geographical areas of Tasmania in comparison to the rate in 2009 (6381); and twenty nine (29) per cent of birthing women elected to be admitted as private patients.

59. Birthing services are available at Royal Hobart Hospital, Launceston General Hospital, Mersey Community Hospital, North East Soldiers Memorial Hospital, Calvary HealthCare (Lenah Valley), Hobart Private Hospital and North West Private Hospital (contracted to provide public maternity services for the communities of Burnie and the surrounds).

60. Birthing services at Queenstown and Smithton have closed, in part due to safety concerns related to diminishing numbers of midwives and General Practice obstetricians and the difficulties in maintaining skills in these professional groups.

61. Funding initiatives supported by the Medical Specialist Outreach Assistance Program have enabled the re-establishment of local services in rural and remote areas, specifically antenatal and postnatal care.

62. Women in advanced stages of pregnancy are however encouraged to relocate closer to birthing services wherever possible. Support is by local social work services and the ‘Patient Travel Assistance Scheme’ to do so.

63. In many of the allied health professions, the majority of the workforce provides services in the private sector. While there may be an adequate supply of new entrants to the workforce, it should be noted that there are significant locations in Tasmania where the community has little or no access to private practitioners. Consequently, these communities rely solely on publicly funded allied health professionals for care. This is particularly relevant in some outer regional areas, and the smaller rural locations and remote communities.

**Affordability**

64. The 2010 Intergenerational Report Australia to 2050: future challenges, found that total government spending is projected to increase to 27.1% of GDP in 2049/50 with around two thirds of the projected increase expected to be on health. Spending on health will rise from 4% of GDP in 2009/10 to 7.1% in 2049/50 and the bulk of the increase will be on Medicare Benefits Schedule (MBS), hospital services and the Pharmaceutical Benefits Scheme (PBS).

65. Aged care expenditure is also projected to rise significantly from 0.8% of GDP in 2009/10 to 1.8% by 2049/50 with residential aged care recording the highest growth

66. The Intergenerational Report indicates that demographics play an important role in increasing health

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system costs. In national terms as the population ages, more people fall into the older age groups that are the most frequent users of the system. From 2009-10 to 2049-50, real health spending on those aged over 65 years is expected to increase around seven-fold. Over the same period, real spending on those aged over 85 years is expected to increase around twelve-fold. The Federal Government estimates that the proportion of working age to support each Australian aged 65 years and over will fall to 2.7, compared to 5 working age people today and 7.5 in 1970\textsuperscript{107}.

**Geographical Distribution**

67. Tasmania is geographically isolated and while this is a driver to develop self-sufficiency, the pathways to achieve this are both complex and costly. Attracting and retaining a skilled health workforce are major challenges facing health services across Australia as a whole—but workforce supply has reached a critical level in many rural and remote communities.

68. The number of doctors, dentists and oral health practitioners, mental health professionals, and allied health professionals in rural and remote areas is substantially lower per capita\textsuperscript{108}.

**Increasing Specialisation**

69. From the late 1930s and 1940s, the growth of specialty medical colleges within Australia has mirrored the international trend away from generalist practice and towards specialisation. During the 1950s this trend was encouraged by fundamental changes in the nature of medical practice such as the growth of technology and increasing focus upon hospital-based services. However, today’s patients are presenting with multiple problems.

70. Our health system is still largely based on a curative model of care which treats the predominant problem of the patient at the time of the presentation. Given the variety of treatment options that can be offered to a patient with multiple and complex co-morbidities, health providers are increasingly required to have knowledge and skills which go beyond a particular sub specialty.

**The Need for Workforce Reform**

71. There are many factors to consider in the provision of delivering a safe and efficient workforce to meet future service needs. These include a changing balance of service delivery and skill mix across health care settings, increased burden of chronic disease and ageing population.

72. Employment, attraction and retention strategies are all impacted by the way in which the workforce is systemically designed, the skills that are needed versus the skills that are available or valued, the desires of individuals to work, the factors that motivate individuals to choose different professions and work in different areas, and the things that keep people satisfied in work.

73. Workforce redesign is required in order to meet the expected increase in service delivery arising from an ageing population and the increasing burden of chronic illness. This will involve looking at who provides different levels and types of service and care, and to whom. There will also be a need to address the trend of increasing specialisation in order to ensure that all communities are able to access appropriate health care.

\textsuperscript{107} ibid, p.4

\textsuperscript{108} Department of Health and Ageing (2008) Rural Health Workforce Audit
74. What is clear is that more of the same is not the answer. Given the shift in balance in the age profile of the population, with a growing older population requiring care, and a shrinking proportion of working aged people, the current supply of workers will not meet future demand.

75. The questions within this Paper have been developed using the five domains from the National Health Workforce Innovation and Reform Strategic Framework for Action 2011–2015\textsuperscript{109}, key priorities identified through the Australian Health Ministers’ Advisory Council, the Health Workforce Australia Future Directions Discussion Paper, and DHHS key priorities to ensure alignment with strategic directions.

76. Your input will assist in identifying potential strategies to address key workforce challenges. A number of questions are posed to prompt discussion and to seek feedback and ensure refinement of the strategies and/or alternative strategies.

\textsuperscript{109} Health Workforce Australia National Health Workforce Innovation and Reform Strategic Framework for Action 2011-2015
# Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tr>
<td>ABF</td>
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</tr>
<tr>
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<td>Australian General Practice Training Program</td>
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<tr>
<td>AHREN</td>
<td>Australian Rural Education Network</td>
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<tr>
<td>AHMAC</td>
<td>Australian Health Ministers Advisory Council</td>
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<td>AHP</td>
<td>Allied Health Providers</td>
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<td>AIDA</td>
<td>Australian Indigenous Doctors</td>
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<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
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<tr>
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<td>Assistant in Nursing</td>
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<tr>
<td>ASGC-RA</td>
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<tr>
<td>ATSIHRTONN</td>
<td>Aboriginal and Torres Strait Islander Health Registered Training Organisation National Network</td>
</tr>
<tr>
<td>CATSIN</td>
<td>Congress of Aboriginal and Torres Strait Islander Nurses</td>
</tr>
<tr>
<td>CGC</td>
<td>Commonwealth Grants Commission</td>
</tr>
<tr>
<td>COAG</td>
<td>Council of Australian Governments</td>
</tr>
<tr>
<td>DHHS</td>
<td>Department of Health and Human Services</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
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<tr>
<td>EN</td>
<td>Enrolled Nurse</td>
</tr>
<tr>
<td>ESoP</td>
<td>Extended Scope of Practice</td>
</tr>
<tr>
<td>FRACGP</td>
<td>Fellowship of Royal Australian College of General Practitioners</td>
</tr>
<tr>
<td>FACRRM</td>
<td>Fellowship of Australian College of Rural and Remote Medicine</td>
</tr>
<tr>
<td>FTE</td>
<td>Full Time Equivalent</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>GPTT</td>
<td>General Practitioner Training Tasmania</td>
</tr>
<tr>
<td>HARP</td>
<td>Hospital Admission Risk Program</td>
</tr>
<tr>
<td>HITH</td>
<td>Hospital in the Home</td>
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<tr>
<td>HWA</td>
<td>Health Workforce Australia</td>
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<tr>
<td>IHP</td>
<td>International Health providers</td>
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<td>Independent Hospitals Pricing Authority</td>
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<tr>
<td>IPE</td>
<td>Inter-professional Education</td>
</tr>
<tr>
<td>IRCTNs</td>
<td>Integrated Regional Clinical Training Networks</td>
</tr>
</tbody>
</table>
MBS  Medical Benefits Schedule
MLO  Medicare Local Organisation
MSOAP  Medical Specialists Outreach Assistance program
NHS  National Health Service
NP  Nurse Practitioner
NATSIHWA  National Aboriginal and Torres Strait Islander Health Worker Association
NPAPH  National Partnership Agreement on Preventive Health
NMTAN  National Medical Training Advisory Network
NSW  New South Wales
OECD  Organisation for Economic and Co-operative Development
PGPPP  Prevocational General Practitioner Placement Program
PNSA  Peri-operative Nurse Surgical Assistant
PBS  Pharmaceutical Benefits Scheme
RA  Remoteness Areas
RACGP  Royal Australian College of General Practitioners
RN  Registered Nurse
SARRAH  Service for Australian Rural and Remote Allied health
SCoH  Standing Council on Health
SMHSOP  Specialist Mental Health Services for Older Persons
TCEN  Tasmanian Clinical Education Network
THO  Tasmanian Health Organisation
UK  United Kingdom
VET  Vocational Education and Training
WHO  World Health Organisation