

Australian Health Workforce Advisory Committee
Australian Medical Workforce Advisory Committee
Australian Health Workforce Officials' Committee

**A MODELS OF CARE APPROACH
TO HEALTH WORKFORCE PLANNING**

Information Paper

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EXECUTIVE SUMMARY

This discussion paper explores a 'models of care' approach to health workforce planning. The paper is designed to encourage thinking and discussion about models of care health workforce planning. The paper does not seek to provide definitive answers to the 'why', 'what' and 'how' of a 'models of care' approach to workforce planning. It is anticipated that answers to these questions will evolve over time as planners and stakeholders further consider or work with this planning approach and reflect and learn from their experiences.

The extent to which this approach will be applied in Australia will of course be a matter for AHMAC and/or individual jurisdictions to determine in light of their service and workforce planning requirements.

It appears that little has been published, either nationally or internationally, that specifically addresses a 'models of care' approach to workforce planning. On the other hand, publications that address the need to change existing models of care to improve patient care (eg achieve improved integration of service delivery) are more prevalent (Weeramanthri et al., 2003). Also more prevalent are publications that address redefining who does what in health care based on identification of competencies required to perform defined functions (National Health Service 1999; Victorian Department of Human Services 2000).

The exploration of new approaches to health workforce planning is being driven by demographic shifts and broad health system changes, including, a predominance of illness associated with an ageing population, increasing consumer demand for services and increasing costs. Further drivers for change include workforce shortages and a predicted shrinkage in the available pool of potential new workers. Faced with these pressures, service agencies are seeking new ways of responding to consumer demand. For example, placing greater emphasis on community based care and on self-directed care combined with strategies to increase the quality and safety of client care and the productivity and cost-effectiveness of service delivery methods (AHMC 2004).

As a result of these pressures, Australian workforce planners are being challenged to work with health care service providers to facilitate new, more consumer-focused and cost-effective ways of using the health workforce. Multi-health-professional and multi-functional approaches to health workforce planning are being considered and several States have undertaken pilot projects using this approach which has been termed 'models of care' health workforce planning. However, to date no national workable 'models of care' approach has been developed.

Among key stakeholders, opinions vary as to what constitutes a 'models of care' approach to health workforce planning. Some perceive it to represent an 'optimisation forecasting model', which first requires definition of a 'best practice' model of care before any projection modelling can be attempted. However, among some multidisciplinary workforces little consensus may exist as to what constitutes an optimal model of care. Indeed it is quite

possible that there may be a number of viable/optimal models of care across any care group or disease entity.

The paper proposes that in the absence of a defined optimal model of care that the models of care approach to workforce planning involves:

- selecting a particular care group (eg people with mental health problems, people with diabetes);
- identifying and describing the most common prevailing model/s of care and exploring commonalities and differences within and across jurisdictions and geographic locations;
- defining the multidisciplinary workforce currently associated with these prevailing model/s of care, including the disciplines/occupations represented, what they do, and the skills and capabilities required;
- estimating the expected growth in demand for the planning period using appropriate indicators (eg population growth estimates relevant to the selected care group, health provider service delivery plans for the next 5-10 years, expected changes in models of service delivery);
- calculating future workforce requirements based on prevailing model/s of care and estimated growth in demand;
- projecting future workforce supply drawing on appropriate education and training preparation, recruitment, retention and attrition sources of data;
- analysing any mismatch in projected workforce requirements and supply estimates (ie 'gap' analysis); and
- recommending strategies to achieve a balance in workforce requirements and supply within the planning period.

The paper recognises the growing need for health service providers and workforce planners to work together to explore new approaches to workforce planning, while at the same time acknowledging that it is not the role of workforce planners to dictate new ways of health professionals or service providers providing care. The processes and methods proposed in this information paper are interactive and based around the notion that in a dynamic environment ways of providing health care will evolve. With these complex issues in mind, this paper proposes a three phase approach to "models of care" workforce planning:

Phase 1: Planning to plan, where those involved identify the health issue or workforce care group to be addressed and clarify the objectives of the planning project. For example, 'To produce workforce plans that are consumer-focused', or 'To produce workforce plans that are aligned with service delivery plans, or 'To produce realistic and sustainable ways to address multiple workforce shortages simultaneously'. Choice of the latter objective may result in workforce planners and service providers working closely together to first define the skills required to meet the service needs of the particular consumer group.

Phase 2: Assessment of present models of care and the workforce requirements of maintaining the status quo approach to the provision of care across the next ten years. It could well be that at the completion of this Phase the conclusion is reached that the current approach to service delivery (i.e., models of care) are not sustainable and recommend that new, more realistic and sustainable approaches need to be explored. Alternatively, the conclusion may be reached that the current approach to service delivery is the optimal approach and that strategies are required to recruit sufficiently appropriately trained staff to

supply future requirement. An important aim of this Phase is to provide evidence, acceptable to all relevant stakeholders, to support whatever workforce strategies are recommended.

Phase 3: Changing models of care, is about change in prevailing models of care should this be the recommendation of key stakeholders following consideration of the findings arising from Phase 2. It is proposed that should this approach be supported that it is best undertaken at State/Territory or regional level and involve service providers and planners working together because it involves challenging existing models of care. Hence, it becomes an organisational change exercise; an exercise that requires careful management at the local level. Such an approach could involve the use of a competency or skills based approach to workforce planning. For information about a skills based approach to workforce planning see 'Nursing Workforce Planning in Australia', pp 66-73, AHWAC 2004.1, Sydney: (www.healthworkforce.health.nsw.gov.au/amwac/ahwac/pdf/nurse_plan_20041.pdf).

INTRODUCTION

As in most countries, the goal of health workforce planning in Australia is to ensure that projected population demand for health care services is matched by workforce supply and in particular to take whatever steps are necessary to ensure that populations most in need receive essential services.

The importance of health workforce planning in Australia is well recognised. Since 1995, the Australia Health Ministers' Advisory Council (AHMAC) has established three national health workforce planning committees, viz., the Australian Medical Workforce Advisory Committee (AMWAC) in 1995, the Australian Health Workforce Advisory Committee (AHWAC) in 2001, and the Australian Health Workforce Officials Committee (AHWOC) in 2002. As their names imply, the focus of AMWAC is the medical workforce, while the focus of AHWAC is both the nursing and allied health workforces. The role of AHWOC is to provide a forum for reaching agreement on key national level health workforce issues requiring government collaborative action and to provide advice on health workforce issues to the Australian Health Ministers' Advisory Council (AHMAC). AHWOC also has a central role to play in co-ordinating the implementation of the recommendations arising from national level workforce planning including the recommendations from the workforce reports completed by AHWAC and AMWAC.

The need to explore new multidisciplinary approaches to workforce planning is being driven by significant demographic changes and changes in the health system. These changes include the fact that most illnesses burdening today's health consumers are complex to manage with input required from several health disciplines vis-à-vis a single discipline or occupational group. Secondly, the demand for health care is growing at rates that funders (government and private) find difficult to sustain. More efficient ways of using the workforce are being actively sought to ensure acceptable levels of access to services. Thirdly, workforce shortages range across health disciplines and specialty areas, particular service areas, and geographic areas. In the face of these shortages, service agencies are examining new ways of responding to demand (eg job-redesign, workforce re-engineering and a greater emphasis on community-based care and on self-directed care). Fourthly, in the longer term the available pool of a potential future workforce is shrinking (AHMC 2004).

Faced with these pressures, Australian workforce planners are being challenged to work with health care service providers to facilitate new, more consumer-focused and effective ways of using the health workforce (AHMAC 2002). Multi-health-professional and multi-functional approaches to health workforce planning are being called for and several States have undertaken pilot projects using what is most commonly referred to as a 'models of care' approach. However, to date no national workable 'models of care' approach has been developed.

Key stakeholders have identified several opportunities and challenges that they perceive a 'models of care' approach to health workforce planning holds. Perceived opportunities of a

'models of care' approach include the development of workforce plans that are potentially more:

- consumer focused;
- closely aligned with service delivery plans;
- multi-disciplinary/occupational; and
- holistic in their approach to addressing workforce issues.

A 'models of care' planning approach also has the potential to extend the knowledge and skill base of health workforce planners to better encompass strategic planning and change management tools.

Challenges associated with using a 'models of care' approach to health workforce planning include:

- Becoming overloaded with information and 'bogged-down' with the complexity of the exercise with implications for the development of plans and reports that key people will read and use and for meeting the deadline expectations of funding bodies and other stakeholders;
- Limiting workforce planning activities to those health issues for which there is a reasonable body of knowledge about what constitutes a model of care/service delivery that will achieve optimal patient outcomes. For example, the evidence-based medicine body of knowledge is limited largely to health problems that lend themselves to randomised controlled trials;
- Entering new domains/territory, such as education or service delivery staffing models, or spending time working with the traditional holders of these domains in order to define and assess essential competencies, skills and knowledge. This exercise is likely to require careful managing and also has resource implications; and
- Respecting and appreciating the diversity of care and service delivery approaches across Australia and within any care area, and as such the likelihood that most areas of care have a number of viable/optimal models of care rather than a single all encompassing model.

The structure of this paper is guided by a series of questions that have been raised by jurisdictional workforce planners and other stakeholders. In seeking to address the following questions the view has been taken that 'models of care' workforce planning does not necessarily represent a definitively superior method of health workforce planning. Conceptually, however, it does offer merit for particular situations and that as such there is value in exploring this approach and attempting to determine a process and method for its application:

- Why the interest in a 'models of care' approach to workforce planning?
- What do we mean by a models of care approach to workforce planning?
- What outcomes do we expect to achieve through a 'models of care' approach to workforce planning?
- Is the workforce planning model used by the National Health Workforce Secretariat and several States/Territories appropriate for use in a 'models of care' approach to workforce planning and if so what adaptations are required?

- Using a 'models of care' approach to workforce planning, what components are best addressed at 1) the national level and 2) the jurisdictional level?
- In what situations is a 'models of care' approach to be preferred over a profession-based or occupation-based approach to workforce planning?

WHY THE INTEREST IN A 'MODELS OF CARE' APPROACH TO WORKFORCE PLANNING?

Changing models of service delivery

As the population ages, morbidity patterns change and the need for health services changes and increases. Chronic health problems have become and will remain the dominant focus of the health system for the foreseeable future (AIHW 2000, AIHW 2004). Leading causes of 'Burden of Disease' in Australia in 2000 included:

- ischaemic heart disease;
- stroke;
- depression;
- cancer (lung, breast and colorectal);
- dementia;
- chronic obstructive pulmonary disease;
- diabetes mellitus;
- asthma; and
- osteoarthritis.

These chronic health problems are frequently complex to manage requiring close linkages between home, primary care services, hospital and nursing home care. For example, a person recovering from a stroke admitted to hospital after a fall may require acute care, rehabilitation, and a range of home and primary care services. New models of care have emerged designed to improve linkages among service providers and consumers and carers.

Consumer access to medical information has improved and their expectations of health professionals have increased and changed. The Internet has enabled consumers to gain access to information about health and illness and as a consequence many come to their health workers armed with the latest evidence of treatment effectiveness. Consumers are also more aware of safety and quality issues and more litigious. Given these changes, new models of provider-consumer communication have developed, models that are patient-empowering and that promote self-management of chronic conditions (Best and Norman 2003).

Technological advances in medicine have frequently changed and increased the type and complexity of the work required of health professionals and other members of the health workforce and new models of service delivery have, and will continue to evolve. The expectation is that in the future advances in technology will accelerate as will their uptake. For example, advances in surgery, radiology, pharmacology, nanotechnology, gene technologies, robotics and e-technologies. The impact of innovations in these areas on workforce requirements remains difficult to assess. Hence, any new approaches to health workforce planning will need to be sufficiently flexible to allow for the unpredictable. What is well known and understood is that most advances in medical technology have resulted in increased complexity in service delivery, increased specialisation and potential for fragmentation in service delivery; with effects on demand, practice and productivity (AHMC 2004; AHWAC, AMWAC and AHWOC 2004 forthcoming, Department of Health and Aged

Care 2000). As a consequence of these pressures, new interdisciplinary models of service delivery have evolved to facilitate collaborative decision-making among an increasingly specialised workforce and new roles have emerged (eg program coordinators, case managers) to enable continuity of care for patients.

Increasing workforce diversity

Health and community services are the fourth largest employing industry in Australia. Between 1996 and 2001, the total number of people employed in health and community services industries increased by 10.6% (or 76,562 persons), from 721,639 to 798,201. The number of people employed in health occupations, during this period, increased by 11.4%, from 404,582 to 450,792. For the key health occupations the main increases were medical practitioners (an increase of 12.6%), medical imaging workers (25%), dentists (11%), registered nurses (5.8%), pharmacists (13%) and nursing assistants and patient carers (18.8%) and allied health workers (27.4%). (AIHW and ABS 2003).

The diversity of the workforce is highlighted by the fact that the Australian Bureau of Statistics Classification of Health Occupation contains 76 different health occupations (AIHW and ABS 2003) of which approximately 24 are registrable under the auspices of a government agency or delegated professional body (Palmer and Short 2000). Qualification levels vary markedly within this workforce, ranging from people with no formal qualifications to highly qualified specialists. Increasing demand for home and community-based services and residential aged care services has seen an increase in the use of health workers with no formal qualifications.

Workforce shortages

It is well known that many health care organisations are experiencing challenges in recruiting qualified professionals in some disciplines due to a general shortage and/or distributional issues. Contributing to this situation is the fact that the health workforce, like the general population, is ageing and preferring to work shorter hours. This applies particularly to the nursing, medical and dental workforces (AHWAC 2004; AMWAC 2004). In addition, disciplines once predominantly male, such as medicine and dentistry, are moving toward an equal mix of males and females and this is impacting on workforce participation rates. Workers in most of the other health occupations remain predominantly female. In 2001, 74% of the total health workforce were female and 34% of the workforce worked part-time (AIHW and ABS 2003). Table 1 lists health disciplines known to be in short supply (AHWOC 2004).

Table1: Health disciplines known to be in short supply in Australia in 2003-04

Nursing	Allied Health	Medicine	Other
<ul style="list-style-type: none"> ▪ General Nursing: <ul style="list-style-type: none"> - Aged care; - Cardiothoracic; - Community; - Critical care; - Emergency; - Indigenous; - Neonatal; - Neurological; - Oncology; - Operating; - Theatre; - Paediatric; - Palliative; - Perioperative; - Renal. ▪ Midwifery ▪ Mental health ▪ Enrolled nurses 	<ul style="list-style-type: none"> ▪ Physiotherapy ▪ Pharmacy (hospital/retail) ▪ Occupational therapy ▪ Speech pathology ▪ Diagnostic radiology ▪ Radiation therapy ▪ Sonography ▪ Nuclear medicine 	<ul style="list-style-type: none"> ▪ Orthopaedic surgery ▪ Ear nose and throat surgery ▪ Obstetrics ▪ Pathology ▪ Radiology ▪ Oncology ▪ Psychiatry ▪ Geriatric medicine ▪ General practice 	<ul style="list-style-type: none"> ▪ Dentistry ▪ Pharmacy

Source: Derived from information contained in the National Health Workforce Strategic Framework, Australian Health Workforce Officials Committee, 2004, Sydney.

The workforce shortage situation in Australia may worsen over the next 10 to 20 years for several reasons. First, Australia has become increasingly reliant on overseas-trained health professionals to address existing shortages and access to these recruits is not guaranteed into the future given increasing competition from other developed countries, such as the United States, Canada and the United Kingdom. Secondly, the size of the population in Australia from which new labour force recruits are drawn is projected to shrink (Department of Health and Aged Care 2001). Thirdly, attractive non-health oriented career options are now available to young people with the result that the health industry is in growing competition for a declining pool of potential new recruits. These challenges are not confined to Australia and a number of hypotheses have been put forward regarding the declining attractiveness of choosing a professional health career (Kanagarajah et al 1996; Blegan 1993).

Increasing costs

Responsibilities for the funding and provision of health services in Australia are complex, involving different levels of government, and the public and the for-profit and not-for-profit non-government sectors. In 1999-2000, government funding accounted for 71.2% of total health expenditure, while the remaining 28.8% was provided by the non-government sector. Between 1960-61 and 2002-03, total health expenditure grew from \$692 million to \$72.2 billion. This represented 4.2% of Gross Domestic Product in 1960-61 and 9.5% in 2002-03

and an increase in per person expenditure from \$65 to \$3,652 (AIHW 2004). The Australian government has the major responsibility for the funding of medical services, pharmaceutical services and aged care services, while State and Territory governments are largely responsible for the public provision of health services, and for public health. For the State/Territory governments, hospitals are the largest area of health expenditure. It is well known that governments and those dependent on government funding are under pressure to achieve balanced budgets and value for their use of the taxpayers dollar. As the population increases and ages and technology advances, demand for, and the cost of, health services continues to increase (AIHW 2004 and AIHW 2002).

The AIHW estimates that 65% of total health services expenditure in Australia can be attributed to the costs of labour (ie wages and salaries and employer contributions to workers' compensation and superannuation (AIHW 2000). Hence, of the \$66,582 million spent on health services in Australia in 2001-02, around \$43,278 million can be attributed to the health workforce. It follows that changes in occupational categories, educational requirements, salaries, and any growth in the health workforce, particularly the professionally qualified workforce, will have a major impact on overall health expenditure.

Search for cost-effective ways of using the health workforce

Given economic pressures, increasing specialisation, changing modes of service delivery and workforce shortages it is not surprising that there is strong support for an approach to health workforce planning that facilitates the development of more consumer-focused and cost-effective ways of using the health workforce. Underpinning these sentiments is the perception that current approaches to workforce utilisation, particularly the utilisation of qualified professionals, are in some cases inappropriate and unsustainable.

In Australia experimentation with new approaches to workforce design is occurring based on definition of required competencies and skill development. These developments are being used at the local level, primarily to solve recruitment or professional shortage issues. These changes represent local responses to changing models of care and needs, which have not, as yet, been integrated into national or jurisdictional level workforce planning activities. In the main these initiatives include a transfer of some of the traditional functions once undertaken by one professional group to another (AMWAC 2003). Australian examples of these developments include (Victorian Department of Human Services 2000):

- Emergence of the nurse practitioner role, with nurses receiving additional competency training to undertake roles normally performed by doctors, such as ordering tests and prescribing pharmaceuticals;
- Expansion of the scope of practice for division 2 or enrolled nurses to authorise administration of prescribed medications, previously the domain of division 1 or registered nurses;
- Increasing use of personal care workers, particularly in aged care, to perform functions that require lower skill levels than state enrolled or registered nurses;
- Substitution of nurses specialising in renal dialysis with renal dialysis technicians who have more specific competencies in delivering renal dialysis (and not the general diagnosis and treatment skills of the general nurse);

- Preference in some operating theatres for anaesthetic technicians in place of theatre nurses, again with more specific competencies;
- Authorising psychologists prescribing in rural settings where psychiatrists are not resident; and
- Expanded role of ambulance officers to prescribe limited drugs of addiction in some circumstances.

Given the above initiatives, it is little wonder that the traditional profession-based or occupation-based approach to health workforce planning is being questioned and new health workforce planning methods are being considered; approaches that facilitate the integration of new approaches to workforce design and workforce planning. A models of care approach to workforce planning may have the potential to expand the options available.

WHAT DO WE MEAN BY A MODELS OF CARE APPROACH TO WORKFORCE PLANNING?

Defining a models of care approach to workforce planning

The 2002 review of AMWAC suggested that a models of care approach to workforce planning involved taking a particular care group eg. mental health, diabetes, asthma, cardiovascular disease and identifying a best practice model(s) of care designed to meet the needs (not demands) of a particular population; the skills and capabilities required to provide that service is determined, and the required workforce supply is then determined (AHMAC 2002). Hence, the planning actions associated with this definition are:

- Identification and description of the present care group assumed to be multi-disciplinary/occupational.
- Identification of a best practice model(s) of care designed to meet the needs of a particular population. Two issues are important here, viz., definition of an acceptable best practice model of care and the emphasis on population need. Defining a best practice model of care is no easy task and this issue is discussed further below. The emphasis on population need is important because it provides a basis for estimating future population requirements given that there are recognised measures available to planners for the measurement of 'need'. Furthermore, the assumptions underpinning this approach to assessing population requirements are well understood.
- Definition of the skills and capabilities required to provide the model of service. The operational implications of this requirement could be interpreted in several ways. For example, it could assume that the present mix of staff is appropriate and the job of planners becomes defining the skills and capabilities currently required of staff in their present roles. It is more likely that the intention was for workforce planners to undertake a grass-roots analysis of the functions to be performed and the skills and capabilities associated with each of these functions and to then explore who is best able to perform these skills etc. If this is the intention, then this activity would involve workforce planners working in close collaboration with service providers in defining present models of service delivery and expected changes in service delivery followed by an analysis of tasks, functions and skill requirements. If this is the preferred option then it has considerable resource and time implications. Furthermore, it is likely to influence the previously defined model of care.
- The workforce supply required. Here the measures of population need would provide the basis for estimating workforce supply growth requirements in the future. However, the multi-disciplinary/occupational mix of this workforce will depend on the outcomes of the skills and capabilities analysis. The recommendations arising from this analysis are likely to be much broader than recommending increases to existing training programs and/or increases in the number of migrants with particular skills/qualifications entering the country.

More recently, AMWAC defined a models of care approach as one that 'determines preferred patient outcomes, then uses these to define optimal models of care, and determines the appropriate workforce supply and mix accordingly' (AMWAC 2003). This definition implies

evaluation of existing models of care based on achievement of preferred patient outcomes in order to produce an 'optimal model(s) of care'. Hence, it appears to assume potential change in existing models of care. It also proposes that the evaluation of existing models of care precede actions to determine the appropriate workforce supply and mix.

The AHWOC survey of State/Territory Health Departments (2003) defined a 'models of care' approach to workforce planning broadly, viz., as being 'multi-profession, based on the model of care in a service (eg mental health)'. They found that among jurisdictions there was considerable variability in how a 'models of care' approach was defined and expressed. Some related it to the statewide structuring of a workforce (eg 'spoke and hub'), others perceived it to mean identifying the health workforce required to provide a particular health program (eg oral health program, mental health program) or stream of services in a particular setting (eg acute care, emergency care). Others perceived it to relate to a particular health problem (eg people with cancer) and the multidisciplinary workforce required to provide the full range of services (eg oncology services) based on recognised or agreed-upon (through extensive consultation and consensus-building) optimal models of service delivery. Still others related it to a particular segment of the population, such as frail elderly people, or children (0-15 years of age).

Queensland Health has defined a model of care as 'a multifaceted concept, which broadly defines the way health services are delivered. It can therefore be applied to health services delivered in a unit, division or whole of District' (Queensland Health 1999). Examples of models of care currently in use were cited as: family centred care; integrated mental health service; shared care programs; case management; pre-admission clinics and preadmission planning processes; transitional care; designated stroke unit/services; and team nursing care.

Internationally, there appears to be little formal effort in place to define and undertake models of care planning, although changing and evolving models of care are acknowledged and recognised (Nasmith 2004; Maynard, McKee and Nolte 2004; Meyers and Burstin 2004). Similarly, the need to move away from a profession based or occupation based approach to health workforce planning is recognised and new approaches based around competencies, skill mix and whole of workforce planning approaches are being highlighted (WHO 2000, Buchanan and Dal Poz 2002; Romanow 2002; Scottish Executive 2002; Sibbald et al 2004).

Issues for consideration

Models of care or models of service

The findings of the AHWOC jurisdictional survey suggested that among jurisdictions the use of the terms 'models of care' and 'models of service' is interchangeable. Some stakeholders warned that a 'model of care' approach to workforce planning which focuses on a particular health problem could contribute further to the fragmentation of service delivery to patients with multiple health problems, such as diabetes mellitus and ischaemic heart disease or cancer and chronic obstructive pulmonary disease. To overcome problems of vertical integration, for five chronic diseases, the Northern Territory Department of Health is exploring an integrated approach to service delivery based on a three-point framework, viz., 'Primary prevention', 'Early detection' and 'Management' (Weeramanthri et al., 2003). It follows that

workforce planning within a health system based on these three broad categories of health service delivery should first identify the relevant service delivery category and, secondly, the set or sub-set of the workforce of particular interest. However, challenges may arise for workforce planners in situations in which a workforce group spans more than one of these service delivery categories. For example, general practice and community/district nurses provide all three types of services.

Best practice or quality improvement focused?

The use of the term 'best practice' is perceived by some stakeholders to be problematic. First, there may be a lack of information available to support any particular 'best practice' model of health care in some situations. Secondly, among health professionals from similar and separate disciplines there may be more than one definition of a 'best practice' model of care, hence, the problem of whose definition to accept for planning purposes or the need to engage in a timely and costly process of consensus-building. Thirdly, a defined 'best practice' model of care that works in one geographic location may not work in another (eg rural and remote regional centres versus inner-metropolitan locations). Fourthly, a 'best practice' model of care may vary across time. This becomes problematic for workforce planning purposes when you are looking at projections spanning 10-20 years. Nevertheless, there is general agreement among stakeholders that a models of care approach to workforce planning should be based on service delivery methods that meet current consumer quality and safety standards and that are quality improvement focused.

Single occupation or multi-occupation focus

Strictly speaking, a models of care approach to workforce planning is not necessarily multi-occupational. For example, some stakeholders interpreted it as being capable of applying to a defined 'model of care' for a single occupational group (eg nurses).

Level of focus and purpose

What is the level of focus of a models of care approach to workforce planning; national, state, region/district, division or unit? Is the purpose to bring about change in existing models of care or models of service delivery and if so who is best placed to drive these changes?

No one single model of care

Respecting and appreciating the diversity of care and service delivery approaches across Australia and within any care area, and as such the likelihood that most areas of care have a number of viable/optimal models of care rather than a single all encompassing model.

Workforce Planning – A Dynamic Process

Health systems and health workforces are dynamic and constantly evolving. This has two key impacts on the health workforce planning process. First, the impact of any broad health policy, service delivery and/or technology change on the workforce needs to be considered as part of the supply and requirement analysis and prediction process. These impacts can be considered in terms of anticipated changes or simulated adjustments. The second consequence of the dynamics of health systems and the health workforce is that there will be a need in any planning exercise to constantly monitor, update and refine the workforce analysis and planning advice.

In terms of dynamics, several basic trends seem likely, and all imply an innovative and constantly evolving workplace and workforce. These trends are:

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

Overall, from the workforce planning perspective any health policy, service delivery or technology change must be quantifiable in terms of an impact on demand, productivity or practice, or a combination of all three.

EXPECTED PLANNING OUTCOMES

Among key stakeholders, five outcomes were expected from use of a models of care approach to workforce planning (AHWOC 2003). These outcomes are examined below with reference to the way in which State/Territory Health Departments have applied them. Not surprisingly, there is some overlap among these expected outcomes.

Workforce plans, which are consumer-focussed

A models of care approach to workforce planning provides an opportunity for the focus to move from provider to the consumer if the approach is to first define 'preferred consumer outcomes from which the health workforce supply and mix are determined'.

This outcome may also be achieved if the approach was 'calculation of future workforce supply using an input/output analysis approach while future requirements are calculated from a range of benchmarks relating to treatments required based on population trends.' For this approach to be consumer-focused would depend on how 'treatments required' was defined. For example it would not necessarily be consumer-focussed if the benchmarks were defined by jurisdictions without consumer involvement in the benchmark determination process.

Workforce plans that are aligned with service delivery plans

Workforce plans that are based on first defining a preferred model(s) of care have the potential to be more closely aligned with service delivery plans. For this to happen, workforce planners would need to work with service providers to explore developments in service delivery and the definition of preferred models of care for the future.

Here it is essential to gain a shared understanding of what is meant by a 'model of care'. Some service providers define a model of care according to the staff mix required to deliver services of acceptable quality. Hence, the focus is on the 'care group' rather than the 'consumer'. For example, in some sectors, it is anticipated that the present model of care (as defined by mix of staff) is unsustainable and a new model of care is emerging. These new models of care are being driven by increasing consumer demand without a corresponding increase in resources, present and anticipated shortages of professional staff, and search for more cost-effective models of care; ones which involve transferring some of the tasks performed by qualified professionals to non-professionals or the realigning of tasks amongst health professionals. Importantly, this approach requires examining the educational and training implications of such a transfer of tasks and skills.

Planning recommendations for a multi-disciplinary and/or multi-occupational segment of the workforce

One State/Territory jurisdiction perceived that a models of care approach 'works primarily with multi-disciplinary teams using a clinical management approach.' Others maintained that this approach to workforce planning enables 'consideration of multiple occupations simultaneously' and 'taking account of the possible or likely impact of change in one occupational group on other related groups'.

If multi-disciplinary planning is the primary reason for using a models of care approach to health workforce planning, then the 'model of care' is likely to be defined by mix of staff rather than by preferred patient outcomes. If this is the case then this may not be a models of care approach but just a profession orientated approach applied across multiple professions. However, this is not necessarily so. Definition of staff mix could be preceded by definition of a model of care based on achieving preferred consumer outcomes. This approach is inferred from the statement that it 'works primarily with multi-disciplinary teams using a clinical management approach'; and this is an important definitional and process distinction. This clinical management approach is most likely to refer to a particular group of consumers (eg people requiring oncology services, people with mental illness). The important expectation here is the development of workforce plans that are more holistic (ie multi-disciplinary or multi-occupational) than would be the case if the focus was uni-disciplinary or uni-occupational.

Realistic and sustainable ways to address multiple workforce shortages simultaneously

As inferred above under 'Workforce plans that are aligned with service delivery plans', a models of care approach to health workforce planning is perceived as having the capacity to address present and anticipated future multi-disciplinary or cross-profession or cross-occupation issues or multiple shortages simultaneously. Achievement of this expectation requires close cooperation between service providers and workforce planners in defining model/s of care based on achieving preferred patient outcomes and a realistic and sustainable staff mix. Outcome strategies arising from such a planning exercise would be expected to be innovative, both supply-side and demand-side.

Control of workforce costs and /or improve workforce productivity

If the focus of a models of care approach to health workforce planning is to control workforce costs, then planners and service providers would need to work together to define preferred model/s of care and the most productive and cost-effective mix of staff to achieve that model of care.

Summary

Most stakeholders agree that a models of care approach to health workforce planning:

- Is concerned with providing services of acceptable or optimal quality to the population of people requiring those services;
- Is multi-disciplinary/occupational, encompassing the full range of care givers associated with the provision of services to the respective population;
- Begins with a description of present models of care associated with the provision of services to the respective population and the present mix of staff required to provide these services;
- Asks 'Where are we now?' and 'Where do we want to go?' This should include an assessment of service delivery targets, how these changes may impact on present models of care and the mix of staff;

- Using future population need estimates and service plans, models workforce supply scenarios for each of the respective disciplines/occupations based on the present way of doing business (eg staff mix) and then examines whether the present approach to providing and staffing services is sustainable;
- Depending on the outcome of the projection modelling, explores strategies for ensuring a sustainable workforce supply into the future. This may include an extensive analysis of the functions and skills required to provide desired model(s) of care and the best people to provide those services in a cost-effective manner. This is likely to be an iterative 'change management' process with the characteristics of the preferred model of care and workforce mix influenced as more information becomes available;
- Links health workforce planning strategies for the future with education and training providers, but explores other strategic options also;
- As far as possible, employs a quality improvement approach to workforce planning and change management; and
- Is inclusive, ie includes stakeholders in the health workforce planning process.

IS THE GENERIC WORKFORCE PLANNING MODEL USED BY THE NATIONAL HEALTH WORKFORCE SECRETARIAT APPROPRIATE FOR USE IN A 'MODELS OF CARE' APPROACH TO WORKFORCE PLANNING AND IF SO WHAT ADAPTATIONS WOULD BE REQUIRED?

National Health Workforce approach to workforce planning

Since the establishment of AMWAC in 1995, AHWAC in 2001 and the National Health Workforce Secretariat in 2003, the national approach to workforce planning has involved describing, evaluating and predicting workforce supply and population requirements for the services provided by a group of service providers based on a range of potential scenarios (ie population requirement scenarios and workforce supply scenarios). It has also involved the development of strategies to alleviate current and anticipated imbalances between supply and requirements. The AHWAC and AMWAC have maintained that to be effective, the workforce planning process requires the participation and commitment of stakeholders, an agreed process, timely access to reliable and relevant data, appropriate methodologies and calculation tools, and an appropriately resourced organisational structure to oversee and conduct the planning.

To date AHWAC and AMWAC planning projects have been single profession or occupation focused. This focus has largely been driven by the need for action to address existing and anticipated profession-based workforce shortages in medicine and nursing and provide advice on training and education intakes. Furthermore, in 1995 when AMWAC was established, few data were available to support even a single-profession-based approach to workforce planning, let-alone a multi-occupational approach. Fortunately, since this time awareness has grown among stakeholders as to the importance of developing good workforce data collection and reporting systems. However, there is still a long way to go before there is a comprehensive national database for all health occupations. Indeed, it is still the case that the best available data on health professions remains those that have a requirement for registration.

The main characteristics of the AHWAC and AMWAC approach to workforce planning can be summarised as:

1. Stakeholder participation (eg representatives of government/s, inter-sectoral organisations, service providers, profession, education and training providers, consumers).
2. A workforce or complex workforce issue of high priority to AHMAC.
3. Project oversight by key workforce stakeholders (ie AHWOC, AHWAC, AMWAC) important to the implementation of recommendations arising from the review.
4. Projects informed by a panel of experts with the ability to advise on data requirements, collection, analysis and interpretation and approaches to addressing identified workforce deficits.
5. A systematic methodology for describing a respective workforce, for evaluating its adequacy in meeting present population requirements, for predicting future requirements and for modelling various workforce supply and requirement scenarios to inform the development of strategies to address present and future workforce deficits/requirements.

6. Publication and distribution of reports endorsed by AHMAC and other key stakeholders.
7. Ongoing monitoring and reporting to AHWOC and AHMAC on the implementation of recommended workforce planning strategies.
8. Reviewing and updating workforce plans on a regular basis or as the need arises (eg due to changes in technology or service delivery).

Of importance to this discussion paper, is the basic methodology (item 5 above) used by AHWAC and AMWAC and its suitability for use in a models of care approach to workforce planning. This methodology is described in detail in the AMWAC 2003 report 'Specialist Medical Workforce Planning in Australia' and in the AHWAC 2004 report 'Nurse Workforce Planning in Australia: A Guide to the Process and Methods'.

Some concerns about the AHWAC and AMWAC approach to workforce planning

Jurisdictional planners have raised some concerns as to the appropriateness of the present AHWAC and AMWAC methodology when using a models of care approach to workforce planning. The common themes amongst voiced concerns have been that it was first developed for use with the medical workforce, its recommendations have focused mainly on supply-side strategies (eg increases in the number of training positions to address present and pending shortages) and its focus has been uni-disciplinary.

Developed for the medical workforce

Whilst this is true, in the Australian context this is a reflection of history given that the examination of medical workforce issues was the first area of the health workforce which AHMAC sought advice and planning on. It is thus understandable that the process and methods developed were applied first to the medical workforce.

Indeed, the general workforce planning approach used with the medical workforce involves the common approaches of supply, gap, requirement and projection analysis – all of which can be applied to any workforce.

Equally true, however, is the reality that each health profession is different and clearly this involves differing considerations as part of the workforce planning process. For example at the national level the process and methods developed for the nursing, general practice and specialist medical workforces have all been subtly different.

Uni-disciplinary focus

To date the majority of the national health workforce reviews commissioned by AHMAC and undertaken by AHWAC (nursing and allied health) and AMWAC (medical) have been uni-disciplinary or at most involved review of two closely related medical disciplines. Among stakeholders there is a perceived need for the focus of workforce planning to be broader than uni-disciplinary and even broader than multi-disciplinary. In other words to encompass the broad range of professionally qualified and non-professionally qualified people involved in the provision of a particular model of care. Some perceived a need for a multi-dimensional approach that begins by examining the functions that need to be performed and the workers that are best able and available to perform those functions. This approach is similar to that

being explored in the United Kingdom where there is an emphasis on defining and developing competencies and multi-skilling (eg definition of the 'health practitioner' role).

Emphasis on supply-side strategies

Some have criticised the AHWAC and AMWAC methodology because many of its reviews of medical and nursing workforces have recommended increases to vocational training programs and university intakes as a means of addressing present and/or pending future shortages. While this emphasis was consistent with the interpretation of the committees' terms of reference, such criticisms suggest that among jurisdictional planners and researchers there is a perceived need for a broader approach to addressing health workforce shortages. However, to what extent workforce planners can and should be expected to recommend requirement-side strategies (ie ways to reduce or change consumer demand and expectations) is questionable. In addition, to date no health workforce planning exercise in Australia has recommended that government deliberately and overtly act in certain ways to control, reduce, constrain or ration consumer demand for health services.

On the other hand, a models of care approach to workforce planning may provide opportunity to explore more innovative, multi-disciplinary and multi-occupational supply-side strategies, and this has certainly been missing from national level workforce planning advice.

Questions raised

Questions raised by the above concerns include 'Is it sensible to consider using a models of care approach to workforce planning at the national level?' If so, 'How will the AHWAC and AMWAC methodology accommodate important discipline based differences when applied to a models of care approach to workforce planning?' and 'Do we need a range of workforce planning methodologies that can be drawn on for particular situations?' These concerns are dealt with in the following section of this paper.

A POTENTIAL MODELS OF CARE APPROACH TO WORKFORCE PLANNING

This section outlines a potential models of care approach to workforce planning that is designed to be sufficiently flexible to cater for important discipline based differences as well as differences in stakeholder outcome expectations.

A models of care approach to health workforce planning would appear to have three major phases and a number of essential processes. Phase 1 involves 'Planning to plan', while Phase 2 involves describing and evaluating the sustainability of present models of care and associated workforce supply and mix arrangements. Depending on the outcome of Phase 2, Phase 3 is about bringing about change in prevailing models of care and associated workforce supply and mix arrangements in situations where this is deemed necessary. This section of the paper details each phase and outlines the likely steps involved in each phase.

PHASE 1: PLANNING TO PLAN

Define a models of care approach to workforce planning

This paper has outlined several definitions of a models of care approach to health workforce planning with each definition containing different operational implications for workforce planners. It is possible that different workforce studies will favour use of a different definition depending on the purpose of the planning exercise and the extent to which a consensus exists among key stakeholders as to what constitutes optimal or best practice service delivery. For these reasons two definitions are outlined here so that planners can select or modify the most appropriate definition for the respective planning exercise:

1. Models of care workforce planning involves taking a particular care group (eg mental health, diabetes, asthma, cardiovascular disease) and identifying existing model/s of care and developing plans designed to meet the needs (not demands) of a particular population; the skills and capabilities of the multidisciplinary workforce required to provide these services is determined, and the required workforce supply is then estimated. It is envisaged that this process will as far as possible be consumer-centred, closely aligned with service delivery planning, and facilitate exploration of optimal methods of service delivery ('models of care').
2. Models of care workforce planning involves taking a particular care group and identifying a best practice model of care designed to meet the needs (not demands) of a particular population; the skills and capabilities required to provide that service is determined, and the required workforce supply is then determined. It is envisaged that this process will as far as possible be consumer-centred and closely aligned with service delivery planning.

Select multi-disciplinary/occupational workforce

1. Selection of health issue and multi-disciplinary/occupational workforce care group

A particular health issue or workforce care group needs to be identified as a high priority area for workforce planning (eg. mental health services, emergency services, oncology services) and the multi-disciplinary/occupational group of care-givers needs to be defined.

Plan the project

2. Establish reference group/working party

Establish a reference group or working party of people with relevant expertise to advise the workforce planners undertaking the project and identify others with whom it may be useful to consult.

3. Define purpose and expected outcomes

Define the purpose and expected outcomes of using a models of care approach to workforce planning. The outcomes of this activity will largely determine the scope and focus of the planning project.

As previously indicated, among key decision-makers the expected outcomes of using a models of care approach to workforce planning may vary. Therefore, it is essential that the expected outcomes of the project be clearly defined at the outset because the questions to be addressed by workforce planners will vary accordingly. It could be that key stakeholders might expect workforce planners to achieve all the following outcomes and the feasibility of such a large undertaking may need to be examined.

To produce workforce plans that are consumer-focussed

- What are the present clinical models of care to achieve the defined preferred consumer outcomes?
- What is presently considered to be the appropriate workforce supply and mix required to deliver these models of care?
- How do present clinical models of care and workforce supply and mix vary by location?
- With a view to the future (ie 5-10 years), what changes in service delivery are expected and desirable that will influence current clinical models of care and the workforce supply and mix?
- Is there consensus among key stakeholders as to what an optimal clinical model(s) of care and workforce supply and mix should be in the future (ie 5-10 years)?
- If there is a consensus among key stakeholders as to an optimal model(s) of care for the future, how will this model(s) of care and associated workforce supply and mix vary by location to ensure equity of access for consumers?'

To produce workforce plans that are aligned with service delivery plans

- What are the present models of care as defined by service providers? It could be that service providers define models of care according to staff mix rather than

consumer preferred outcomes. If this is the case planners will need to decide the criteria by which they will require service providers to define existing models of care.

- What changes in service delivery are desirable and expected in the next 5-10 years?
- With these changes in mind, is there consensus among service providers as to a preferred clinical model(s) of care and workforce supply and mix for the future (ie 5-10 years)?
- How will this preferred future clinical model(s) of care and workforce supply and mix vary by location to ensure equity of access for consumers?'

To produce workforce plans for a multi-disciplinary and/or multi-occupational segment of the workforce

- What is the present multi-disciplinary (possibly multi-occupational) workforce supply and mix required to provide defined existing models of clinical care?
- What changes are expected and desirable in the next 5-10 years in the workforce supply and mix required to provide the preferred model(s) of clinical care?
- How will this preferred workforce supply and mix and clinical model(s) of care vary by location to ensure equity of access for consumers?

To produce realistic and sustainable ways to address multiple workforce shortages simultaneously

- What is the present multi-disciplinary/multi-occupational workforce supply and mix required to provide defined existing models of clinical care?
- Based on this definition of workforce supply and mix, what workforce shortages presently exist and are expected to continue or worsen in the future?'
- Is there consensus among consumers and service providers as to an optimal clinical model(s) of care for the future (ie 5-10 years)?
- Is there a more realistic and sustainable way of organising staff to provide the defined optimal model(s) of clinical care?
- How will this preferred workforce supply and mix and clinical model(s) of care vary by location to ensure equity of access for consumers?

To control escalating workforce costs

- With respect to the selected health problem or issue, what is the most cost-effective way that services to consumers could be provided?
- What is the present multi-disciplinary/multi-occupational workforce supply and mix required to provide the defined existing model(s) of clinical care?
- What changes in multi-disciplinary/multi-occupational workforce supply and mix are required to control the costs associated with existing and future preferred model(s) of clinical care.

PHASE 2: ASSESSMENT OF PRESENT MODELS OF CARE

Descriptive analysis

1. Describe present model(s) of care/service delivery and determine whether an 'optimal model of care' that is acceptable to all key stakeholders exists

It could be that among key stakeholders there is no agreement as to what constitutes an 'optimal clinical model(s) of care'. This raises the question as to whether the workforce planning project should be delayed until a consensus is reached about this issue or whether to progress the project by undertaking workforce supply and requirements modelling based on existing models of care, including staff mix (or 'ways of doing business')? In either case, this modelling should seek to address the question, 'Is the present way of doing business sustainable?'

Queensland Health (2000) suggests the use of the following elements to describe a model of care. The purpose of collecting this information is not only to provide a good picture of the present model of service delivery but also to gain insight into the quality and cost of the services being delivered and any problems associated with the model:

- Values and principles;
- Current structure and roles (ie Who does what and how do they relate to each other?);
- Care delivery processes;
- Referral patterns (policies and processes, consumer flows, flexibility);
- Patient outcomes;
- Outside comments and perceptions (eg community perceptions; other stakeholder perceptions);
- Staffing profile (eg staff and skill mix);
- Communication structures; and
- Cost of service delivery.

2. Describe population requiring services

This description will vary depending on the scope of the project (eg national, state, regional). Population characteristics might include:

- Number;
- Demographics;
- Socioeconomic profile;
- Health needs profile using accepted epidemiological and planning measures, by geographic location (this may require mapping);
- Service utilisation; and
- Service availability by geographic location (this may require mapping).

3. Consult with service providers and consumers

Consult with service providers and consumers in order to describe 'Where are we now? And 'Where do we want to go'. Issues to be described include:

'Where are we now?'

- present models of care associated with the provision of services to the respective population;
- the present mix of staff required to provide these services; and
- present service delivery targets;

'Where do we want to go?'

- proposed changes in service delivery models;
- proposed changes in mix of staff; and
- future service delivery targets.

4. Describe present multi-disciplinary/occupational workforce

For each care group associated with the model(s) of care, as far as possible describe:

Present workforce

- Number and characteristics (age, sex, qualifications, visa status, possibly ethnic background);
- Workforce participation (full-time/part-time; hours worked, on average, per week);
- Geographic distribution (State/Territory; urban/rural);
- Health care service distribution (ie type of service); and
- Type of work performed (functions) and competencies required.

Workforce additions

- Sources of recruitment (eg training institutions, re-entry, migration), including years of training required etc;
- Number and characteristics of potential new recruits (age, sex, qualifications, visa status, possibly ethnic background, possibly career expectations); and
- Recruitment trends and policies likely to influence sources of recruitment.

Workforce attrition

- Retirements, including expected age of retirement;
- Drop-out from the workforce, trends and reasons for drop-out;
- Deaths; and
- Migration.

Evaluative analysis

1. Evaluate the adequacy of the present models of care

Using appropriate indicators assess the adequacy of the present models of care. Assessment of the adequacy of existing models of care could be informed by several indicators, such as:

- Consumer outcomes;
- Community perceptions (consumers and carers);
- Key stakeholder perceptions (eg general practitioner and other service providers); and
- Cost-effectiveness analysis.

2. Evaluate the adequacy of the multi-disciplinary/occupational workforce associated with the present model of care

Assessment of workforce adequacy might draw on a variety of requirement-side and supply-side indicators depending on the availability of data. For example:

Requirement-side

- Population need indicators by geographic location (eg unfilled positions or funded vacancies; consumer access; practitioner/population ratio; consumer and carer assessments; consumer waiting times; quality of care indicators, such as, adverse events).

Supply-side

- Excessive hours of work;
- Workforce attrition;
- Views of the respective workforce as to the adequacy of supply; and
- Views of providing agencies as to the adequacy of present supply.

Predictive and evaluative analysis

In the absence of any consensus among key stakeholders as to an 'optimal model(s) of care:

1. Estimate future workforce requirements based on the present way of 'doing business'

Estimate future workforce requirement scenarios using appropriate indicators of need for the target population and growth estimates based on jurisdictional service delivery targets.

2. Model workforce supply and requirement scenarios based on the present way of doing business and future workforce requirement estimates

Model workforce supply and requirement scenarios for the next 10-15 years for each of the respective care groups based on the present way of doing business (eg models of care and workforce supply and use) and estimated 'need' growth rates and taking into account any existing shortages/excesses in supply.

3. Evaluate any disparity (eg gap) between projected supply and demand and the sustainability of the present way of doing business

Using projection modelling and previously defined supply and requirements estimates, examine any future disparity between supply and demand based on the present models of care (ie approach to providing and staffing services) and evaluate the sustainability of this approach over the next 10-15 years.

It is interesting to note that Queensland Health has found a growing gap between future population need for services provided by one multi-disciplinary care-group and projected future workforce supply. As a result it has been decided to explore alternative ways of staffing services using a patient-centred, quality improvement approach and change management approach. The outcome of these strategies is likely to result in a redefinition of models of care and workforce-supply requirements.

Recommend strategies

1. Recommend strategies for ensuring a sustainable workforce supply into the future

Depending on the outcome of the projection modelling and assessment of sustainability, recommend strategies for ensuring a sustainable workforce supply into the future. If done nationally, these recommendations should be developed in consultation with State/Territory Health Departments. These recommendations may include increases/decreases in enrolments in relevant education and training programs, increases in the number of re-entry programs, workforce retention strategies, and changes in review of the present approach to delivering services (ie models of care and workforce mix etc) with a view to changing to a more cost-effective and sustainable approach.

Strategies to bring about change in existing models of care extend well beyond the present boundaries of national level workforce planners into the realm of jurisdictional organisational change. Hence, it is likely that they would involve jurisdictional workforce planners working with service providers and clinicians in a grass-roots analysis of present models of care and approaches to workforce recruitment, retention and deployment.

2. Monitor progress toward achievement of recommended strategies

3. Review models of care and workforce situation

PHASE 3: CHANGING MODELS OF CARE

As indicated above, Phase 3 of a models of care approach to health workforce planning could be about facilitating change in prevailing models of care that are unsustainable. Such a proposal implies the implementation of organisational change; an activity that requires careful and skilful management at the local level.

Importantly, strategies to bring about change in models of care should be undertaken in a manner that does not compromise the quality and safety of the services provided to patients. Ideally, these changes would be based on achieving certain specified criteria and evaluated accordingly. For example, such criteria might include improvements in the quality and safety of services provided to consumers. The outcomes of strategies to bring about change in models of care at jurisdictional level could then be used to inform national level health workforce planning.

USING A 'MODELS OF CARE' APPROACH TO WORKFORCE PLANNING, WHAT COMPONENTS ARE BEST ADDRESSED AT 1) THE NATIONAL LEVEL AND 2) THE JURISDICTIONAL LEVEL?

The issue of level of focus and the role of a national health workforce planning body vis-à-vis State/Territory health authorities requires careful consideration because a models of care approach to workforce planning implies a blurring of traditional boundaries. This discussion paper seeks to progress the definition of the elements of a models of care approach to workforce planning that all jurisdictions and other key stakeholders might agree to and in so doing, it begins to inform functions that can be usefully undertaken at national and State/Territory level.

As indicated previously, AHWOC has developed a vision and broad set of principles to guide approaches to workforce planning throughout Australia, including a models of care approach (AHMC 2004).

This paper has proposed a three-phase approach to models of care health workforce planning. Phase 1 involves planning to plan, Phase 2 involves describing existing models of care pertaining to a selected high priority health problem and evaluating the sustainability of persisting to do business in this way into the future. If this analysis finds that the present model/s of care are not sustainable then it proposes the implementation of Phase 3. The purpose of Phase 3 is the definition and implementation of more sustainable models of care.

It is obvious that States and Territories need to be involved in all Phases of this approach to health workforce planning. However, if national perspectives are required then Phases 1 and 2 would best be undertaken nationally, while Phase 3 activities would best be undertaken at a State/Territory level. Phase 3 is best undertaken at the State/Territory level because it is about evolving models of care. Hence, it represents an organisational change process that is best managed at the local level.

IN WHAT SITUATIONS MIGHT A 'MODELS OF CARE' APPROACH TO BE PREFERRED OVER A PROFESSION-BASED OR OCCUPATION-BASED APPROACH TO WORKFORCE PLANNING?

There are a number of basic, but essential, requirements for successful health workforce planning, which can be summarised as:

- an appropriately resourced organisational structure to oversee the planning;
- stakeholder participation and commitment;
- clear principles, objectives, methodologies, models and processes, including having in place accepted and transparent methodologies and calculation tools for describing, evaluating and predicting workforce supply and requirements; and
- access to accurate, reliable, relevant and timely data (quantitative and qualitative, supply, and requirements).

Profession or occupation-based planning

State/Territory Health Departments have identified the strengths of the profession-based approach to workforce planning as:

- provision of a thorough and detailed analysis of a given profession;
- consideration of the selected profession as a whole;
- ability to forecast longer-term projections more accurately; and
- the ability to forecast education and vocational training intake targets and the fact that this clearly challenges organisations in the education and training sectors to be responsive to health sector needs.

This may be preferred approach when:

- Current and/or projected shortages in an essential occupational group;
- Unsustainable cost-escalation associated with a particular occupational group.

Models of care workforce planning

The AMWAC Review (2002) raised the following potential concerns about the use of a models of care approach to workforce planning:

- introducing more complexity into an already complex area;
- planning for a model of care which may or may not be able to be implemented;
- difficulty in achieving consensus on any given model of care given variation in consumer needs, clinical perceptions and judgements and Australia's federal system of government;
- geographic and population differences making one model of care unlikely (so there may need to be several); and
- consumer acceptance of a model based on assessed need, as compared with meeting consumer demand.

Strengths of a models of care approach to workforce planning have been identified as:

- it can consider multiple occupations simultaneously;
- it promotes a multidisciplinary approach;

- it has the potential to be more resource and time efficient than profession-based approaches; and
- it is more closely linked to service delivery than profession-based approaches.

May be preferred approach when:

- a multi-disciplinary/occupational approach to service delivery is preferred due to nature of patient problem;
- models of service delivery have changed or are desired toward a more multi-disciplinary/occupational approach;
- opportunity to improve patient outcomes through close analysis of all the occupations involved in providing a particular model of care/service; and
- there is potential for achieving workforce cost-savings or improving workforce productivity from using this approach (ie to achieve change in approaches to service delivery in known areas of inefficiency).

SOME CONCLUSIONS

This discussion paper has explored a 'models of care' approach to health workforce planning with a view to promoting a shared understanding among key stakeholders. The paper is designed to encourage thinking and discussion about models of care health workforce planning. The paper does not seek to provide definitive answers to the 'why', 'what' and 'how' of a 'models of care' approach to workforce planning. It is anticipated that answers to these questions will evolve over time as planners and stakeholders work with this planning approach and reflect and learn from their experiences.

It appears that little has been published, either nationally or internationally, that specifically addresses a 'models of care' approach to workforce planning. On the other hand, publications that address the need to change existing models of care to improve patient care (eg achieve improved integration of service delivery) are more prevalent. Also more prevalent are publications that address redefining who does what in health care based on identification of competencies required to perform defined functions.

The need to explore new approaches to health workforce planning is being driven by demographic shifts and broad health system changes, including, a predominance of illness associated with an ageing population, increasing consumer demand for services and increasing costs. Further drivers for change include workforce shortages and a predicted shrinkage in the available pool of potential new workers. Faced with these pressures, service agencies are seeking new ways of responding to consumer demand. For example, placing greater emphasis on community based care and on self-directed care combined with strategies to increase the quality and safety of client care and the productivity and cost-effectiveness of service delivery methods.

As a result of these pressures, Australian workforce planners are being challenged to work with health care service providers to facilitate new, more consumer-focused and cost-effective ways of using the health workforce. Multi-health-professional and multi-functional approaches to health workforce planning are being considered and several States have undertaken pilot projects using this approach which has been termed 'models of care' health workforce planning. However, to date no national workable 'models of care' approach has been developed.

Among key stakeholders, opinions vary as to what constitutes a 'models of care' approach to health workforce planning. Some perceive it to represent an 'optimisation forecasting model', which first requires definition of a 'best practice' model of care before any projection modelling can be attempted. However, among some multidisciplinary workforces little consensus may exist as to what constitutes an optimal model of care. Indeed it is quite possible that there may be a number of viable/optimal models of care across any care group or disease entity.

The paper has proposed that in the absence of a defined optimal model of care that the models of care approach to workforce planning involves:

- selecting a particular care group (eg people with mental health problems, people with diabetes);
- identifying and describing the most common prevailing model/s of care and exploring commonalities and differences within and across jurisdictions and geographic locations;
- defining the multidisciplinary workforce currently associated with these prevailing model/s of care, including the disciplines/occupations represented, what they do, and the skills and capabilities required;
- estimating the expected growth in demand for the planning period using appropriate indicators (eg population growth estimates relevant to the selected care group, health provider service delivery plans for the next 5-10 years, expected changes in models of service delivery);
- calculating future workforce requirements based on prevailing model/s of care and estimated growth in demand;
- projecting future workforce supply drawing on appropriate education and training preparation, recruitment, retention and attrition sources of data;
- analysing any mismatch in projected workforce requirements and supply estimates (ie 'gap' analysis); and
- recommending strategies to achieve a balance in workforce requirements and supply within the planning period.

It is important to note that models of care health workforce planning does not have as its focus health workforce planners dictating new ways of health professionals or service providers providing care, whilst recognising that in a dynamic environment ways of providing health care will evolve. The processes and methods proposed in the information paper are interactive and based around the notion that health service planners and health workforce planners should be working more collaboratively.

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ABBREVIATIONS

ABS	Australian Bureau of Statistics
ACT	Australian Capital Territory
ANC	Australian Nursing Council
AHMAC	Australian Health Ministers' Advisory Committee
AHWOC	Australian Health Workforce Officials' Committee
AHWAC	Australian Health Workforce Advisory Committee
AIHW	Australian Institute of Health and Welfare
AMWAC	Australian Medical Workforce Advisory Committee
DoHA	Department of Health and Ageing
NHS	National Health Service
NSW	New South Wales
NT	Northern Territory
Qld	Queensland
RRMA	Rural, Remote, Metropolitan Areas
SA	South Australia
Tas	Tasmania
UK	United Kingdom
WA	Western Australia

AUSTRALIAN HEALTH WORKFORCE ADVISORY COMMITTEE - TERMS OF REFERENCE

The Australian Health Ministers' Advisory Council (AHMAC) established AHWAC to assist with the development of a more strategic focus to national nurse, midwifery and allied health workforce planning in Australia and advise on national health workforce matters, including workforce supply, distribution and future requirements.

AHWAC reports to AHMAC, and through AHMAC to the Australian Health Ministers' Conference. AHWAC is one of three AHMAC workforce committees, the other two being the:

- Australian Health Workforce Officials' Committee; and
- Australian Medical Workforce Advisory Committee.

The Australian Health Workforce Officials' Committee (AHWOC) provides a forum for reaching agreement on key national level health workforce issues requiring government collaborative action and provides advice on health workforce issues to the Australian Health Ministers' Advisory Council (AHMAC). AHWOC also has a central role to play in co-ordinating the implementation of the recommendations arising from the workforce planning analysis undertaken by AHWAC and AMWAC. AHWOC comprises a nominee from the Commonwealth/State/Territory health departments and the Commonwealth Department of Education, Science and Training.

AHWAC provides advice to the AHMAC on a range of nurse, midwifery and allied health workforce matters, including:

- workforce supply and demand in Australia;
- the composition, balance and distribution of the health workforce in Australia; and
- the establishment and development of data collections concerned with the health workforce.

The Australian Medical Workforce Advisory Committee fulfils a similar role to AHWAC but with a focus on the medical workforce.

AUSTRALIAN MEDICAL WORKFORCE ADVISORY COMMITTEE - TERMS OF REFERENCE

The Australian Health Ministers' Advisory Council (AHMAC) established the Australian Medical Workforce Advisory Committee (AMWAC) to advise on national medical workforce matters, including workforce supply, distribution, and future requirements.

AMWAC reports to the AHMAC, and through AHMAC to the Australian Health Ministers' Conference. AMWAC is one of three AHMAC workforce committees, the other two being the:

- Australian Health Workforce Officials' Committee; and
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The Australian Health Workforce Officials' Committee (AHWOC) provides a forum for reaching agreement on key national level health workforce issues requiring government collaborative action and provides advice on health workforce issues to the Australian Health Ministers' Advisory Council (AHMAC). AHWOC also has a central role to play in co-ordinating the implementation of the recommendations arising from the workforce planning analysis undertaken by AHWOC and AMWAC. AHWOC comprises a nominee from the Australian/State/Territory health departments and the Australian Department of Education, Science and Training. The Australian Health Workforce Advisory Committee fulfils a similar role to AMWAC but with a focus on the nursing, midwifery and allied health workforces.

AMWAC oversees a medical workforce research program which is approved by AHMAC. This specific medical program is complementary to, and linked with, the broader health workforce research agenda overseen for AHMAC by AHWOC.

The terms of reference AMWAC operates under are:

1. To provide advice to the Australian Health Ministers' Advisory Council on a range of medical workforce matters, including:
 - the structure, balance and geographic distribution of the medical workforce in Australia;
 - medical workforce supply and demand; and
 - the number and distribution of education and training places needed to meet future demand as suggested by patterns of supply, population health status, practice developments and changing models of health care.
2. To develop models for describing and predicting future medical workforce requirements, and provide advice on its methodology, including indicators and benchmarks, for use by employing and workforce controlling bodies including governments, specialist medical colleges and tertiary institutions at:
 - national level;
 - state and territory levels; and
 - intra-state and territory.
3. To oversee the establishment and development of data collections concerned with the medical workforce, and analyse and report on those data to assist workforce planning.

4. To work in co-ordination and co-operation with the Australian Health Workforce Officials' Committee (AHWOC) in the assessment of the relationship between medical workforce requirements and new or alternative workforce structures, profiles and broader health human resources planning requirements.
5. To provide AHMAC with advice as requested on:
 - best practice models of care;
 - future service delivery and workforce developments; and
 - dynamic scenario planning for the medical workforce.
6. To take into account in its planning, and provide advice in its reports, on information on evidence based practice and outcomes.
7. To advise AHMAC on strengths and weaknesses of possible approaches to achieving desirable workforce supply in accordance with quality health care practices.

AUSTRALIAN HEALTH WORKFORCE OFFICIALS' COMMITTEE – MEMBERSHIP

Chair

Mr John Ramsay Secretary, Department of Health and Human Services, Tasmania

Nominee of Australian Department of Health and Ageing

Mr Brett Lennon Assistant Secretary, Health Services Improvement Division

Nominee of Australian Capital Territory Department of Health, Housing and Community Care

Ms Megan Cahill Executive Director, Policy and Planning

Nominee of New South Wales Health Department

Ms Deborah Hyland Director, Workforce Development and Leadership Branch

Nominee of Northern Territory Department of Health and Community Services

Mr Mark Hathaway Director, Strategic Workforce Services

Nominee of Queensland Health

Mr Peter McKay Manager, Organisational Development

Nominee of Department of Human Services, South Australia

Mr Rod Bishop Executive Director, Corporate Resources

Nominee of Department of Human Services, Victoria

Mr Peter Allen Under Secretary

Mr Peter Carver Director, Service and Workforce Planning

Nominee of Department of Health, Western Australia

Mr Rob Lindsay Director, Workforce Directorate

Nominee of Australian Department of Education, Science and Training

Ms Maria Fernandez Manager, Higher Education Funding Branch

Observers

Dr Jeannette Young Chair, Australian Medical Workforce Advisory Committee

Ms Helen Townley Executive Officer, Australian Health Workforce Officials' Committee

Ms Justine Curnow A/g Executive Officer, National Health Workforce Secretariat

AUSTRALIAN HEALTH WORKFORCE ADVISORY COMMITTEE - MEMBERSHIP

Chair

Mr John Ramsay Secretary, Department of Health and Human Services, Tasmania

Nominee of the Australian Department of Health and Ageing

Ms Mary Murnane Deputy Secretary

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Ms Sue Norrie Principal Nursing Adviser, Queensland Health

Nominee of Australian Institute of Health and Welfare

Dr Ken Tallis Head, Resources Division

Nominee of the Australian Medical Workforce Advisory Committee

Dr Jeannette Young Chair

Nominees of the Australian Vice Chancellors' Committee

Prof. Ken Bowman Dean, Faculty of Health Science, Queensland University of
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Prof. Pauline Nugent Dean of School of Nursing, Deakin University, Melbourne

Nominee of Community Services and Health Industry Skills Council

Mr Tony Farley Chair

Nominee of the Australian Department of Education, Science and Training

Ms Maria Fernandez Manager, Higher Education Funding Branch

Member with consumer expertise

Ms Dell Horey Health Issues Centre

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Ms Glenice Taylor Head, Labour Force Unit,
Australian Institute of Health and Welfare

Ms Helen Townley Executive Officer,
Australian Health Workforce Officials' Committee

AUSTRALIAN MEDICAL WORKFORCE ADVISORY COMMITTEE - MEMBERSHIP

Chair

Dr Jeannette Young Executive Director, Medical Services, Princess Alexandra Hospital, Brisbane

Chair of the Australian Health Workforce Officials' Committee

Mr John Ramsay Secretary, Tasmanian Department of Health and Human Services

Nominees of the Australian Health Ministers' Advisory Council

Mr Brett Lennon Assistant Secretary, Health Services Improvement Division, Department of Health and Ageing

Nominee of the Australian Indigenous Doctors' Association

Mr Alan Eldridge Chief Executive Officer

Nominee of Australian Institute of Health and Welfare

Dr Richard Madden Director, Australian Institute of Health and Welfare

Nominee of the Australian Medical Association

Dr Robyn Mason Secretary General, Australian Medical Association

Nominee of the Australian Medical Council

Dr Jo Flynn President, Medical Practitioners' Board of Victoria

Nominee of the Australian Vice Chancellors' Committee

Professor Paul Gatenby Dean, Medical School, Australian National University

Nominee of the Committee of Presidents of Medical Colleges

Dr Robin Mortimer Director, Endocrinology, Royal Brisbane and Women's Hospital

Nominee of the Royal Australian College of General Practitioners

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Ms Maria Fernandez Manager, Higher Education Funding Branch, Department of Education, Science and Training

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Ms Helen Townley Executive Officer,
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NATIONAL HEALTH WORKFORCE STRATEGIC FRAMEWORK

Australia's first National Health Workforce Strategic Framework was released by Australian Health Ministers in April 2004 (Australian Health Ministers' Conference 2004). The Framework is designed to guide national health workforce policy and planning and Australia's investment in its health workforce throughout the decade. It is a forward looking positive document that focuses on delivering a vision for the Australian health workforce, meeting challenges proactively and ensuring that actions are sustainable and linked to an overall direction. The Framework recognises that a collaborative, multidisciplinary approach is needed to effectively tackle health workforce issues.

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

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

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

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

The set of goals which underlie the vision for the Australian health workforce of the first part of the 21st century are to ensure Australia has available a health workforce that is:

- population and health consumer focussed, ie. able to deliver safe, appropriate, quality care that maximises health outcomes, improves the health and well being of the Australian community and accommodates community expectations, all within a population health framework;
- sustainable: in terms of service and financial sustainability, and ensuring there is adequate workforce supply, both now and into the future;

- distributed to achieve equitable health outcomes: to ensure equitable access to health care regardless of location;
- suitably trained and competent: ie. appropriately educated with continuing maintenance and improvement of professional competence;
- flexible and integrated: able to undertake multiple tasks, work in community and/or institution based settings and in multidisciplinary teams, but also that work-life balance is respected;
- employable, ie. optimal use can be made of available skills and new skills taught; and
- valued: ie. career satisfaction is maximised and work is undertaken within a supportive environment and culture.

And the vision that encapsulates this is:

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

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

The principles have been constructed so as to ensure that they can be applied at either the national or jurisdictional or regional level. The use of the seven principles and related strategies should ensure sufficient scope is available to jurisdictions and regions to accommodate variations in emphasis in health workforce policy that will inevitably be necessary due to differences in priorities and circumstances in each jurisdiction.

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

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

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

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

