A NEW APPROACH TO AUSTRALIA'S HEALTH WORKFORCE

Jill Iliffe, July 2007

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Australia's health system is dependent on its health workforce. Numerous reports on the health workforce over the last decade have warned of impending crisis and the need for urgent action if the Australian community is to be assured of safe and efficient health care from a safe and sufficient health workforce.

Health care in Australia is provided in a range of settings. Services that promote, maintain or restore health, support the aged, people who have a disability or a mental health problem and those who are birthing or dying, are located in the community, acute and sub-acute public or private hospitals, the non-government sector and residential aged care. The workers who provide these services are equally diverse, ranging from those educated at the vocational level through to highly qualified professionals with Bachelor, Masters or PhD qualifications.

A health workforce policy must encompass this diverse group of people and take into account their career and life paths, and the fit between their educational qualifications and their scope of practice. It must recognise differences and similarities between roles and facilitate communication, cooperation and integration across disciplines. It must also accommodate dynamic change to existing roles and the emergence of new roles.

In 2004, the Australian Health Ministers' Conference (AHMC), comprising all Australian Government, State, and Territory Ministers with direct responsibility for health matters, in consultation with a broad range of people involved in the provision of health care, developed a strategic framework to guide national health workforce policy and planning (p.5).[1] The framework outlines the direction for national health workforce planning, articulates guiding principles and sets out strategies to achieve planning goals.

This *National Health Workforce Strategic Framework* recognised that a collaborative, multidisciplinary, whole of government approach was required, and that Australia should focus, at a minimum, on national self sufficiency in workforce supply. It also recognised that workforce planning and the education of health workers must be directly linked; that the distribution of the health workforce should enable equitable access to health care; and that health care settings should value their workforce and be places where people want to work.

Shortly after the release of the AHMC framework, the Council of Australian Governments (COAG) commissioned the Productivity Commission to undertake a study to:

> *... examine issues impacting on the health workforce including the supply of, and demand for, health workforce professionals, and propose solutions to ensure the continued delivery of quality health care over the next ten years.*[2]

COAG received the Productivity Commission report and its twenty-one recommendations in December 2005. Key recommendations included:

- COAG endorsing the AHMC National Health Workforce Strategic Framework
- the establishment of an advisory health workforce improvement agency to evaluate and, where appropriate, facilitate innovation in the health workforce
- the establishment of an advisory health workforce education and training council
- the establishment of a single national accreditation board for professional education and

training

» the establishment of a single registration board for health professionals

» the establishment of an independent standing review committee to advise on changes to the Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS)

» workforce projections linked to education and training places for the health workforce through the Australian Health Minister's Advisory Council

» ensuring provision for the particular requirements of rural and remote areas, and

» ensuring provision for the particular requirements of special needs groups.[3]

In its response to the Productivity Commission recommendations, the Australian Government has given priority to national registration for health professionals and national accreditation of courses leading to registration, setting an implementation date of 1 July 2008. Funding of $19.8 million has been allocated to support these changes and consultation with stakeholders to determine the preferred model is progressing rapidly.

However, far from streamlining registration and accreditation processes, the proposed models introduce a new layer of bureaucracy that is likely to conflict with the registered health professions, given that it is to be funded by registration fees, and its proposed role is to approve standards, fees and budgets. It is also likely that the distraction of implementing national registration and accreditation will put further reforms of the health system and/or its workforce on hold. Clearly, the introduction of national registration and accreditation, while welcome, is not going to solve the broad range of issues concerning the health workforce.

The Australian Government has responded to the shortages in the health workforce by increasing the number of places in the higher education sector, particularly in medicine and nursing, in an unplanned, uncoordinated and *ad hoc* way.

Table 1: New undergraduate places nursing and medicine 2004-2006

Nursing	
2006	1036[4]
	431: increasing to 1148 places by 2010 (mental health focus)[4]
2004	440: increasing to 1094 by 2008 (aged care focus)[5]
	210: increasing to 574 by 2007[5]
	1054: increasing to 2882 by 2008 (Higher Education Support Act)[6]
Medicine	
2006	605[4]
	234: increasing to 1400 as students continue their course[6]

Two hundred and ten new clinical psychology places (increasing to 400 places by 2008) were also announced in 2006, as well as 573 other health related places.

The additional nursing places should yield a completion rate of 8,793 graduates entering the workforce in 2010[7], which still falls far short of the 13,483 graduates the Australian Health Ministers Advisory Council (which includes the head of each of the Australian Government, State and Territory Authorities) suggested would be required by 2010.

What all this means is that health workforce shortages are being addressed, but in a piecemeal fashion, largely in response to political pressure. Current practice is no substitute for comprehensive national workforce planning based on an agreed methodology.

The Australian Government has responded to a number of calls to support innovation and a multidisciplinary approach to primary health care, including:

» support for Divisions of General Practice

» financial incentives for general practitioners to employ practice nurses, and

» changes to Medicare so that a range of nursing, dental and allied health services – particularly physiotherapy and clinical psychology – conducted 'for or on behalf of a medical practitioner' qualify for a Medicare rebate.

These responses have been largely welcomed by the health community. A consistent criticism, however, has been they have entrenched the current care model of general practitioner as the gatekeeper to the system, rather than trialling any new models of care.

The health workforce comprised around 7% of the total civilian workforce in Australia in 2001, and the proportion is likely to have grown since then[8]. Nurses make up more than half the health workforce (54%), followed by medical practitioners (12%) and allied health professionals (9%). Health expenditure in Australia is around 9.7% of GDP, with the health workforce accounting for around two thirds of overall spending.[9]

The Productivity Commission noted that the number of health workers in any particular discipline is not markedly different from the OECD average (see Table 2), though different models of care and population spread between countries limit direct comparisons.

Table 2: Number of selected health professionals per 1,000 population 2002-2003

	Practising doctors	General practitioners	Medical specialists	Nurses	Dentists	Pharmacists
Australia	2.5	1.4	1.2	10.2	0.5	0.8
OECD	2.9	0.8	1.7	8.2	0.6	0.7

Source: Commonwealth of Australia 2005 Australia's Health Workforce Productivity Commission Research Report. Canberra. pp.339-340

Australia's health workforce is also said to be growing at nearly twice the rate of the Australian population, with the largest increases occurring among allied health and complementary health professionals.[10] This rate of workforce expansion suggests that serious policy examination of health, the health care system, its workforce and practices is indeed warranted.

There have been many reports on the health workforce at both national and State/Territory level over the past five years. Some focus on specific disciplines or specialist sub-groups within disciplines, while others have related to the health workforce generally. However, some consistent themes have emerged in those reports, identifying issues of concern for Australia's health workforce and highlighting policy areas that need to be addressed.

Changing demography

The ageing of Australia's population presents significant concerns for future health workforce planning. Providing care for increasing numbers of very old people with specific disease patterns, shrinking workforce participation as the population ages, and decreasing numbers of unpaid carers and volunteers suggest an increasing care demand with a decreasing workforce supply.[11] The ageing population profile also has implications for the education of the health workforce, demanding a focus on issues of ageing,

such as dementia. Demographic changes affect all health workforce occupational groups. For example, improvements in oral health have resulted in an increase in the number of older patients who have retained their teeth. Consequently, more of them are visiting dentists and requiring more time and complex care to service.[12]

Changing models of health service delivery

Changing demographics are also driving different health care needs and responses. The Productivity Commission stated that:

> *Future health care demand is expected to change in line with anticipated changes in the burden of disease facing the community. This will fundamentally affect the models of care employed in service delivery, the number and types of health care workers that will be required, and the development of multidisciplinary approaches to care.*[13]

Inadequate coordination between governments, planners, educators and service providers; fragmented roles and responsibilities; inflexible regulatory practices; perverse funding and payment incentives; on top of entrenched custom and practice, were all cited as barriers to the development of innovative, flexible and efficient models of care.

The general consensus appears to be that a greater emphasis on- and investment in- preventing ill health is required to both contain costs and improve safety and quality. Early intervention and self management of health and ill health is needed, with a focus on primary health care provided in community settings, rather than institutions. For this to be effective, services need to be better integrated to allow ready movement between the community, in-patient and residential sectors, and the provision of care must be co-operative across disciplines.

The Australian Government has resisted calls for the development of a primary health care policy based on multidisciplinary care provided via community health centres, and has instead focussed its funding initiatives on enhancing the role of the general practitioner as the primary care provider in the community.

Health funding

Funding for health service provision is shared between the Australian and State and Territory governments, which together fund over two-thirds of health costs.[14] The mixed funding system results in different types and levels of health service provision across jurisdictions, encourages duplication of services and cost shifting, and blurs the boundaries for transparency and accountability. Consumers and the health workforce are all disadvantaged in the process.

Funding for the education of the health workforce is likewise shared between the Australian and State and Territory governments, with an increasing contribution being made by individual citizens. In addition to the lack of coordination between governments, there is also a lack of coordination between the provision of health services and the education of the health workforce that provides these services. Medicine is a possible exception, where the Australian Government mandates the number of training places. The Productivity Commission claims that governments, and the Australian Government in

particular, have long *shaped the size and composition of the health workforce through their role in funding training and service delivery.*[15]

A good example of this is the 30% private health insurance rebate. The Australian Health Care Reform Alliance (AHCRA), a coalition of over 50 health care organisations, argues strongly for a 'one funder' model for health, and the separation of funding responsibility and service provision. One of the models proposed by the Alliance is for the Australian Government to take full responsibility for funding health services on a weighted per capita basis, with the States and Territories taking responsibility for providing the services.

There is general agreement that the cost of health care will continue to increase. The Productivity Commission predicts growth to 16% of GDP by 2044-45, with the fiscal burden on government at least 10% of GDP if it continues to fund approximately two-thirds of health costs.[16] Even though Australia is currently devoting less of its GDP to health than many other developed countries, containing these costs will be imperative for the sustainability of the health system.

The need for health reform

The need for health reform has been well articulated by AHCRA. While welcoming the interest of COAG and AHMAC in the health workforce, AHCRA maintains that effective improvements in the health workforce cannot be achieved if they occur in isolation. AHCRA has therefore called for structural changes to the way health care is funded and provided.

The Senate Inquiry into Public Hospital Funding (2000) and the House of Representatives Inquiry into Health Funding (2005) both spent considerable time detailing the inefficiencies, duplication, cost and lack of accountability in the way Australian health care is funded. From political leaders to clinicians at the coal face, there have been many calls for rationalising the funding arrangements between Australian governments.

Similarly there have been calls for greater flexibility within the health workforce, particularly at the margins, and for the redefinition, redesign or expansion of some occupational roles and responsibilities. One of the seven principles of the National Health Workforce Strategic Framework recognises that *complementary realignment of existing workforce roles or the creation of new roles may be necessary.*[17] The Productivity Commission recommended the establishment of an advisory health workforce improvement agency to evaluate and, where appropriate, facilitate major health workforce innovation. This recommendation was not taken up by the Australian Government. Instead, it was decided to establish a taskforce reporting to the AHMC through AHMAC, to undertake project based work and provide advice on workforce innovation and reform. This suggests that nothing will happen, certainly in the short term.

Workforce shortages

Workforce shortages are reported by nearly all the health workforce occupational groups. The Department of Education, Science and Training 2006 Skills Needs Table shows podiatrists are sought in all States and Territories, registered nurses, physiotherapists and dentists are sought in six of the seven jurisdictions and pharmacists and medical imaging technicians are sought in five of them.[18]

The Australian Government's *Migration Occupations in Demand List* (MODL)[19] indicates a current need for anaesthetists, dentists, dermatologists, emergency medicine specialists, general medical practitioners, hospital pharmacists, medical diagnostic radiographers, obstetricians and gynaecologists, occupational therapists, ophthalmologists, paediatricians, pathologists, physiotherapists, podiatrists,

psychiatrists, radiologists, registered nurses, mental health nurses and midwives, retail pharmacists, specialist medical practitioners, specialist physicians, speech pathologists, sonographers and surgeons.

The Productivity Commission commented on the difficulty of quantifying or validating health workforce shortages, given the difficulty of establishing health care demand and an appropriate level of workforce response. This is particularly so in an environment where care demand is distorted and manipulable by government funding initiatives and resourcing - for example, education places for the health workforce.[20]

In 2002, the Australian Medical Workforce Advisory Committee (AMWAC) estimated a shortage of between 800 and 1300 general practitioners, or 4-6% of the general practitioner workforce.[21] Modelling of the specialist medical workforce by AMWAC highlighted existing or emerging shortages in all but one of the 24 groups examined. The Australian Institute of Health and Welfare (AIHW) reported that between 2000 and 2004 there was an overall increase in the medical practitioner supply from 270 to 283 Full Time Equivalent (FTE) practitioners per 100,000 population. However the supply of primary care practitioners decreased from 102 to 98 FTEs over the same period because the 4.4% rise in their number did not compensate for the 1.5 hour reduction in their average weekly working hours.[22]

AHWAC has estimated that between 10,182 and 12,270 new graduate nurses are needed to enter the workforce in 2006 and between 10,712 and 13,483 in 2010. New enrolled nurse requirements are projected to be between 5734 in 2006 and 6201 in 2010.[23] Despite the increased places allocated by the Australian Government since 2004, particularly for medicine and nursing, the numbers still fall far short of estimated supply.

Table 3: Undergraduate nurse completions 2000 and 2003 (actual) and 2006 to 2009 (projected)

2000	2003	2004	2005	2006	2007	2008	2009
5049	5630	5873	6457	7332	8009	8501	8793

Source: Preston, B. 2006. *Nurse workforce futures* Council of Deans of Nursing and Midwifery (Australia and New Zealand): http://www.cdnm.edu.au Table E.1 p.105

In dentistry, the Australian Research Centre for Population Oral Health (ARCPOH) estimated an additional 120 undergraduate dental places are required each year to 2010[24], and a review of the pharmacy workforce estimated that the shortage of pharmacists will increase from 2,000 to 3,000 by 2010 unless remedial action is taken.[25]

The distribution and utilisation of the health workforce

Apart from nursing, none of the occupational groups that make up the health workforce in Australia are distributed equitably between metropolitan, rural and remote areas. Between 2000 and 2004, the supply of medical practitioners increased supply in metropolitan areas and decreased in non-metropolitan areas.

Table 3: Geographic distribution of medical practitioners 2000-2004

(Full-time equivalent per head of population)

	Major city	Inner regional*	Outer regional*	Remote	Very remote
2000	309	172	147	152	138

2004	329	183	143	133	95

Source: Australian Institute of Health and Welfare 2006 *Medical labour force 2004.* p.vi

*Note: The geographic locations are based on the ABS Australian Standard Geographical Classification. Major cities and inner regional are classed as metropolitan; outer regional as rural; and remote/very remote as remote.

There have been some innovative responses to this problem, including outreach services by visiting medical specialists and allied health professionals and the creative use of technology to provide support and advice to workers in rural and remote areas. However, these have not necessarily been taken up in a coordinated or comprehensive way at a national level and workforce shortages continue to contribute to the poorer health outcomes of people living in rural and remote areas, particularly Indigenous people. Government incentives and other initiatives to attract health workers to rural and remote areas have focused almost entirely on the medical profession and have not been as successful as anticipated.

Table 4: Geographic location of the health workforce 2001

Occupational group	Major cities	Inner	Outer	Remote	Very
General medical practice	73.0%	18.2%	7.4%	1.0%	0.3%
Specialist medical practice	77.4%	17.3%	4.9%	0.4%	0.1%
Nurses	65.8%	21.5%	10.3%	1.6%	0.8%
Dental services	74.3%	17.5%	7.2%	0.8%	0.2%
Optometry and optical dispensing	73.7%	19.2%	6.6%	0.5%	0.03%
Physiotherapy	74.5%	17.9%	6.5%	0.8%	0.2%
Distribution of Australian population	66.3%	20.7%	10.4%	1.7%	0.9%

Source: Commonwealth of Australia 2005 *Australia's Health Workforce* Productivity Commission Research Report. Canberra. p.336

*Note: The geographic locations are based on the ABS Australian Standard Geographical Classification. Major cities and inner regional are classed as metropolitan; outer regional as rural; and remote/very remote as remote.

There is also an argument that the health workforce is not well utilised. A prime example is the effective resistance by the medical profession to the utilisation of nurse practitioners, highly educated and experienced nurses who could make a major contribution to the health care of the Australian community, particularly as nurses are so well distributed across the country. In contrast, there has been support in some medical circles for the introduction of physician assistants, a new and additional category of worker who would be under the control of doctors. Another example is community pharmacy where government regulation encourages pharmacists to spend more time running gift shops than on advice and dispensing medicines.

The ageing of the health workforce

Just as the Australian population is ageing, so is the Australian health workforce. In 2004 the average age of registered nurses was 43.2 years, up from 41.2 years in 1999. For enrolled nurses it was 43.6 years, up from 41.1 years in 1999. The proportion of nurses over the age of 50 increased from 21.5% in 1999 to 29.8% which is almost a third of the nursing workforce.[26]

In 2004 the average age of medical practitioners was 45.6 years, compared to 45.5 years in 2000. A more concerning statistic, however, is that 51% of medical practitioners are over the age of 45 years and 16% of them are over the age of 55 years.[27]

The most recent published data for physiotherapists is from the year 2002. This shows their average

age as 39.1 years,[28] up from 38.6 in 1998.[29] Podiatrists demonstrate a similar pattern: the average age of podiatrists in 2003 was 38.5 years, up from 38.2 years in 1999.[30]

These figures have implications for workforce planning as well as the education sector. Around 50% of the health workforce will be contemplating retirement within the next 15-20 years and it is likely they will be those with the most experience, specialist qualifications and expertise.

Changing patterns of work and work/family balance

Retaining the current workforce and gaining maximum benefit from the investment in their education is as important as recruiting new entrants into the health workforce. One of the key principles in the National Health Workforce Strategic Framework is the creation of health care environments that are places in which people want to work and develop and are valued.[31]

Most of the health occupational groups report that a significant proportion of their workforce is not currently working in their profession. In medicine the figure in 2004 was 9.9%.[32] For nursing it was 10%.[33] It was 17% for physiotherapists in 2002[34], 6.7% for podiatrists in 2003,[35] and 5.5% for dentists in 2000.[36] Initiatives such as funded re-entry programs to encourage health professionals back into the workforce have the advantages of a quicker response time and lower costs than 'from-scratch' education.

A significant proportion of the health workforce works part time, either in an attempt to manage workloads, or balance work and family commitments. In 2004, 49.6% of nurses worked part time, a decrease from 50% in 2003, 53.3% in 2001 and 52.7% in 1999. They worked an average of 32.8 hours per week, an increase from 32.5 hours in 2003, 30.7 hours in 2001 and 30.6 hours in 1999.[37] Other occupational groups have similar patterns of work.

Demonstrating the current policy reliance on medical practitioners, a reduction in work to an average week of 44 hours in 2004, from 45.5 hours in 2000 was more than offset by the rise in practitioner numbers. The net result was an increase in supply from 270 to 283 full time equivalent practitioners per 100,000 population, between 2000 and 2004.

Linking workforce needs and workforce education

A common theme emerging from the literature is the lack of formal national workforce planning to link workforce needs with educational places. The Productivity Commission recommended developing three year agreements between the Australian Government and the State and Territory Governments for the allocation of higher education health places.[38]

In a continuing refusal to commit to stable policy settings, the Australian Government responded with a Memorandum of Understanding with the State and Territory Governments. This agreed to *better consultation on health related university places* and the inclusion of an *annual agreement on national workforce priorities and advice on education and training that addresses current and emerging national skills shortages* within the responsibilities of the Ministerial Council on Education, Employment, Training and Youth Affairs (MCEETYA).[39]

One of the major difficulties for workforce planners is the lack of comprehensive, accurate and timely data on which to base projections. Currently, data on the health workforce are at best two years old and for some professions they are up to four years old. The data on nursing, which makes up more than 50%

of the health workforce, is three years old.

Unresolved issues in relation to clinical education

A common concern is the lack of quality clinical education places and the pressure on the existing health workforce to meeting the clinical training needs of students and new entrants to the professions. The Productivity Commission suggests that a lack of accurate and comprehensive data on who is providing clinical training, where it is being provided, and how the costs are distributed across the various players made it difficult to assess the extent of the problem and offer solutions.[40]

The Commission found it was essential to establish a national information base on available clinical training capacity, and the number of undergraduate and graduate students seeking clinical placements across disciplines. The Commission also considered that unless there was a dedicated funding pool for clinical training and more transparency in the way costs were distributed, the private sector, which benefits from the contribution the public sector makes, would be unable to make a more meaningful contribution to clinical training.

Various submissions to the Productivity Commission noted that even at the local level, in institutions where clinical training took place, there was no centralised information about what clinical training was being provided to whom at any given time, few clinical coordinators who reconciled clinical education needs across disciplines on an institutional basis, and few clinical educators or supervisors who provided support to both students and the existing health workforce.

Better use of information and other new technologies

There is enormous potential for the better use of information technology (IT), technologies for more accurate and efficient care, and to improve the provision of care to rural and remote communities.

The introduction of information technology in the Australian health sector has been sporadic and uncoordinated at all levels and across all areas of responsibility. There has been marked resistance to using technology and embracing new ideas, particularly as the health workforce is rarely consulted on the practicability of new technology. The introduction of new technology is more often driven by governments and software vendors arguing for the adoption of their software or systems, to the exclusion of all other possibilities. Despite considerable effort and expenditure in these areas, there are still serious difficulties with many aspects of IT.

Despite progress in providing support to general medical practice to computerise, and in connecting hospitals, general practitioners and aged care facilities, potential improvements in care and cost efficiency are not being fully realised.

The Productivity Commission noted that incorporation of new technologies could add significantly to the future cost of health care. Offsetting that is the potential for health care technology to reduce costs in other areas, such as the way health services are provided, the roles of the health workforce and their educational needs.

Reliance on permanent or temporary migration

The difficulty of recruiting medical practitioners and nurses locally, a consequence of the workforce policy stances outlined above, has forced the Australian Government to use favourable visa conditions to attract and recruit health professionals from other countries.

This raises several issues of concern. One relates to the ethics of actively recruiting health profession-

als educated in other countries, thereby disadvantaging their countries of origin. Another issue lies in ensuring that the level of English proficiency and knowledge of the Australian health system is sufficient for the practitioner to provide safe care, in the interests of both their patients and colleagues. It is also essential that health professionals educated in other countries are required to meet the same standards of practice and behaviour demanded of health professionals educated in Australia.

Recruiting health professionals educated in other countries should be complementary to, and not a substitute for, workforce planning to achieve self sufficiency. This is the first principle of the National Health Workforce Strategic Framework, although the Productivity Commission suggested a goal of self sufficiency might be *unduly restrictive in the context of the international nature of the health workforce.*[41] Net self sufficiency is probably a more rational goal and there has been little discussion about the desirability of Australia moving beyond the self sufficiency principle to a position of educating and exporting health workers to other countries facing similar shortages.

A POLICY RESPONSE

All Australian governments have endorsed the National Health Workforce Strategic Framework. This document was developed in consultation with a wide range of experts in the health sector. The principles underpinning the Framework provide a solid base on which to build a health workforce policy for Australia. The principles encompass:

» ensuring and sustaining supply

» workforce distribution that optimises access to health care and meets the health needs of all Australians

» health environments being places in which people want to work

» ensuring the health workforce is always skilled and competent

» optimal use of skills and workforce adaptability

» recognising that health workforce policy and planning must be informed by the best available evidence and linked to the broader health system, and

» recognising that health workforce policy involves all stakeholders working collaboratively together.[42]

While these principles are all laudable, health workforce policy and practice must move to address the concerns outlined above.

Workforce policy and planning cannot be separated from the context in which health professionals work. A rational approach to health funding is needed. This could begin by opening the dialogue for a different funding model. There is an urgent need for the systematic elimination of cost shifting, duplication and inefficiency in health service delivery that results from the current confusions in funding by the Australian and State and Territory governments. In this context, the recommendation of the Australian Health Care Reform Alliance for a Health Reform Council or Commission is worth exploring.

A shift in focus from acute to primary health care, emphasising health education, early intervention and multidisciplinary care should be a priority. A national network of primary health care centres staffed by multidisciplinary teams should be established. General practitioners are integral to a primary health care model and must be engaged in this process.

There will be an inevitable increased demand for health and aged care in the future due to the ageing of

the Australian population. There must be planning for a health workforce with the necessary knowledge and skill to meet this demand. One option proposed is for flexible planning ratios in each occupational group to be established in consultation with the professions. These ratios would take into account the changing demographics of the Australian population over time, the ageing of the health workforce, and the trend to part time work and reduced hours. There are already planning ratios for the number of hospital and aged care beds at any given time. Establishing target ratios for the health workforce per 100,000 population would enable sufficient education places to be allocated to meet workforce needs.

To contain future costs for health service delivery and meet the health care needs of an ageing population, different models of health service delivery are essential. A true multidisciplinary approach means challenging traditional roles and responsibilities and the silo approach to health care provision, where each occupational group makes decisions about the care they provide to an individual in isolation from the rest of the health care team.

Health care needs to be provided by teams centred on the person who needs the care. The establishment of multidisciplinary teams in community settings, attached, for example, to Divisions of General Practice, general practitioners or primary health care centres is critical to a new cooperative approach to health care where all members of the team work together, where each contribution is valued and where the leader of the team is the health professional most appropriate to address the specific need of the patient. The present 'general practitioner as gatekeeper' funding model hinders this team approach to care.

Policy change is essential if Australia's health care system is to be sustainable into the future. Initial steps which can be taken now are:

» establishing and strengthening community health centres across the nation, staffed by primary health care teams which include the general medical practitioners in the community;

» the introduction of an independent health reform council or commission to examine the best model of health funding for Australia, and the best ways to utilise the Australian health workforce; and

» national workforce planning linking education places to workplace needs.

Without some immediate action, the health workforce will not be able to meet the future health care needs of the Australian community.

Endnotes

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