

## 5. Terms of Reference 2

### Review clinical workforce management systems to deliver high quality health services

#### 5.1 Background

The ability to provide quality health services depends on the availability of a workforce of highly skilled and trained health professionals. The general public expects to be treated by practitioners who are qualified and safe and competent to practise.

Queensland Health is the largest employer of health professionals in Queensland. In the consultations across Queensland Health districts, their dedication, professionalism and commitment to patient care was clearly apparent. The clinicians currently working in the system are the cornerstone of the public health system and play a critical role in supervising, training and mentoring the health workforce of the future.

Queensland Health is competing in a global market for the health workforce and there are growing shortages being experienced across the medical, nursing and allied health professions. In this context, it is important that Queensland Health's workforce management systems support clinicians to deliver services and assist in attracting and retaining the best and most highly skilled practitioners in the State's public health system.

An effective workforce management system would be expected to include long term workforce planning, effective recruitment and retention processes, appropriate remuneration and employment conditions, a fair and transparent staff complaints system, quality controls including credentialing and periodic reassessment of skills, access to training and professional development, mechanisms for allocating staff, and up to date workplace health and safety management systems.

Most importantly, the workforce management system as a whole should support, value and nurture staff. Health professionals are working in increasingly complex and stressful environments characterised by rising workloads, sicker patients, rapid technological advances and growing community expectations about what health services can deliver.

The Review received numerous reports of clinicians working in Queensland Health who feel undervalued and marginalised from a system which does not allow them sufficient time to undertake teaching and research, where they are expected to treat more and more patients, where their skills are not appreciated, where junior staff feel unsupported and where they have limited ability to influence the way the health system is run.

The Review found that while Queensland Health has established workforce management systems, the systems are not being used effectively and in some cases there are major gaps. For instance, while detailed workforce data is available at the central level through sophisticated Human Resource information management systems such as LATTICE, there is no monitoring or analysis of the data to inform workforce planning. Workforce planning is not linked to service delivery needs and access to training and professional development for staff varies across the State.

Responsibility for recruitment and retention of staff is diffused throughout the various levels of the organisation and there is no formal reassessment of the skills and abilities of practitioners. Furthermore, many of these workforce administrative and management systems impose additional burdens on front-line staff which reduces the time available for delivering patient care and adds further stress to the workplace.

### **Workforce Pressures**

In a global and national environment of competition for the health workforce, Queensland Health faces significant challenges in recruiting and retaining clinicians to meet the current and future needs of the State's population. As noted above, growing shortages are being experienced across most health professional groups including doctors, nurses and allied health professionals.

The size, nature, skill level and availability of the health workforce is influenced by many factors, some of which are outside Queensland Health's and the Queensland Government's control. For example:

- *Population growth and ageing:* Over the next 25 years, growth in Australia's working age population is projected to slow significantly from an average net growth of around 170,000 per annum to an annual net growth of around 12,000 per annum or approximately 125,000 in total for the entire decade between 2020 and 2030. This means there will be fewer workers to care for more people.<sup>71</sup> The health workforce is itself ageing which will further increase workforce pressures.
- *Commonwealth Government policy and funding decisions:* The Commonwealth Government controls the number of university places for medical students, the number of Medicare provider numbers for new graduates and skilled immigration intakes and requirements.
- *Education and training:* Universities design curricula for health professional qualifications and the Australian Medical Colleges determine the number of medical specialty training places, the length of training programs and accredit training places in hospitals.

#### *Medical workforce*

As shown in the table below, Queensland has the lowest level of doctors per head of population of any state or territory. In 2003/04, Queensland had 333 registered doctors per 100,000 population while the national average was 381 registered doctors per 100,000 population. Queensland would need an extra 1860 doctors to reach the national average. These figures are for all doctors working in Queensland, not just those employed by Queensland Health. In terms of public hospital medical staff, the table shows that Queensland has the second lowest number of public hospital salaried medical officers in Australia with 93 salaried medical officers per 100,000 head of population compared to 101 nationally. An additional 310 public hospital doctors would be needed to meet the national average.

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<sup>71</sup> Queensland Health Initial Submission to the Bundaberg Hospital Commission of Inquiry, 16 May 2005, p 7

Number of Registered Medical Practitioners &amp; Public Hospital Medical Officers per 100,000 by State/Territory - 2003/2004

	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
Total Number of Registered Practitioners	26,011	18,016	12,920	7,065	6,309	2,047	1,945	1,497	75,810
Population	6,731,295	4,972,779	3,882,037	1,982,204	1,534,250	482,128	324,021	199,913	19,908,714
Rate per 100,000 population	386	362	333	356	411	425	600	749	381
Total Number of Full-time equivalent salaried medical officers	6700	5389	3602	1883	1678	367	317	246	20182
Population	6,731,295	4,972,779	3,882,037	1,982,204	1,534,250	482,128	324,021	199,913	19,908,714
Rate per 100,000 population	100	108	93	95	109	76	98	123	101

Source: Medical Board Annual Reports All States and Territories 2003/04 excluding Northern Territory

Source: Australian Hospital Statistics 2003/04

ABS Catalogue No. 3210 December 2004

In the mid to late 1990s, the Commonwealth Government made a number of policy decisions to constrain growth in medical and health expenditure which impacted on the Australian medical workforce. In particular, the Commonwealth:

- reduced medical school intakes;
- reduced net additions to the workforce from immigration;
- reduced annual intakes for general practice training programs; and
- denied access to Medicare provider numbers for new graduates until they entered a recognised general or specialist training program.<sup>72</sup>

In recognition of the subsequent impact on medical workforce, the Commonwealth has since increased medical school training places. Where University of Queensland was previously the sole tertiary institution offering medicine, Queensland now has three additional medical schools (James Cook University, Griffith University, Bond University). However, the benefits will not be fully realised until 2010 when all four medical schools produce graduates entering the workforce. In the meantime, Queensland Health estimates the gap between the supply of local graduate doctors and Queensland Health's workforce requirements will increase by an additional 478 in 2006 to 993 by 2010.

Until the time larger numbers of new graduate doctors are available in Queensland, options to meet medical workforce needs are:

- to recruit doctors from interstate
- to recruit doctors from overseas
- increase the use of visiting medical officers and partner with private sector general practitioners
- review the incentives which keep full time specialists and senior medical staff in the public system
- implement changes to workforce roles
- better utilise capabilities of the existing clinical workforce.

The increase in local medical graduates from an estimated 232 in 2004 to 540 in 2010 will itself create challenges in providing adequate teaching supervision as these graduates pursue general or specialist training in Queensland hospitals, the responsibility for which falls almost entirely on the public system. This has been a traditional role of State run hospitals since their inception. Graduates in their first year internship, residents in their next two post-graduate years, and registrars or specialist trainees in the next three to five years are required to deliver health services under the supervision of senior staff.

<sup>72</sup> Queensland Health Initial Submission to the Bundaberg Hospital Commission of Inquiry, 16 May 2005, p 7

While Queensland has relatively lower numbers of doctors on a population share basis than other jurisdictions, the number of medical practitioners in Queensland has been steadily increasing. The table below shows the number of medical practitioners registered in Queensland has increased by 15.5 percent over the last five years. In 1999, there were 11,185 registered practitioners and this increased to 12,920 registered medical practitioners in 2004. Significant increases occurred in the registration of conditional specialists, which more than doubled from 159 to 356 registrants and area of need registrations, which increased from 540 to 968 registrants over the same period.

Conditional specialists include overseas trained doctors who received their primary medical training overseas and are ineligible for general registration but who have completed a specialist training program in the Australian system. Registration of these doctors is conditional on them confining their practice to an approved specialty field. Area of need registrants are overseas trained doctors who are given special purpose registration to practice in areas where there are considered to be insufficient numbers of locally available doctors. These generally include rural and remote areas where it is more difficult to fill vacancies.

#### Medical Registrants (Queensland 1999 - 2004)

	1999	2000	2001	2002	2003	2004	% Change
<b>General Registrants</b>	6,627	6,716	6,530	6,878	6,968	7,237	9.2%
<b>Specialist Registrants</b>	3,425	3,529	3,635	3,742	3,738	3,801	11.0%
<b>Internship/surgical training*</b>	259	275	266	234	281	n/a	
<b>Conditional Specialists</b>	159	172	216	215	285	356	123.9%
<b>Area of Need</b>	540	688	843	827	871	968	79.3%
<b>Area of Need Deemed Specialists</b>	n/a	n/a/	n/a/	n/a/	58	59	
<b>Post Graduate</b>	111	121	125	128	160	151	36.0%
<b>General Practice</b>	n/a	16	41	66	101	168	
<b>Other</b>	64	72	60	72	73	180	181.3%
<b>Total Registered Medical Practitioners</b>	11,185	11,589	11,716	12,162	12,535	12,920	15.5%

\* This category was absorbed into general registrants in 2004.

Source: Medical Board Queensland Annual Report 2003/04

#### Queensland Health's clinical workforce

Queensland Health has been increasing the numbers of doctors it employs in the public system with a growing reliance on the use of overseas trained doctors. The table below<sup>73</sup> shows the number of visiting medical officers<sup>74</sup> (on a full time equivalent basis) has fallen by 41 percent between 1996 and 2005 while the number of employed staff clinicians has increased by 69 percent over the same period. Professional staff have increased by 59 percent while the growth in nursing staff numbers has been more modest at 12 percent over the same period. The statistics on professional staff include allied health practitioners but also include other professions such as scientists, public health staff and some Corporate Office staff. Figures for professional staff are therefore not a reliable indicator of allied health trends.

<sup>73</sup> See Appendix for notes on all workforce statistics provided by the Queensland Health Human Resource Management Information Systems Unit.

<sup>74</sup> Visiting medical officers are private practitioners doing sessional work in the public sector.

**Queensland Health Clinical Workforce (FTE) (1996-2005)**

Stream	1996	2005	% change
VMOs	407	240	-41%
Medical	2027	3434	69%
Nursing	15118	16943	12%
Professional	3112	4961	59%

Source: Queensland Health Human Resource Management Information System

*Overseas trained doctors*

Of the 3,434 full time equivalent doctors employed by Queensland Health in 2005, 737 or one in five had provisional registration, the category which is predominantly made up of overseas trained doctors practising in areas of need. Outside the Royal Brisbane Hospital and Princess Alexandra Hospital, 27 percent or over a quarter of all doctors hold provisional registration.

Queensland, Western Australia and the Northern Territory have a high level of dependence on overseas trained doctors reflecting the more dispersed populations of these States. It should be noted that other western countries such as the United Kingdom, Canada, the United States and New Zealand are also increasingly relying on overseas trained doctors to meet workforce shortages.<sup>75</sup>

Queensland Health's data on staff numbers is sourced from the payroll system and as such is considered to provide a reliable measure of trends in staff numbers over time. The findings have been checked against other relevant data collections including the Australian Hospital Statistics collection and the Australian Institute of Health and Welfare labour force surveys. The table below from Australian Hospital Statistics shows the number of medical staff employed in Queensland public hospitals increased by 29.8 percent compared to the national average of 31.2 percent. Victoria recorded the highest level of employment growth with 53.5 percent over the same period.

**Full-time Equivalent Staff Numbers - Salaried Medical Officers**

Rank	4	1	3	2	8	5	7	6	Total
State	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	
AHS 1997-98	5,392	3,511	2,774	1,400	1,512	304	284	210	15,387
AHS 2003-04	6,700	5,389	3,602	1,883	1,678	367	317	246	20,182
% Increase	24.3	53.5	29.8	34.5	11.0	20.7	11.6	17.1	31.2

Source: Australian Hospital Statistics 1997-98 to 2003-04

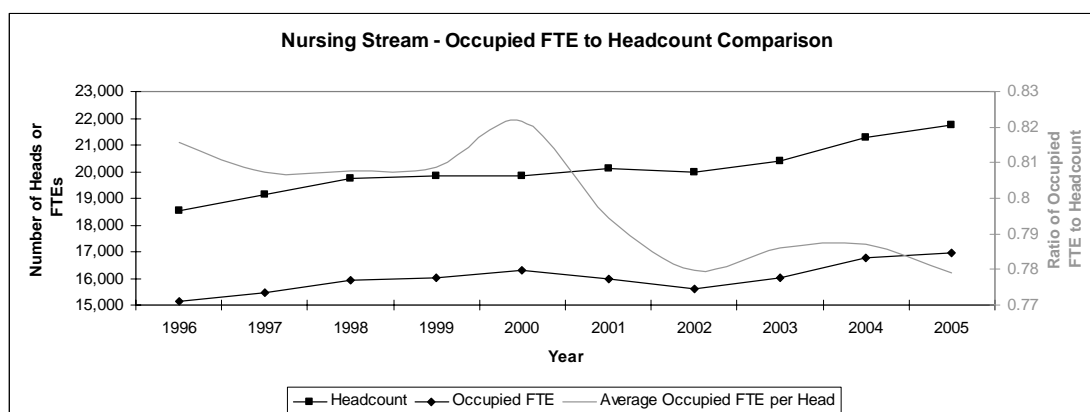
The Australian Institute of Health and Welfare (AIHW) Labour Force Survey 2002 has been widely quoted in terms of the growth in the numbers of medical practitioners in Queensland. The survey showed an increase in employed medical practitioners of only 1.7 percent over the period 1997 to 2002 compared to national growth of 12.0 percent over the same period. This data is now somewhat dated and is inconsistent with trends both in the Australian Hospital Statistics data, the Medical Board registration data and Queensland Health's payroll data (noting both the AIHW and the Medical Board are concerned with total numbers of medical practitioners not just those working in public

<sup>75</sup> Birrell B and Hawthorne L, Medicare Plus and Overseas Trained Medical Doctors, *People and Place*, vol. 12, no. 2, 2004

hospitals). While the AIHW survey provides useful information on the characteristics of the medical workforce, it has limitations as a reliable measure of growth in doctor numbers as it is a voluntary survey completed by doctors who are renewing their registration. Nevertheless, the conclusions drawn by the data regarding the relatively lower share of doctors in Queensland compared to other States are broadly consistent with the other data analysis.

Queensland Health has provided the Review team with a 10 year analysis of trends in full-time and part-time working hours. Despite commentary about the increasing feminisation of the medical workforce and the shift towards part-time work, this data shows that in the medical stream, there has been a tendency in the past 10 years for more of the Queensland Health medical workforce to work full time hours. VMOs by their nature tend to work on a sessional basis at an average of 8.5 hours per week in Queensland Health facilities. Similarly, this data shows an increasing tendency for the professional stream to work full-time hours, although this increase is not occurring as fast as in the medical stream.

In contrast, as shown in the table below, a much higher proportion of nursing staff are working part-time and there has been an increasing tendency over the past 10 years towards part-time work (indicated by a decreasing occupied FTE per head measure).



Source: Human Resource Management Information Systems Unit

Despite the growth in clinician numbers, clinicians in all sites visited reported pressures on staffing levels in response to changing service demands arising from population growth, increased acuity and demographic changes. While increases in some disciplines have exceeded population growth, there are no effective measures to determine optimum workforce levels.

National comparisons are also available with regard to growth in nursing and allied health professional staff. The tables below show that Queensland experienced the second lowest growth in nursing numbers, with an increase of 2.9 percent over the period 1997/98 to 2003/04 compared to 16.1 percent nationally. With respect to allied health professionals, the data shows negative growth over the reporting period (-10.5 percent) placing Queensland last in terms of growth in the allied health workforce. The difference as compared with the growth recorded in Queensland Health’s own data on professional stream employees (which includes but is not limited to allied health practitioners) could be attributed to different definitions of professional, allied health and diagnostic staff and

the fact that increases in allied health staff in community health settings are not included in the Australian Hospital Statistics data.

#### Full-time Equivalent Staff Numbers - Total Nurses

Rank of % Increase	3	1	7	5	6	2	4	8	Total
Jurisdiction	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	
AHS 1997-98	28,517	16,714	14,246	7,598	7,371	1,520	1,329	944	78,239
AHS 2003-04	31,865	24,028	14,661	8,158	7,813	1,806	1,479	941	90,751
% Increase	11.7	43.8	2.9	7.4	6.0	18.8	11.3	-0.3	16.0

Source: Australian Hospital Statistics 1997-98 to 2003-04

#### Full-time Equivalent Staff Numbers - Diagnostic & Allied Health Professionals

Rank of % Increase	3	1	7	5	4	6	8	2	Total
Jurisdiction	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	
AHS 1997-98	8,193	5,993	3,611	2,262	1,739	361	440	149	22,748
AHS 2003-04	10,005	10,784	3,231	2,230	1,965	349	349	261	29,174
% Increase	22.1	79.9	-10.5	-1.4	13.0	-3.3	-20.7	75.2	28.2

Source: Australian Hospital Statistics 1997-98 to 2003-04

### Clinical workforce management systems

Queensland Health's workforce management systems are highly complex and include whole of Government systems such as enterprise bargaining arrangements, merit based recruitment and selection processes, grievance procedures and dismissal processes. They also include quality and safety assurance systems such as credentialing and clinical privileging policies and training and education programs for staff.

#### Enterprise Bargaining

There are nine parent awards that apply to staff within Queensland Health under the current enterprise bargaining arrangements:

- Two awards for district health service nurses – one for nurses in public hospitals and one for other public health sector nurses (ie in psychiatric hospitals and Eventide nursing homes). In addition to these two awards, there is an MX award, which was the arbitrated outcome of the last enterprise bargaining negotiations and contains wage increases and additional conditions. The MX award will be terminated and replaced when the next enterprise bargaining agreement for nurses is reached.
- Three awards for medical staff – one for senior medical officers and resident medical officers, one for medical superintendents and medical officers with right of private practice, and a third for public servant medical officers employed in Queensland Health Corporate Office and doctors employed in other government departments.
- One award for district health services employees, which covers professional, technical, operational, dental and administrative streams.
- One public service award which applies to administrative, professional, technical, operational and nursing staff employed in Corporate Office (and nurses employed in other government departments) and for public servants employed in other government departments.

- Two awards for building and engineering staff.

In addition to the above awards, there is a separate public sector award regarding family leave.

#### *Workforce Quality and Safety Systems*

The Medical Board of Queensland has the primary role as gatekeeper in the system for ensuring that medical practitioners are appropriately qualified and safe and competent to practise. The Board is responsible for registering medical practitioners to ensure they meet legislative requirements regarding appropriate training and entry standards before they can practise anywhere in Queensland. Apart from its role in endorsing first year doctor training programs for accreditation and registration, the Medical Board plays no ongoing role in reviewing the currency or quality of practice of individual medical practitioners. Doctors must, however, renew their registration annually.

Queensland Health has developed detailed policies and guidelines to provide for the periodic review of doctors' credentials and clinical privileges as an ongoing quality assurance mechanism. Credentials refer to the formal qualifications, training, experience and clinical competence of medical practitioners while clinical privileges is the term used to describe the range and scope of clinical functions a practitioner may undertake in a particular facility.

District Managers are responsible for ensuring that all medical practitioners operating within Queensland Health have their credentials and clinical privileges periodically reviewed by a relevant Committee. The Committee which is comprised of medical practitioners makes recommendations to the District Manager who is ultimately responsible for appointing a practitioner to a specified position or providing admitting rights to a private practitioner at a public facility.

Concerns have been raised with the Review about whether Queensland Health's credentialing and clinical privileges policies and guidelines are being strictly adhered to across the Districts as well as concerns that where they are being applied, there is considerable variability. The events surrounding Bundaberg certainly raise questions about the adequacy of implementation of the current credentialing system as a means of giving both the hospital and the general community confidence in the quality of care provided by individual medical practitioners (see section 5.2 on recruitment for discussion of proposed reforms to medical credentialing arrangements for overseas trained doctors).

There are also training systems within Queensland Health aimed at promoting quality care including clinical placements for student nurses and allied health professionals, training for medical graduates employed as junior doctors, and complex specialist training arrangements in teaching hospitals, which are accredited by the Australian Medical Colleges. Section 5.4 provides more detail on training arrangements.

#### *Other Workforce Management Systems*

In addition, there are a number of information systems, including LATTICE (a personnel and payroll system), ESP (a nurse rostering system) and systems to determine nurse to patient ratios, including TREND CARE and the use of the Business Planning Framework. As noted earlier, such systems are a rich source of information about the workforce. However, the information is not centrally analysed to inform policy development or

workforce planning and their operation is seen to impose additional burdens on clinicians and reduce time available for clinical care.

### **Recruitment, retention and staff satisfaction**

The Review team has identified that recruitment and retention trends are not measured or monitored centrally. It is understood that the Workforce Board within Queensland Health intends to redress this deficiency and is currently improving data sets with a view to central analysis.

Data collected by the Department of Industrial Relations compares workforce information in Queensland Health with the wider public sector. This data shows that for the March 2005 quarter Queensland Health had:

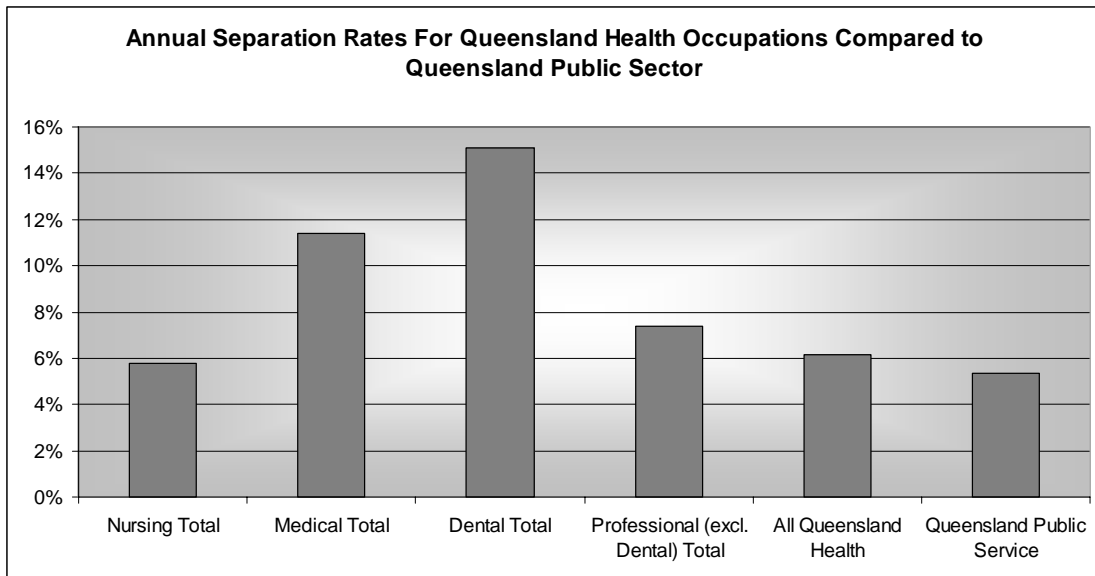
- higher rates of absenteeism (3.89 percent for Queensland Health as compared with 3.61 percent for the public sector)
- higher percentage of employees taking work cover leave (1 percent as compared with 0.89 for the public sector).

For the purposes of the Review, Queensland Health compared data from the Department of Industrial Relations in order to calculate comparative separation rates, including rates by professional groups.<sup>76</sup> As shown in the two graphs below, broad trends are:

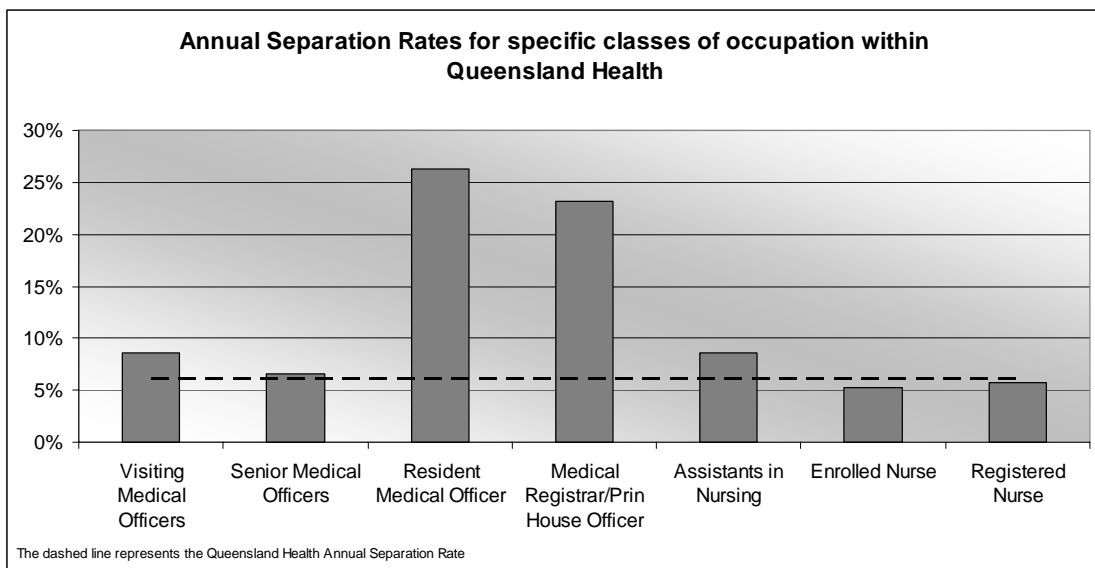
- overall, a higher separation rate for Queensland Health and each professional group as compared with the wider Queensland public sector
- separation rates for senior medical staff and visiting medical staff are higher than the Queensland Health average, with significantly higher separation rates for junior medical staff - this is due to annual contractual arrangements for junior doctors which result in high turnover at the end of each year
- separation rates for registered nurses and enrolled nurses are at or below the Queensland Health average whilst separation rates for assistants in nursing are higher
- separation rates for all professional groups are higher than the Queensland Health average.

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<sup>76</sup>Turnover rates illustrate the proportion of terminations for each professional group as compared with the *total annual headcount* of employees in each group for the Queensland Public Service figure provided by the Department of Industrial Relations. The Queensland Health figures are the proportion of terminations compared to the *average fortnightly headcount* of employees in each group. This will have the tendency to slightly inflate the Queensland Health figures. See appendix.

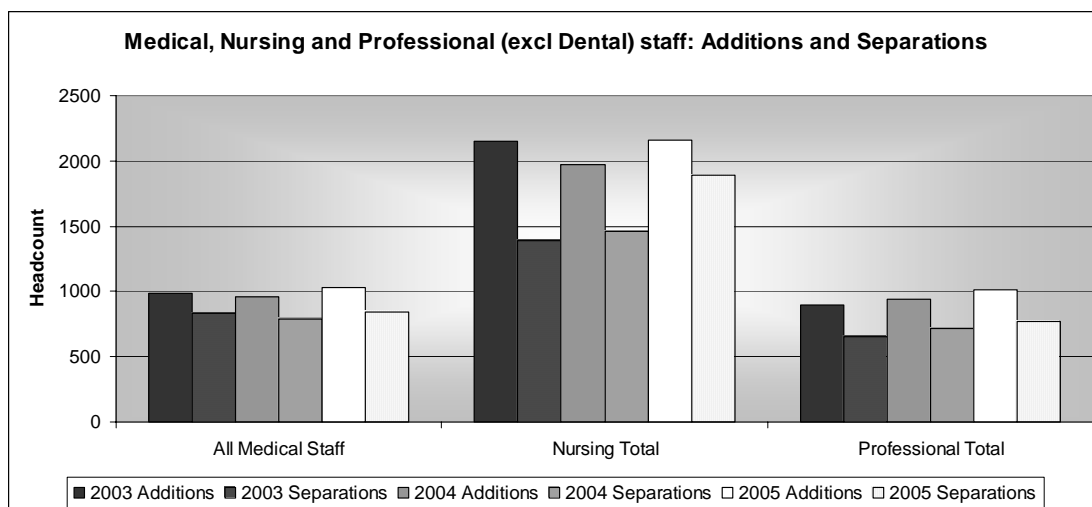


Source: Human Resource Management Information Systems Unit



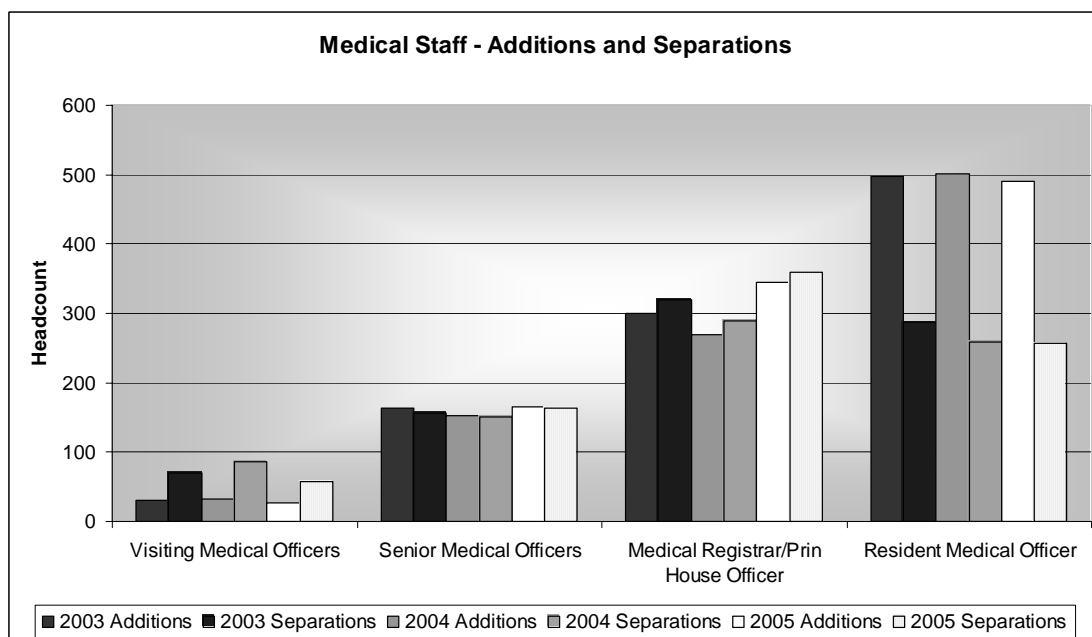
Source: Human Resource Management Information Systems Unit

For the purpose of the Review, Queensland Health also produced comparative data about additions and separations to provide a snapshot of net employee increases or decreases amongst each professional group. As shown in the graph below, there are net increases in medical, nursing and professional staff over the past three years.

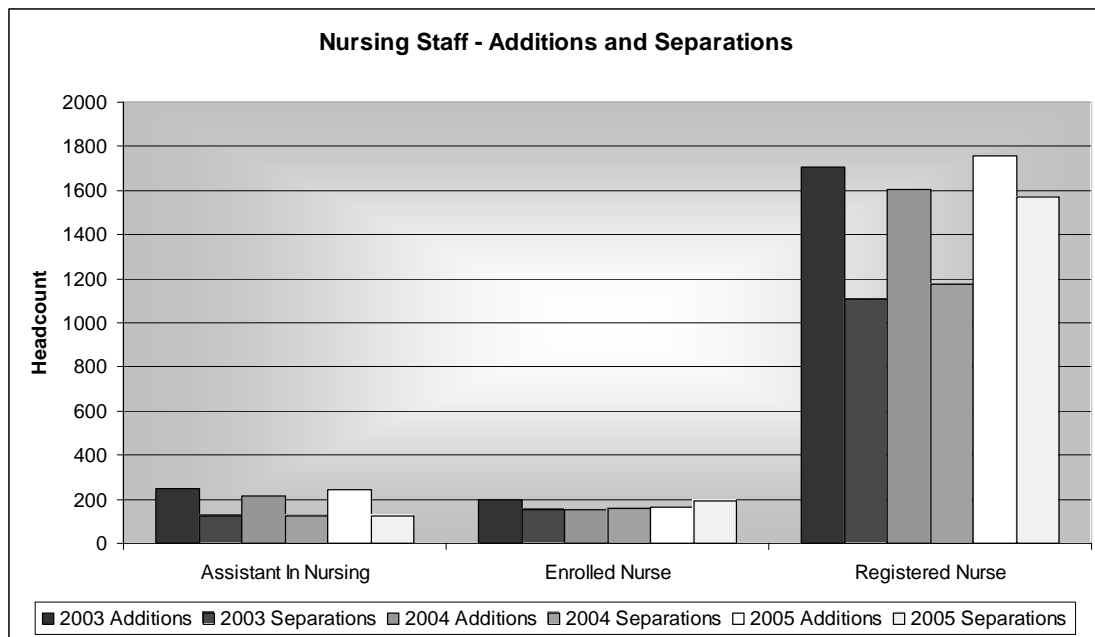


Source: Human Resource Management Information Systems Unit

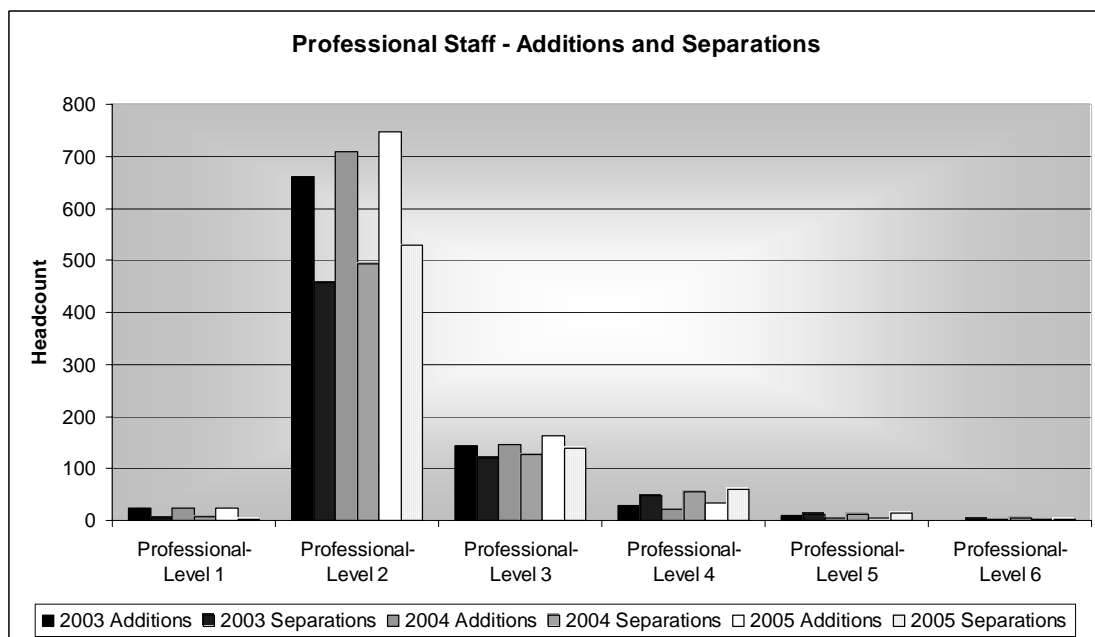
The three tables below provide a snapshot within the different professional groups. This shows net increases for senior medical staff and resident medical officers, registered and assistant nurses, and lower levels of the professional streams. However, there is evidence of overall attrition for visiting medical officers, registrars, enrolled nurses, and higher levels within the professional stream.



Source: Human Resource Management Information Systems Unit



Source: Human Resource Management Information Systems Unit



Source: Human Resource Management Information Systems Unit

There have been some assertions that Queensland Health is deliberately reducing use of visiting medical officers. Whilst there has been an overall loss of visiting medical staff, the Review team has not found any evidence of a deliberate strategy within Queensland Health to reduce this section of the medical workforce. Turnover and attrition in certain districts has been attributed to a range of local factors rather than any deliberate, central strategy.

Anecdotally, clinical staff in the sites visited reported that clinicians, particularly Australian trained doctors, are leaving the public sector in significant numbers to pursue private sector opportunities or opportunities in other jurisdictions offering better remuneration. As separations and turnover statistics do not distinguish between provisionally registered overseas trained doctors and locally trained doctors, it is not possible to verify this anecdotal feedback. However, the Review team will seek qualitatively to test this claim further.

### *Remuneration*

Remuneration is a key driver of recruitment and retention and the differential between health professionals employed by Queensland Health and those in private practice or interstate public systems varies by discipline. Comparable statistics on income differentials are still being gathered. However, some general comments can be made at this stage.

Overall, Queensland Health pays 5.6 percent less in average salaries for its public hospital workforce (including administration and clerical staff) than interstate public hospitals. In comparison, Queensland average weekly earnings generally are around 6 to 7 percent below the national average.

Broadly, it is understood that nurses receive higher remuneration than their private sector counterparts and earn slightly less than their interstate public sector counterparts. For the final report, Queensland Health will provide more detailed comparative data on remuneration for nurses in the private sector and interstate public health systems.

Queensland Health doctors tend to earn far less than their private sector counterparts, particularly in procedural specialties. Information from the Health Insurance Commission is being sought to provide indicative information on income earned by private medical specialists. On an interstate public sector basis, it is difficult to obtain reliable comparisons of the overall value of remuneration packages. For example, whilst Queensland Health tends not to pay competitive salaries at the higher pay scales for staff specialists, its private practice percentage payments to doctors operating limited private practice are significantly higher than any other state except for South Australia and its study leave arrangements are comparatively generous.

That said, the Review team has been presented with specific examples which highlight the flexibility of interstate statutory health authorities to negotiate very generous packages for medical staff. For example, the salary package for a medical officer employed by the Bendigo Health Care Group in Victoria totals \$400,000, as compared with between \$247,000 to \$272,000 for Queensland Health medical officers. The Bendigo employee would also enjoy more generous long service leave, sick leave and study leave. (One such position was recently taken up by a former Queensland Health specialist).

During the site visits, a number of junior doctors pointed out that they earned less than graduates in other professions and some tradespeople, despite having undertaken many more years of education and training. The Review team will investigate this claim for the final report to determine comparative training requirements and incomes for medical and other graduates and junior tradespeople.

Amongst the allied health professions, the Review team is still seeking comparative data on interstate public sector salaries. For most allied health professions, Queensland Health advises that it offers equivalent or competitive remuneration relative to community,

private and other government employers. The one exception is pharmacy, where private sector employment offers significantly better remuneration. Some professions such as audiology, dietetics, occupational therapy, physiotherapy, speech therapy, psychology and podiatry have a strong private practice culture, whilst private employers of radiographers, sonographers and radiation therapists have more flexibility than the public sector to offer increased remuneration in times of workforce shortage.

Queensland Health dentists generally enjoy comparable remuneration to their interstate counterparts but do not earn as much as private salaried or self-employed private dentists.

In terms of staff morale, exit and satisfaction surveys are rare and ad hoc, and managed on a district by district basis. There is some evidence that districts do use this data in decision making about recruitment for some categories of staff. Again, the Review team has identified that there is no centralised system to gather, monitor or analyse staff satisfaction trends, including exit interviews of staff leaving the public health system. For the purpose of the Review, a staff satisfaction survey was undertaken in West Moreton and Rockhampton districts and in the Health Services Directorate in Corporate Office, results of which are analysed in Chapter 7 on culture.

Key findings from the consultation with clinical staff in health districts is outlined below, including feedback on factors that would assist in retaining existing clinicians in the public health system and assist in making Queensland Health an employer of choice.

## **5.2 Recruitment**

### **5.2.1 Key findings**

#### **Overall recruitment system**

There is a general view that the recruitment processes, which determine how, where and when advertisement occurs, do not assist with the successful recruitment of staff across the organisation. Our observations and results of consultation suggest that the current procedures actually hinder the process.

There is a pervading view that the current system does not assist in ensuring the most suitable person gets the job. This is more evident in regional and remote services. Because the one recruitment process applies for all categories of staff, the perception exists that some potential employees are disinclined to apply.

The recruitment process is consistently described as cumbersome, inflexible, slow to respond, inappropriate and lacking transparency. The inflexibility described is in relation to having the one policy and process for all categories of staff regardless of level, department or geographical location. There was also a view that written selection criteria and interviews do not test applicants' suitability for some operational and clinical roles.

Many staff alleged that the characteristics of this system go in some way in aiding management in keeping budgets under control. That is to say that if the process is slow and cumbersome, it takes longer to fill positions, therefore reducing budget pressures in some labour budgets. This is a perception which has been difficult to challenge in the districts visited. While some positions are backfilled, because of the nature of others, vacancies can exist for, in some cases, many months and in one case of a paediatric specialist, 18 months.

It was also reported that the districts were highly competitive or in a “war for staff”, with a tendency to try to “outbid” each other in an effort to attract desirable candidates for jobs. This appears in such examples as principal house officers being paid as senior medical officers, or PO3 allied health positions being upgraded to PO4 positions. So rather than use “flexibility in remuneration and incentives”, the system is manipulated in other covert ways.

The role of Shared Service Provider (SSP) districts was raised at many forums with staff who believe that the SSP or HR Department played a role in causing the delays in recruitment. The perception is that there are now many layers of authorisation which unnecessarily cause delays in advertising. It has been conveyed to the Review team that often HR advice is inconsistent and that the service offered has diminished. However, it could also be districts delaying tactics.

#### *Overseas Trained Doctors*

As noted previously, Queensland Health’s reliance on overseas trained doctors has been increasing over the past several years. This can be primarily attributed to insufficient numbers of locally trained doctors (see section 5.4 for overview of the limited numbers of medical student places in Queensland). This has led to a series of issues in terms of recruitment of such doctors. Districts have had to implement the recruitment process for overseas doctors either directly with possible employees or through recruitment agencies. The result in terms of successful recruitment of appropriate staff has varied between districts.

A centralised process has been proposed and a detailed action plan is being developed. The RAPTS (Recruitment, Assessment, Placement, Training and Support for International Medical Graduates) program will be the process for the recruitment of all overseas trained doctors regardless of their residency or registration status, for employees in Queensland Health.

Given the continuing shortage of locally trained doctors, it is clear that Queensland Health will continue to rely on the services of overseas trained doctors. It is a perception that this is a cheaper option than employing Australian doctors. Evidence shows that the employment of each overseas trained doctor can cost in the range of 10 – 20 thousand dollars, which includes a recruitment firm fee, relocation expenses, including moving of the family and assisted accommodation upon arrival. It is difficult to see that this could be viewed as a viable financial alternative.

Evidence during site visits indicates that the districts require corporate assistance with a standardised approach to the employment of suitable overseas trained staff. Currently, overseas trained doctors are not credentialed until they arrive to take up positions. Credentialing will be a requirement before appointment under the RAPTS program.

Internationally, there is some evidence that the current publicity around overseas trained doctors and some of the changes associated with Area of Need certification is making Queensland unattractive. It is therefore possible that service provision, particularly in provincial and rural areas may decline as the ability to attract clinicians in these centres diminishes.

The effect of the current well publicised issues of patient safety and bullying in Queensland Health has obviously damaged the reputation of the department as an employer. Anecdotal evidence supports that staff are now deciding to leave because the reputation issues around Queensland Health have become the “tipping point” for the decision.

This issue of reputation is likely to be most keenly felt in those areas exposed to most recruiting. History from other inquiries suggests that attracting suitable leaders and staff to Bundaberg may be a big problem for some time. Discussion with people involved in the King Edward Inquiry (Perth) and more recently Campbelltown (Sydney) suggests that Bundaberg may have exceptional difficulty over many years attracting executives and clinicians. Both King Edward and Campbelltown hospitals experienced prolonged vacancies at executive nursing levels after the conclusion of their inquiries. This comment is not presupposing the outcome of other inquiries but simply reflecting the known effect of reputational issues on staffing.

Feedback also suggests that permanent staff specialists are hopeful that forthcoming enterprise bargaining negotiations may significantly enhance their salary and working conditions. They confirm that if the outcome of their negotiations is not perceived positively, then this will significantly worsen current workforce capability and reduce service provision.

#### *Challenges in regional and remote districts*

There is a clear disparity between the ability of different districts to attract staff. Where there are obvious life style advantages of living in a certain geographical area, the problems are less evident eg Brisbane, Cairns and the Gold Coast. The problems of recruitment are also less evident where there is a critical mass of services, either in terms of the size of facility and the number of services being provided, or where there are strong clinical links between supporting services and facilities.

Regional areas are now continually experiencing the recruitment problems which until a few years ago, were quarantined to the rural and remote areas. These problems include:

- Inability to attract Australian graduates to hospital roles in regional hospitals as Registrars or senior medical officers.
- Districts reporting difficulty in attracting visiting medical officers to the public system. However, the perception by visiting medical officers in the districts visited by the Review team was that Queensland Health does not want or value them and instead prefers to employ full time staff specialists rather than visiting medical officers.
- Difficulty in being able to offer adequate working conditions in terms of on call responsibilities and registrar support.

In terms of other professional groups, the problems are mirrored. There is little incentive for nursing and allied health staff to move to the more geographically dispersed areas of Queensland and more limited career paths in smaller centres. They are increasingly resistant to working in isolation with limited support from Australian trained doctors. The level of responsibility they have to carry is seen as unacceptable. They report numerous instances of the system being stretched beyond safe limits.

Where nurses are recruited, it is usually in those places that attract an incentive package. The rural and remote incentive packages only apply to nursing and only in some identified areas. The district managers have no discretion in offering incentive packages. However, it is evident that some positions are graded at higher levels in some districts, in order to attract applicants. Clear examples of this practice exist across the state.

#### *Accommodating flexible working conditions*

There is often inflexibility in terms of the working conditions offered to nursing staff. For example, some staff want part-time and flexible hours to meet family needs. The Review team was given examples where nursing services were not prepared to show flexibility in employment. Equally, there were districts where nurses considered that full-time staff were disadvantaged and received the less desirable shifts because day shifts tended to be given to part-time staff to accommodate family needs. Most significantly, patients complain they do not see the same nurse twice during their hospital stay, raising concerns about continuity and proper management of care.

### **Specific issues relating to recruitment**

#### *Advertising*

Queensland Health is bound by the Guide to Queensland Government Advertising (Department of the Premier and Cabinet, March 2005). Once a vacancy is identified, a request to advertise form and Job Description is sent to Human Resources. The District Manager is required to authorise advertisement. All requests for advertising must go through Staff Search Data Services in Corporate Office to ascertain if there are redeployees suitable for the position. This requirement applies to clinical and non-clinical vacancies. There is evidence to suggest that this process can take up to three months.

If no redeployees are identified, the vacancy is then advertised. If a medical vacancy is advertised in Australia and does not attract any applicants, then the international recruitment process begins to recruit an overseas trained doctor through the engagement of a pre-qualified search firm.

Recruitment of interns and resident medical officers is complicated by the fact that they are employed on 12 month contracts in all states and territories. This leads to a cyclical problem of each state vying for first placement of advertisements in order to entice graduates interstate, and potential staff perceiving disadvantage by having to apply earlier and earlier for jobs.

The current government policy restricts Queensland Health from advertising outside the guidelines. The current advertising style is not viewed as attractive or appealing, limited information is given and is not at all competitive with other states. It is perceived that Queensland Health does not see advertising as an opportunity to “sell” itself to potential employees. Staff believe that Queensland Health is too bound by the process rather than trying to find creative ways of ensuring we get the best candidate for the job. Advertising

is a proven poor method of seeking Australian trained doctors. Applicants are more likely to be drawn through local contacts and hospitals with reputations for clinical excellence and teaching and research opportunities.

#### *Remuneration*

Staff consistently stated that Queensland Health salaries for some professional groups lag behind other states (see earlier discussion for interstate and private sector comparisons). Whilst many staff felt this was an issue, it was also perceived that Queensland Health could make some concessions in this area but chose not to. There were numerous examples given to demonstrate the deficiencies in the remuneration system across Queensland Health.

Some staff indicated that the system of evaluating positions (the Job Evaluation Management System [JEMS] process) is neither transparently nor consistently applied. Many staff do not have confidence that this system meets the needs of the individuals or the department.

The Nurses Career Structure negotiated in the MX Award, also lacks the support of many nurses. Lack of transparency and consistent application were repeatedly cited by nurses across Queensland Health. The Review team were shown examples where like positions were evaluated differently in several districts. Whilst there is a process in place to consider cases where nurses believe their positions should have been regraded, many staff lack the confidence that this approach will be of assistance to them.

Many believed that there is capacity for Queensland Health to apply some flexibility in those areas which relate in an indirect way to remuneration such as access to study leave etc.

#### *Accommodation*

Subsidised accommodation is an expectation of most new employees going to centres away from the south east corner. Districts with the capacity to offer accommodation have a distinct advantage over those who are less able to offer it. The types and standards of accommodation offered are not consistent across the state. Nor is the process for offering accommodation consistent. For example, in one case, a policy exists that accommodation will be offered for a period of time, but often the policy is not applied consistently across streams of staff.

In one regional area, a doctor suggested that Queensland Health could consider offering mortgage assistance in addition to rental assistance, as staff purchasing a home were making a longer-term commitment to living in the area. Such an initiative could be weighted in favour of more remote centres to aid in retention.

#### *Specialty staffing shortages*

There is evidence to suggest that Queensland faces shortages in some specific specialties. According to data published by the Australian Medical Workforce Advisory Committee, Queensland has difficulty reaching recommended medical specialist numbers in gastroenterology; haematology; medical oncology; ear nose and throat (ENT); orthopaedic surgery; emergency medicine; obstetrics and gynaecology; pathology; psychiatry; and radiology.

According to the Australian Health Workforce Advisory Committee 2003-04 annual report, increased university places for nursing and dentistry do not meet recommended levels to address workforce shortages and areas of shortage which are considered key priorities include: critical care nursing, midwifery and mental health nursing. Additional information regarding Queensland-specific nursing and allied health shortages will be sought for the final report.

On site visits, the Review team was also advised of shortages in both medical, and nursing staff in neonatology and intensive care (particularly outside the major metropolitan hospitals), whilst medical shortages were described in neurosurgery, paediatrics, and mental health. Visits also identified many allied health vacancies both in metropolitan and regional centres. Pharmacy vacancies for example exist in both Metropolitan and Regional centres.

Staff feel that whilst the difficulties are well known, Queensland Health appears to not be taking any direct action to improve the department's capacity to attract staff.

### 5.2.2 Principles for consideration

- An approach that allows local flexibility in terms of how recruitment can occur in a State context of service and workforce planning and take account of proposals in respect of workforce redesign (see section 5.6);
- In times of constrained supply, consider statewide interests in recruiting and integrate efforts to avoid competition across districts;
- To support evidence based planning, key indicators of recruitment pressures such as vacancy rates by location and discipline should be systematically monitored and analysed;
- Health professionals are most likely to be attracted to hospitals with a reputation not only for professional excellence, clinical complexity, teaching and research but for a reputation of being a good employer;
- Recruitment systems should be responsive to the need for speedy advertising and interviewing timeframes and be competitive with the timing and conditions in other states;
- Ensure that position descriptions accurately reflect job requirements;
- Ensure a standardised process for the recruitment, assessment, placement, training and support of overseas trained doctors based on minimum standards of knowledge, skills, abilities, communication and cultural safety; and
- Ensure that related matters such as the terms and conditions of employment of overseas trained doctors and the courses provided by the Centre for International Medical Graduates are directed to supporting overseas trained doctors to achieving the Australian Standard via the Australian Medical Council certification or Fellowship of an Australian College

## 5.3 Retention

### 5.3.1 Key findings

The Review found that staff retention was affected by a number of factors including workloads, remuneration, management support, budget constraints, and opportunities to develop collegiate networks within and across professional groups. In general, the key concerns that emerged during consultation across the various disciplines were:

- Clinical staff felt stretched and described a “pressure cooker” environment which could not further accommodate increasing demand and additional responsibilities, leading them to feel that they are working unsafe hours and practices. Medical staff reported working hours above those recommended for safe practice due to patient demand and staff shortages and identified rosters for weekend and night shifts as a particular problem;
- Lack of response to concerns being raised with administrators in respect of service needs, staffing levels and safe practice;
- Limited or no input into clinically related decisions eg equipment replacement or repair, introduction of new practice, interventions or testing;
- A perception that decisions were driven primarily by budget constraints at the expense of quality care and patient safety and anger that new resources were not flowing into clinical areas at a time of budget surplus;
- Not having alternative avenues to resolve concerns given Code of Conduct limitations on raising concerns outside direct lines of reporting;
- Concern that staff complaints, grievance and performance management processes were not dealt with in a timely way and were not successfully addressing poor performance or removing bullies – particularly at senior levels;
- Frustration with the amount of mandatory training required to support Corporate Office policies, which reduced opportunities for clinical training;
- Difficulty accessing training or taking leave entitlements due to limitations on staff backfilling;
- Concern that high clinical workloads are reducing time available to supervise junior clinicians; and
- A common perception that despite care being available in public hospitals seven days a week, 24 hours a day, activities are focussed around standard business hours. Rostering practice seem to support this, with all administrative and the bulk of medical staff rostered within business hours. Hospitals in effect are a Monday to Friday operation.

## Medical staff

### *Salaried staff*

Senior medical staff identified the following factors influencing their decision to work in the public health system: maintenance of clinical and collegiate networks; opportunity to see more complex and challenging cases and opportunities for teaching and research. Junior doctors (including residents and registrars) must work in the Queensland public system to meet pre-requisite practice requirements for GP or other specialist training programs. Many indicated their intention to move into private practice upon attaining requisite qualifications for a variety of reasons.

Doctors at forums around Queensland were generally highly disillusioned and felt unsupported by senior health administrators. In many of the sites visited, there was an “us and them” mentality between doctors and administrators, even where administrators were themselves doctors who no longer practiced. [In smaller sites the high clinical workload of the Medical Superintendent meant that the position tended not to be regarded as administrative.] Key concerns included:

- Difficulty accessing award entitlements to study leave including timeliness of approvals, large amounts of paperwork, eight layers of requisite approval and restrictions on travel and accommodation arrangements imposed by Queensland Health.
- Rostering of doctors was reported to be inappropriate or inadequate in some cases in respect of both Australian trained junior doctors and overseas trained doctors not necessarily having the skill level or experience to deal with the tasks required eg night duty where specialist support may not be readily available. Some overseas trained doctors reported being placed on night shift without sufficient orientation, induction or support.
- For senior staff specialists and visiting medical officers, not having sufficient time for teaching or research due to high clinical workload and working unsafe hours. This was particularly noticeable in regional and remote areas with unsustainable levels of on call due to workforce shortages.
- Many junior medical staff felt exposed due to lack of specialist availability for supervision and did not believe they were working within safe hours policy eg
  - Recreation leave requests were often rejected with large accumulation of doctor leave.
  - There is evidence that teaching accreditation for some medical specialties at certain hospitals has been withdrawn and/or placed on notice.
- Lack of flexible working options eg working 40 hours in 4 days.
- High risk exposure due to vacancies and reliance on overseas trained doctors, including in junior and registrar positions.
- No basic workplace amenities – eg a tea room to discuss work issues with colleagues, parking spaces, lockers for junior doctors, offices for staff specialists and personal space for interns, residents or registrars.

### *Visiting medical officers (VMOs)*

There are some tensions highlighted between staff specialists and VMOs. There has also been some recent public commentary extolling the virtues of VMOs over full time employees. Such comments are unhelpful and will need to be addressed and dispelled within the hospital sector. VMOs and senior staff specialists receive different remuneration and entitlements under current enterprise bargaining arrangements. The inclusion of VMOs in the State's enterprise bargaining arrangements is unusual and in contrast to the contract based approach used in most other jurisdictions.

VMOs throughout the State:

- Expressed a willingness to contribute more to the public health system
- Shared a consistent experience of feeling completely marginalised from the public health system, perceiving subtle and overt signs of being undervalued and feeling excluded from much communication and opportunity for input beyond clinical work (eg advisory committees)
- Pointed out that Queensland Health had consistently reduced VMO hours and substituted overseas trained doctors
- Re-affirmed their willingness to teach
- In some regional centres, VMOs reported that they were not afforded the opportunity to work sessional time but were asked to contribute to the callout and after hours roster.

### **Nursing staff**

Nurses represent a significant number of Queensland Health employees. In 2001, nurses represented just over 40 percent of the total Queensland Health workforce. Of these, over 50 percent work part-time and over 90 percent are female. Nursing numbers in Queensland are lower than other states.

Nurses identified the following factors as influencing their decision to work in the public system: flexibility; job security and associated benefits; better remuneration as compared with private sector opportunities; proximity to home and family (in regional areas). Nurses expressed a view that they are behind other states in remuneration and working conditions. Areas that require attention include addressing workload concerns, improving access to staff education and development and better workforce planning.

Nursing staff similarly described an "us and them" mentality between clinicians and administrators and indicated they felt overworked and unable to stretch any further. Key concerns included:

- Lack of financial incentive to progress to nurse unit manager (NUM) positions given generous penalty rates for junior nurses and "role creep" resulting in NUMs spending increasing amounts of time on administrative, reporting and data entry
- Lack of equity compared with medical staff in respect of not having award entitlements to study leave or other benefits such as car parks.
- In some regional areas, senior nurses felt exposed because they were the senior operative providing most support to junior doctors, especially those from other cultures with poor English language skills

- Concern that graduate nurses were not work ready and, together with students nurses, placed a burden on senior nursing
- For graduate nurses, feeling exposed due to lack of supervision
- In some districts, lack of onsite child care to support working parents.

### **Allied health**

Allied health staff similarly felt overworked and stretched. Key concerns included:

- Poor career path as compared with nurses, with limited advancement in the clinical stream and a perception that many management jobs are being created in the nursing stream
- Lack of equity compared with: medical staff in respect of not having award entitlements to study leave or other benefits such as car parks; and nursing staff in respect of a qualification allowance.

There has previously been little growth funding available within Queensland Health to allow for growth in numbers of allied health professionals employed within facilities and/or programs. Commonwealth funding is often quarantined and limited to specific programs such as community based rehabilitation.

Formalised supervision programs are a feature of many of the allied health professions. Limited numbers means limited supervision of these professionals as well as for junior allied health professionals. Added to this is the increased burden of under resourced clinical placement of allied health students from various Queensland universities.

Queensland Health has not been considered an employer of choice, rather one of necessity to gain vital post registration experience and then leave for better jobs and conditions. The lack of a rewarding career path for allied health professionals is a barrier to keeping qualified staff in the system. The continual turnaround of more junior staff in some areas is a disincentive for the more experienced staff to stay.

### **Dentists**

Dentists identified remuneration (see section 5.1) and job satisfaction as key issues impacting on retention. Dentists report that much of the work in Queensland Health is less interesting because of the volume of emergencies that are required to be dealt with (up to 80 percent of workload). The nature of this work is necessarily less planned and less interesting. It also involves the management of clients who are often angry and frustrated at the system's capacity to respond to their emergency needs.

Options around contracting out some emergency work would be a "circuit breaker" which dentists believe would enable an opportunity to allow dentists to undertake some of the more complex procedures.

### 5.3.2 Principles for consideration

Based on consultation findings, strategies to retain the highly skilled and dedicated clinicians already working in Queensland Health should be premised on some key principles including:

- Immediate steps to begin to reaffirm to all clinical staff that they are valued
- To support evidence based workforce planning and management, indicators of staff satisfaction should be systematically monitored and analysed eg absenteeism, turnover, results of staff surveys
- Acknowledgement of the complexities of leadership and change management in contemporary health systems and implementation of upskilling initiatives for middle and senior managers in clinical areas
- Some localised flexibility to negotiate remuneration and benefits, particularly for medical staff in regional and remote areas
- Workloads, rostering and resourcing should factor in time for skill development, supervision and non-clinical responsibilities
- Decision making and budget management should, as far as possible, be devolved to clinicians with appropriate support
- Decisions impacting on clinical areas made by senior administrators, including budget allocations, should be transparent and include reasons for decisions
- New Corporate Office policies should be appropriately resourced and targeted so as not to place additional burdens on clinicians
- Clinical rotations and exchanges should be supported to assist staff in regional services and promote workforce renewal
- Improved career pathways for nursing and allied health professionals in clinical streams
- Working hours and conditions should be safe and flexible to support expectations of the contemporary workforce and career mobility
- Where possible, there should be equity across professional groups in respect of developmental opportunities eg study leave
- Provide staff with basic employee entitlements such as meeting and office spaces etc.

## 5.4 Education, Teaching and Training

Queensland's public health sector has traditionally been the training site for all local doctors. Queensland's public and private health systems will cease to perform to expectation if sufficient trained clinicians are not available. It is obvious that a highly skilled and trained health workforce is crucial in providing quality health services to the community, now and into the future in the public, private and non-government sectors.

Access to appropriate training and supervision is particularly important for new graduates entering the health workforce to ensure they have the appropriate level of skills and expertise to practise safely and competently. Ongoing education and access to professional development for senior clinicians are also important in maintaining skill levels and assisting staff to cope with rapid advances in technology and practice.

#### 5.4.1 Key findings

Education arrangements differ between the various health professional groups working in Queensland Health. One suggestion that emerged during consultations and in reviewing health workforce literature was establishing some shared university based education for all health professionals to ensure a core skill set across professional groups, foster cross-disciplinary team work and facilitate mobility between professions. However, an alternative view was that professional groups are separately educated at university for good reasons but that opportunities for multi-disciplinary training and continuing education in workplace settings should be fully explored to foster team work on a facility basis.

In terms of existing training arrangements, the medical profession has the most formalised arrangements involving specialist based public hospital training programs where doctors undertake an internship period in a teaching hospital and then go on to further vocational training which in the case of some medical specialists can take a further 10 years or more.

Medical training arrangements are similar across the country and there are a number of national bodies involved including the Australian Medical Colleges, the Commonwealth government, and the Australian Medical Workforce Advisory Committee.

Increasing pressures on service delivery in Queensland Health have highlighted the tension that can sometimes exist between service delivery and training objectives in the system. Many clinicians claim that Queensland Health is neglecting training and education as it struggles to cope with increasing demands for services. Problems reported by the medical profession include:

- lack of coordination of training placements and programs and lack of local leaders for medical teaching at district level
- lack of adequate supervision and support of junior staff due to resourcing constraints and increasing service demands
- insufficient numbers of medical training positions with Queensland failing to meet Australian Medical Workforce Advisory Committee recommendations in a number of key specialties
- inadequacies in training for overseas trained doctors with significant variations in the skills and abilities of graduates seeking registration
- failure to take into account training and supervision requirements when determining numbers of senior medical staff positions
- insufficient resourcing of medical educators and lack of recognition of the role of Directors of Clinical Training and Medical Education officers

- restrictions on time allowed to be spent by visiting medical officers training junior staff
- lack of mentoring support particularly in rural and remote areas.

The Medical Board is responsible for accrediting intern training programs run by all hospitals. The Post-Graduate Medical Education Foundation of Queensland (PMEFQ), an external body to Queensland Health, undertakes the accreditation on behalf of the Medical Board and checks standards are being met. The PMEFQ is also involved in training for doctors apart from interns which it undertakes independently.

Directors of Clinical Training and Medical Education Officers are responsible for junior doctor training in the hospital setting. While the aim of accreditation and training is to ensure that all hospitals have sufficient experience, education and supervision resources to allow junior doctors to meet their training needs, the experience of junior doctors can vary depending on the individual facility and the availability of senior staff.

After completing two years hospital training, most junior doctors will seek admission to a vocational training program. The medical colleges are responsible for accrediting vocational specialist training positions in public hospitals. Queensland is not meeting the Australian Medical Workforce Advisory Committee recommendations for training numbers in a significant number of specialties including gastroenterology, haematology, medical oncology, ear, nose and throat, orthopaedic surgery, emergency medicine, obstetrics and gynaecology, pathology, psychiatry and radiology. These are also areas where national shortages are being experienced.

Overall, the number of vocational medical training positions in Queensland increased by 11 percent from 947 in 1997 to 1,051 in 2004 while the number rose nationally by 12.6 percent from 5,665 to 6,378 positions over the same period. As the table below shows, Queensland has relatively lower levels of medical training positions as do Western Australia and Tasmania. New South Wales and Victoria, on the other hand, have shares of medical training places higher than their respective population shares.

**Total number of recognised vocational training positions/trainees in programs, by State and Territory 1997-2004**

	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	AUST
<b>1997</b>	1,827	1,447	947	497	540	115	70	164	5,665
<b>1998</b>	1,825	1,407	939	534	534	108	43	166	5,564
<b>1999</b>	1,839	1,438	950	476	555	121	79	146	5,604
<b>2000</b>	1,826	1,487	947	498	581	112	77	138	5,666
<b>2001</b>	1,839	1,472	930	480	572	116	80	148	5,637
<b>2002</b>	1,971	1,524	968	502	556	109	86	140	5,856
<b>2003</b>	2,044	1,656	1,020	543	562	94	99	100	6,118
<b>2004</b>	2,185	1,786	1,051	531	565	103	81	76	6,378
% Share	34.2	28	16.5	8.3	8.9	1.6	1.3	1.2	100
% Pop'n	33.6	24.7	19.2	7.7	9.8	2.4	1	1.6	100

Source: Medical Training Review Panel Reports 1 to 8

The lower number of medical training places in Queensland has been attributed to the fact that up until recently, only one tertiary facility, the University of Queensland, provided under-graduate degree courses in medicine. This situation is about to change as the first graduates from James Cook University enter the system next year. Medical courses have also been established at Griffith and Bond Universities, with the first graduates entering the workforce in 2009 and 2010.

The supply of medical graduates into the system is expected to double by 2010 with the expansion of medical courses across the State's universities. This will pose major challenges to Queensland's public hospital system in terms of the need for additional training positions and the extra demands for supervision which will be placed on senior specialist staff.

This has led to questions around the continued suitability of the current medical training system which is based on an apprentice type model and undertaken predominantly in metropolitan and regional public teaching hospitals. The model requires that junior doctors spend specified blocks of time working in different clinical settings under the supervision of a senior staff member.

If increasing graduate numbers are accompanied by worsening senior medical staff shortages then this model may be difficult to sustain. While medical training has traditionally been undertaken in the public sector, some training has commenced in the private sector in Queensland. Queensland Health has recently entered into arrangements to allow training for surgical registrars to be shared between the public and private sectors. This trend is likely to continue with the growth in the private sector and the increasing numbers of training places required.

Accreditation for some anatomical pathology training positions was withdrawn from Queensland Health in 2003 by the Royal College of Pathologists due to concerns about the sufficiency of numbers of senior pathology staff but has since been reinstated. The Commonwealth has also recently approved two additional pathology training positions in the private sector in response to national shortages.

In terms of continuing education, as noted under section 5.3, doctors report major frustrations with the convoluted approval processes required for them to attend overseas conferences and to take study leave. These processes act as a deterrent to professional development for senior staff and are inconsistent with a culture of continuous improvement and learning.

There are numerous players involved in medical training including the Commonwealth and State Governments, universities, colleges, registration boards, professional associations, and the private sector. The multiplicity of players and their differing objectives makes long term coordinated planning critical in addressing future medical training needs.

### **Nursing and Allied Health**

In service training arrangements following university graduation for nurses and allied health professionals are not as formalised and vary from State to State and within the State, between the various health facilities. Graduate nurses receive registration upon completion of their degree. However, some hospitals require that nurses complete the Queensland Health Transition to Nursing package before they can work independently, while other facilities have less structured arrangements and on the job training. Training for allied health professionals is not as extensive and well developed as it is for the nursing and medical professions.

Queensland Health has implemented a number of strategies to improve training and education for the nursing profession including the development of a Statewide Nursing

Staff Development Framework to provide a coordinated direction for training across the State. Nurse educators are employed in most of the medium and larger sized facilities and there has been a major emphasis on developing transition programs for new graduate nurses and nurses re-entering the workforce. Special programs for nurses working in rural and remote areas have also been developed.

Notwithstanding these efforts, there is considerable variation in the delivery and quality of training undertaken across the Districts. Generally, access to training is restricted in rural and remote areas and there can be disparities in availability between community and acute settings. Some Districts have put in place a range of training programs including specific skills development programs for Emergency Department and Intensive Care nurses while in other facilities, there are no specific training or education programs available.

Differences can be attributed to infrastructure, availability of nurse educators, and the level of staff and organisational commitment to training and professional development. The increasing casualisation of the nursing workforce also presents challenges for training as resources are usually allocated on the basis of the number of full time equivalent staff employed.

In addition to issues identified under section 5.3, major concerns raised by nurses with regard to training across Queensland Health include:

- the inability to backfill positions and release staff for training
- a lack of time to adequately supervise junior staff
- perceived inadequacies with the work-readiness of graduate nurses
- insufficient resourcing and lack of incentives for ongoing training
- limited application of the qualification allowance for nurses, meaning there is no monetary recognition of some qualifications
- transition programs place an additional burden on clinical staff who are expected to undertake more formal educator roles on top of clinical workload
- a focus on administrative mandatory training, frequently emanating from Corporate Office, which is not risk based or appropriately targeted, is seen as of little value by staff and is not related to higher priority clinical requirements
- at one district, nurses said there had been no training clinically in the previous two years.

Allied health comprises a diverse range of professionals with different training needs and requirements. While Queensland Health has recognised the need for improved training for allied health professionals, as with nurses, the application of training strategies can be variable across the State. The relatively smaller numbers of each professional group within the allied health profession makes mentoring support difficult particularly in the smaller Health Service Districts where there may be only one or two practitioners.

Common complaints from allied health staff include increasing patient demands which limits time available to support junior staff, inability to backfill positions and attend training, and difficulties associated with meeting specific registration board requirements regarding supervised practice. The Review team also noted the industrial action which

occurred in 2004 where allied health staff withdrew supervision for clinical placements due to concerns about lack of resourcing to support supervision. Allied health staff also report dissatisfaction with their preparation for the work environment and a lack of support and preparation for working in rural and remote areas. The majority of professional development undertaken by allied health employees is self-funded which also acts as a major disincentive for professionals to keep their skills up to date.

Queensland Health opened its new Skills Development Centre (SDC) in September 2004. It is a world class facility with sophisticated virtual reality simulation training equipment. In its planning phases it was thought that this unit would operate on a predominantly fee for service basis and its management structure and focus gives significant attention to the need to generate revenue.

There is currently some criticism that this centre is not being fully utilized although it is acknowledged that curriculum is still being developed.

The Centre for International Medical Graduates, (CIMG) previously run by UQ has been incorporated into the Centre and staff employed and located with Queensland Health and the Skills Development Centre since July 2004. The CIMG prepares permanent resident overseas trained doctors for Australian registration and assists them to find employment.

Concerns have been raised with the Review about the adequacy of the current preparation being given to overseas graduates and the variation in skills and competencies. Opportunities to enhance the role of the Skills Development Centre to supplement the traditional apprentice based medical training model and to strengthen the role of the CIMG will be further examined as part of the Review.

#### **5.4.2 Principles for consideration**

- Queensland Health would have a culture which values training and professional development for its workforce and takes action to ensure this occurs
- Teaching and training would be seen as part of the core activities of health services and be made available on a needs basis across professional groups and services
- Where possible and appropriate, cross-disciplinary training would be encouraged to foster effective multi-disciplinary team work and support mobility between professional groups
- Improved coordination and collaboration between the various entities involved in medical training is required to meet the challenges associated with increasing numbers of graduates
- Training for overseas trained doctors would be based on minimum standards of knowledge, skills, abilities, communication and cultural safety
- Opportunities would be examined for greater private and non-government involvement in medical training to relieve pressure on the public system
- Training would be closely linked to service delivery needs and quality and safety improvement programs
- Employer and employee commit to and fulfil their respective teaching, educating, training and development roles and responsibilities.

## 5.5 Clinical leadership

In an environment of increasing service demands, workforce shortages and rapid advances in technology and where staff are feeling overworked and overburdened, clinical leadership is critical in inspiring staff to strive for excellence and in promoting safety and quality in health care. While there is no agreed common definition of clinical leadership, the concept encompasses a range of attributes displayed by clinicians who are able to inspire, influence and lead their colleagues and promulgate best practice at the service interface with patients. Staff want to be part of systems which have respected and capable leaders.

This ability to lead and influence can occur in formal and informal ways. Clinicians can lead and influence as part of their formal organisational position or through the relationships they develop with their colleagues. In order to encourage continuous improvements in performance and a culture which promotes quality and safety, it is imperative that Queensland Health fosters and develops clinical leadership throughout the organisation. An earlier decision to remove doctor meeting spaces in all public hospitals was one way of reducing the potential for doctors to lead and influence through informal methods.

District visits confirmed there is enormous need to reinforce and recognise the importance of clinical leadership and the need to draw on, and improve the skills and abilities of senior clinicians. There are a number of challenges in pursuing this agenda inherent in the operation of the current system which need to be addressed in order to sustain a safe and quality health service in Queensland.

There has been a shift towards greater budget devolution and responsibility to senior clinicians which has been accompanied by increased administrative tasks and paper work. Nurse Unit Managers estimate they spend a significant amount of their time undertaking administrative type duties. Doctors and allied health staff are experiencing similar increases in the level of administrative tasks required to be undertaken and complain of having to spend more and more time dealing with various information management systems.

There is a strongly held view amongst clinicians that the high administrative workload required of senior clinicians reduces the time available for clinical leadership in the hospitals. While Queensland Health may espouse clinical leadership values and principles, the translation into action is being hampered by other demands on clinicians which are given greater priority. Clinical leadership is not formally incorporated or encouraged in working roles - in fact, there are some instances where it has been overtly and covertly discouraged. Clinicians are not given adequate leadership development and mentoring.

There is also a tension between the roles played by administrators and clinicians in the area of clinical leadership. For example, there is a tendency to view clinicians who become administrators as no longer being clinically focussed and with little understanding of service delivery pressures at the coalface. There is a perception that clinical managers are only interested in budget performance and not clinical quality and safety.

### 5.5.1 Principles for consideration

- Systems and practices are in place that stimulate, encourage and promote the concept of clinical leadership
- Clinical leaders articulate a clear vision for their discipline, align and coordinate leadership activities across disciplines and motivate and enthuse their staff
- Clinical leaders model high standards of practice and drive cultural change
- Workplaces empower and support senior clinical staff to focus on coaching, mentoring and leadership of the clinical workforce rather than administrative tasks
- The system identifies and invests in clinical leaders and provides support through formal professional leadership development, training and support
- Changes to clinical processes are clinician driven and clinicians take a greater role in resource allocation decisions
- Clinicians are involved in setting the safety and quality agenda and taking responsibility for implementing that agenda.

## 5.6 *Measures to assist in improving the availability of clinicians*

A range of views were offered during the consultations on measures to assist in improving the availability of clinicians. This section first discusses issues around recruitment and credentialing of overseas trained doctors, and then outlines key findings arising from the Review team's site visits.

It should be noted from the outset that health workforce pressures are such that no single solution will resolve current or future shortages. The Review team has therefore canvassed a range of options for further analysis and review.

### 5.6.1 Overseas trained doctors

The current requirement for Queensland Health to employ doctors who do not have Australian qualifications is likely to continue for many years. The recent additional medical schools, whilst welcome, will not significantly begin to assist this situation until 2009 with additional trained doctors becoming available between 2010 and 2017.

There are many initiatives that can be undertaken which would reduce the volume of overseas trained doctors required however it is difficult to construct a scenario that abolishes totally the need for some.

It is clear that the current recruiting process, using multiple contracted agents or personal contacts does not provide an adequate platform to ensure that staff employed have the cultural, language and clinical skills required to provide the Queensland community with confidence in their skills. There has been no mandatory requirement for the induction of these overseas trained doctors to include issues of cultural awareness or other specific likely knowledge deficits.

Currently, once overseas trained doctors are employed by Queensland Health there is no mandated process for providing ongoing assessment, training and support which is additional to that provided to fully (Australian) registered doctors. This is unacceptable given that the provisional registration (Area of Need) under which they work, acknowledge that they have not attained the national Australian standard by examination which would allow full, not conditional registration.

The Medical Board has recently announced changes to their requirements for provisional registration. They are:

#### Pre Registration

- International computer-administered screening examination (to be implemented from July 2006)
- On-line primary source verification of all qualifications (to be implemented from July 2006)
- English language proficiency (was implemented from May 2004)
- Review experience and background including relevant College assessment of experience
- Assess evidence of fitness for registration, including character, certificates of good standing and references
- Assess job description according to categories based on level of decision making, clinical profile, available supports and supervision
- Individual assessment of fitness for the described position and, based on that assessment, require a clinical interview or a clinical examination

#### Post Registration

- Initial period under direct supervision (1-3 months)
- Mandatory professional development and training within a defined period about such matters as the legislative framework applying in the jurisdiction, Aboriginal health, Women's Health, cross cultural training, Health Insurance Commission requirements and working in the Australian health care system
- Completion of the Australian Medical Council ('AMC') examination or specialist recognition within a defined period of years from initial area of need registration
- Standardized work reports after one month, three months, six months and twelve months from the initial date of registration

Currently, work is being undertaken within Queensland Health to propose profound changes to the process of recruiting, assessing, placing, training and supporting overseas trained doctors.

Queensland Health is proposing to implement a standardised process for the recruitment, assessment, placement, training and support of overseas trained doctors based on minimum standards of knowledge, skills, abilities, communication and cultural safety (RAPTS Program).

RAPTS would be the process for recruitment of all overseas trained doctors regardless of their residency or registration status, for employment in Queensland Health. RAPTS could be administered centrally or in satellite sites.

Overseas trained doctors seeking to work in Queensland Health would either apply for specific vacancies or lodge expressions of interest with RAPTS. The screening process, as the first part of the recruitment phase, would ensure that the applicant has undergone a credential check, met English language requirements and passed the online screening examination (from July 2006), each of which is mandated by the Medical Board of Queensland. The curriculum vitae supplied by the applicant would be screened by appropriately qualified personnel (different personnel depending on the level and specialty of position they are applying for). The applicant would then undergo a clinical interview to assess knowledge, skills, abilities, communication and cultural safety. This interview will be conducted over the telephone by a panel of appropriate personnel. The outcome of the interview will be to determine suitability for employment at a particular level and locale based on the clinical decision making required of the position and the supervision requirements of the applicant. Offer of a job in Queensland Health would remain the responsibility of the employing facility.

Terms and conditions of employment of overseas trained doctors would support requirements to achieve Australian Medical Council certification and/or Fellowship of an Australian College within a specified time from first registration with the Medical Board of Queensland. Progress towards these Australian standards would be expected and monitored by the employing facility.

Prior to commencement of employment, all overseas trained doctors would undergo training as mandated by the Medical Board of Queensland in the areas of Aboriginal Health; Women's Health; the Australian and Queensland Health Care Systems; the Health Insurance Commission and Cross Cultural Issues. Queensland Health would also provide, prior to commencement of employment, a standardised orientation including such topics as patient safety and information on state wide systems such as pathology, radiology and prescribing. The opportunity and advantage of providing basic and advanced life support training or other clinical training, at this time, should be considered.

Support for overseas trained doctors would be provided via mentorship through Queensland Health and/or the Association of International Medical Graduates of Australia and New Zealand (AIMGANZ). Overseas trained doctors would be case managed with individual learning plans to facilitate achievement of AMC certification and/or Fellowship of an Australian College. The Centre for International Medical Graduates is the provider of educational courses to assist in preparing for the AMC MCQ and clinical examinations.

Obviously, this proposal works with and builds on the new requirements from the Medical Board.

*Implications of these Initiatives*

The many factors now being addressed around overseas trained doctors will change the current workforce situation.

The Medical Board initiatives and those proposed in the RAPTS program aim to provide additional requirements to improve the qualities of the overseas trained doctor staff seeing patients in Queensland Health. They also, over time, may give additional confidence to the population of Queensland that the overseas trained doctors they see will provide appropriate care.

Unfortunately there is already, and will continue to be an unwelcome consequence around the availability of clinicians to provide services. This is inevitable given the Queensland, Australian and global shortage of medical practitioners.

There is already documented evidence that the media issues around Bundaberg, the interruption to Area of Need applications and the new measures proposed by the Medical Board have, in some way diminished Queensland as a destination of choice for well trained overseas trained doctors who are much sought after globally. The proposed RAPTS process may or may not increase this problem.

There is no doubt that a number of well trained overseas trained doctors have withdrawn from previous commitments to commence work in Queensland Health in the latter six months of 2005. It is difficult to quantify the significance of this in terms of the inevitable reduction in services able to be provided. At the time of this interim report (30 June 2005) the situation with respect to recruitment is changing on a weekly basis.

It is therefore important that Queensland Health explore all reasonable options in terms of clinical practice delivery including new models of care to reduce Queensland's reliance on overseas trained doctors. Some of these options are discussed below in section 5.6.2.

There are a number of implications on service delivery arising from the current focus on issues in Queensland Health. It is becoming apparent that staff are reassessing risk and increasingly transferring patients to Brisbane for care. This is affecting tertiary service provision. This effect is most felt in the intensive care units of major tertiary facilities.

The need to increase the funding of tertiary intensive care services to allow additional staffed beds be made available needs urgent consideration.

In response to some of these implications, the Australian Medical Association (AMA) is finalising a proposal to put in place a system with the Specialist Colleges for additional mentoring and training of overseas trained doctors.

The newly implemented Queensland Medical Board requirements have increased the time required to employ a new overseas trained doctor. A potential gap now exists between cessation of contracts and employment of new doctors. This will be of particular significance for rural and remote services given their higher reliance on overseas trained doctors.

All data regarding overseas trained doctors, their placement, training and progress towards the general, specialist or general practice registration would be collected and collated to continually inform the RAPTS process and other workforce initiatives of Queensland Health.

## 5.6.2 Key findings

In addition to the suggestions outlined under sections 5.2 and 5.3 to improve incentives for recruitment and retention, two broad themes emerged through the consultations: better utilising the skills of the current workforce and increasing the number of clinicians available to provide services on behalf of Queensland Health. The Review team is considering all options at this stage of the Review.

### **Better utilising the current workforce**

#### *Aligning task complexity with required skills*

The current clinical workforce would be more available if required tasks are performed by those with the required skill to achieve these tasks safely. Currently tasks are performed based on very broad professional groupings (doctors, nurses, physiotherapists etc), each with specified roles. However, many tasks are best achieved by teams. The current model has been modified in a number of overseas health systems and, in Queensland, nurse practitioners are being trialled in a number of disciplines. During the site visits, clinicians highlighted examples of such changes including:

- Nurse practitioners enabling doctors to focus on higher order tasks
- Clinical pathways defining discharge parameters, progressive medical assessment and nurse initiated discharges
- Team nursing: aligning tasks with experience and training and allowing less skilled workers far less demanding tasks
- Much greater scope for allied health staff including radiographer reporting of certain kinds of images, physiotherapist assessment of skeletal issues
- Systems to encourage GPs to manage that part of the disease process that is appropriate eg referring GPs to complete procedural follow up visits thus freeing up specialists to focus on new cases
- Appropriate administrative assistance to do those necessary administrative tasks currently done by clinicians
- Surgical assistants who assist surgeons in theatre and perform less complex aspects of surgical procedures to free up the time of highly skilled surgeons.

Advice received from the two panels of eminent professionals established to assist the Review has incorporated the following key themes:

- There is frequent debate about the generalities of nurse practitioner/ physician assistant roles that leads to unhelpful comments such as “dumbing down medicine”
- When the specifics of what is envisaged is actually discussed within the health service team environment (doctors, nurse, allied health professional) the roles/duties envisaged have invariably resulted in complementary and more efficient practice, with necessary training and safeguards to ensure safety related to the experience of the personnel involved

- There is a difference between nurse practitioner (experienced nurses authorised in their own right to undertake certain procedures) trialled successfully in a number of positions to date within Queensland Health, and physician assistants or surgical assistants, who practice under the delegated authority of a medical practitioner or surgeon. One source of physician assistance can involve personnel (such as paramedics/ambulance officers) resulting in additional resource capacity

There are many who question whether current teaching and learning programs are sufficiently efficient or effective and claim education and teaching can be better planned, accelerated and time condensed.

During district visits, mixed views were offered on the above reforms. Some clinicians, particularly doctors who did not have experience of such reforms, did not believe that tasks should be devolved to other professional groups. However, clinicians with direct experience of some of these reforms tended to believe firmly that Queensland Health should extend scope of practice for nurses and allied health professionals as appropriate. This highlights the opportunity for those doctors who have a positive experience of this initiative to play a “champion” role in supporting any scope of practice reforms and assuring their peers that such reforms can be achieved without compromising patient safety.

#### *Redesigning the work practice*

There is a large amount of non-productive work done in all settings which arises because of the historical work patterns in health care. It would seem that there is little systematisation of the clinical care setting and little evidence of modern work flow reform which has improved the productivity of most non-health sectors.

The Review team observed high bed occupancy rates in many of the hospitals visited, leading to bed blockages, poor logistics and dysfunction in the system. To the concern of clinicians and patients, bed pressures led in some cases to inappropriate placements of patients eg men in women’s wards, elderly women in the maternity ward. Staff in the hospitals with sustained high occupancy rates considered they did not have the opportunity to even the flow of patients or experience “down time.”

A simple example is the lack of widespread implementation of outcome based clinical pathways into the health care work environment. A setting which did do this successfully not only improved the clinical care provided but simultaneously reduced the paperwork done by nurses by 44 percent. Put simply, well planned agreed pathways for patient care if implemented well, can replace much of the unnecessary repetitive, traditional paperwork currently done by staff, particularly nursing staff. Documentation is done by exception and is minimized.

It is likely that significant gains might be made in workforce availability if work redesign was implemented and essential non-clinical tasks were devolved to non-clinical categories of staff. To draw an analogy with the police force, there is an opportunity to “civilianise” some roles in the health system, supporting front line clinicians with basic roles such as roster clerks.

## **Increasing the number of clinicians available**

### *Pay and conditions*

As noted earlier in this chapter, income differentials between the public and private sector were repeatedly raised during consultations. There are significant income differentials between publicly employed staff specialists and those in private practice. There are also differentials when compared with interstate statutory health authorities (eg the Bendigo group), which have greater flexibility in negotiating remuneration packages. In terms of other professional groups, there is also a significant income differential between public and private pharmacists and dentists.

As noted under sections 5.2 and 5.3, the relative maldistribution of clinicians in the south-east corner of Queensland limits availability of clinicians in regional and rural areas. There was strong support for improving incentives to work in regional and remote areas, including improved accommodation, training, relieving arrangements and a sophisticated support process for families when they relocate to rural areas. There may be a role for local government in this area.

There were also suggestions to design career pathways that reward working for a specified term in a rural or remote setting. For example, creating appointment incentives for positions in tertiary hospitals following a term in more remote settings. Other suggestions to improve and increase service to rural and remote areas included increased use of metropolitan doctors through tele-medicine (eg for radiology and psychiatry) and to seek re-weighting of Medicare rebates to favour regional, rural and remote locations.

### *Utilising the whole workforce*

In other states, particularly New South Wales, there is a much closer relationship between GPs and hospitals than there is in Queensland, particularly in regional and rural areas. A number of NSW rural hospitals have services fully provided by the GPs in the town. In regional, rural and larger centres, there is an opportunity in Queensland to better link with and draw on the private general practitioner workforce in a variety of roles. GP Divisions and associations throughout the State have raised this issue. The Review team observed an innovative model in Longreach whereby all medical services to Longreach Hospital were provided through a contractual arrangement with local procedural GPs. The Review team will further investigate this as a possible model for wider application.

The role of visiting specialists for both training and service provision could also be increased. Mechanisms to increase this include appropriate remuneration. Similarly, there may be an opportunity to draw on private dentists or pharmacists and to outsource some services to reduce waiting lists – either on a short term basis (as occurred with outsourcing cataract surgery in 2004) or through ongoing arrangements (eg outsourcing of some emergency dental work).

Whilst these options may have a higher cost, there is a need to better draw on the capability of the private health sector in areas where the public sector is unable to meet demand.

### **Clarifying the service roles and the training roles in health services**

The current requirement for junior medical staff is significantly related to the historical apprenticeship model for medical training primarily undertaken in public hospital settings. This hypothesis has been validated through targeted consultations undertaken by the Review team. Alternate models such as those in Canada would significantly reduce the requirement for junior medical staff.

In some parts of Canada the specialist provides clinical services directly to patients on a fee-for-service. Junior medical staff are employed specifically for training purposes and are clearly present to be trained and not to provide service. Services are provided by the specialist. Adoption of this model in Queensland would reduce the requirement for overseas trained doctors at resident medical officer level. However, further work would need to be undertaken to assess the feasibility of adopting such an approach.

#### **5.6.3 Principles for consideration**

All options to improve the availability of clinicians need to be explored as there are no “quick fix” solutions to address current and future health workforce shortages. The following principles should underpin measures to increase clinician availability:

- The system makes the most effective use of the current clinical workforce including doctors, nurses, allied health and other practitioners
- A standardised process for the recruitment; assessment; placement; training and support of overseas trained doctors based on minimum standards of knowledge, skills, abilities, communication and cultural safety is in place
- Terms and conditions of employment of overseas trained doctors and the courses provided by the Centre for International Medical Graduates are directed to supporting overseas trained doctors to achieving the Australian Standard via Australian Medical Council certification or Fellowship of an Australian College
- The value of clinicians is maximised by ensuring they work in well organised systems (work redesign) and that professional boundaries do not impede the delivery of care (align task complexity with skill required)
- The workforce, particularly the medical and allied health workforce is viewed as a whole and focussed on increasing the interaction with the private sector in all areas of workforce shortage
- Partnerships with GPs are maximised both to optimise use of the local medical workforce in rural and remote communities and to improve the continuum of care for patients generally
- The system is open to the adoption of new models which have the potential to significantly reduce the clinical hours required using the current apprenticeship model
- There is a coordinated approach with responsible bodies such as colleges, universities and the Commonwealth Government.