Future workforce strategy for better healthcare in Queensland 2013–2018

December 2013

QH94 01/14

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Published by the State of Queensland (Queensland Health), December 2013

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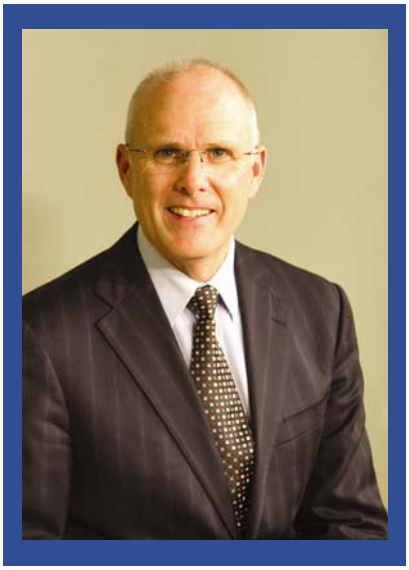

In February 2013, the Queensland Government released the *Blueprint for better healthcare in Queensland*. The blueprint defines an agenda for change to meet the challenges of a growing demand on our health system, while also taking advantage of the opportunities that will ensure we continuously improve the services we deliver to patients. The blueprint has four principal themes:

1. Health services focused on patients and people.
2. Empowering the community and our health workforce.
3. Providing Queenslanders with value in health services.
4. Investing, innovating and planning for the future.

As a service industry, the healthcare sector is dependent on its workforce to provide its services. Our vision for Queensland's healthcare system is a skilled and empowered workforce that meets the needs of Queenslanders in delivering high quality, cost-effective care.

The *Future workforce strategy for better healthcare in Queensland 2013–2018* is a five year plan with key initiatives and deliverables aimed at:

1. Creating a workplace *culture* and *leadership* environment which places a high value on scarce health resources, valuing our employees, and putting patients first.
2. Orienting health services to better meet local health needs, which requires significant change to many of the established *cultures* and *practice* that impact on *performance* and a strong *culture* of *customer service.*
3. *Empowering* healthcare staff to lead system reform and improve *service delivery.*
4. Growing total health *capacity* and increasing health services across a system of *public, private and not-for-profit providers.*
5. Partnering with Hospital and Health Services, private, not-for-profit sectors and other levels of government on *workforce planning* and other strategies to develop the future *capability* of the health workforce.
6. Improving the financial *performance* of our healthcare system to match the national average by mid–2014.
7. Breaking down traditional professional barriers and being open to new ways of working and *models* of care.
8. A flexible, easy to understand employment and industrial relations system that facilitates local decision-making.

The *Future workforce strategy for better healthcare in Queensland 2013–2018* articulates the significant workforce reform required to achieve the government's

strategic directions set out in the blueprint. I encourage all staff across the department and the Hospital and Health Services (HHSs) to familiarise themselves with the key actions and deliverables outlined in the strategy. Together we are all responsible for leading the way and adopting the required changes in our thinking, our work practices, our attitudes and our behaviours to ensure we deliver better services for the patients of Queensland.

Ian Maynard
Director-General
2013

1. Introduction

Queensland's capacity to deliver health services and achieve positive health outcomes for the population, both now and into the future, is largely contingent upon the health workforce. It is critical to ensure that there are sufficient numbers of the right staff, with the right mix, in the right place and the right time, and that the workforce is appropriately skilled to work collaboratively and efficiently to deliver patient focussed care and create positive health patient journeys and experiences.

This future workforce strategy consists of a framework and action plan for building a skilled and empowered workforce that leads the nation in the delivery of high quality, cost-effective healthcare services. Key initiatives and deliverables have been grouped into five workforce streams:

1. Workforce regulation.
2. Workforce models.
3. Workforce capacity and capability.
4. Culture and work practices.
5. Empowered workforce.

2. National health context and priorities

The Productivity Commission Research Report: Australia's Health Workforce 2005[1] emphasised the need for an urgent response to the health workforce needs of the nation and provided recommendations to assist the health industry throughout Australia to recognise and manage the significant workforce challenges in providing accessible and quality healthcare into the future. The Productivity Commission Report represented a turning point in the development of national policy and infrastructure to drive health workforce policy and reform.

Health workforce policy issues are now key areas of discussion at Council of Australian Governments (COAG), Standing Council on Health (SCoH), and Australian Health Ministers Advisory Council (AHMAC).

The development of the National Registration and Accreditation Scheme (NRAS) and establishment of Health Workforce Australia (HWA) are two key national initiatives in response to the health workforce challenges facing the nation. In addition, significant service expansions funded under COAG National Partnership Agreements (NPA) are driving not only service change and improvement but also workforce reform and redesign. Targeted services under the NPA include emergency services, elective surgery, subacute care, cancer care, aged care and mental health. For example, under the NPA on Improving Public Hospital Services, Queensland has committed to achieve set national emergency access targets and national elective surgery targets focusing on reducing wait times for these services, and the provision of new subacute beds.

[1] Productivity Commission 2005, *Australia's Health Workforce*, Research Report, Canberra.

2.1 Health Workforce Australia

Health Workforce Australia (HWA) was established in 2009 as the lead national agency to drive health workforce reform under the National Partnership Agreement on Hospital and Health Workforce Reform 2008. This national reform agenda aims to improve:

- health workforce capacity
- efficiency and productivity through improving clinical training
- facilitation of more efficient workforce utilisation
- international recruitment
- effective and accurate planning for the health workforce.

HWA have produced a number of key documents which are guiding the national workforce reform effort.

The *National Health Workforce Innovation and Reform Strategic Framework for Action 2011-2015*[2] provides the overarching national platform to guide health workforce policy and planning reforms in Australia. This document emphasises the un-sustainability of current practices, and provides five domains for action which together will create a foundation for an integrated robust workforce to meet Australia's healthcare needs.

Health Workforce 2025: Doctors, Nurses and Midwives 2012[3] demonstrates that more innovative solutions are required than just adding to the existing health workforce. The report presents the need for coordinated, long-term reforms by governments, professions and the higher education and training sector as well as reforms to boost productivity, flexibility and retention; improve geographic distribution; improve training, planning and capacity; and boost immigration.

2.2 National Registration and Accreditation Scheme

The clinical workforce is diverse and includes professions and disciplines that may require registration to practice. The National Registration and Accreditation Scheme (the scheme) became operational on 1 July 2010 and provides a single point nationally for the setting and management of registration and accreditation standards for 14 health professions. Currently included professions are:

- medical
- nursing and midwifery
- pharmacy
- physiotherapy
- dental (dentists, dental prosthetists, dental therapists, and dental hygienists)
- psychology
- optometry
- osteopathy

[2] Health Workforce Australia 2011: National Health Workforce Innovation and Reform Strategic Framework for Action 2011–2015
[3] Health Workforce Australia 2012: Health Workforce 2025—Doctors, Nurses and Midwives—Volumes 1, 2 and 3

- chiropractic and podiatry
- Aboriginal and Torres Strait Islander health practitioners
- occupational therapists
- Chinese medicine practitioners
- medical radiation practitioners (diagnostic radiography, radiation therapy and nuclear medicine technology).

The scheme provides for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered in the above professions. However, national registration and accreditation arrangements also provide mechanisms to facilitate workforce mobility across Australia, the provision of high quality education and training of registered health practitioners, and the thorough and open assessment of relevant overseas-trained health practitioners. Open and transparent processes are being established to guide consideration across registered professions of changes to scopes of practice, and identification of specialties.

The scheme collects national health labour force data through the registration process. Over time it is anticipated that this collection will provide timely and consistent data to inform more robust workforce planning nationally and within/across jurisdictions.

Not all professions need to be registered. There are numerous professions who are not required to be registered under the scheme, who play a key role in the delivery of healthcare services[4]. Many of these professions maintain their professional standards through self-regulation. The lack of a centralised collection process for the workforce data for these professions has made workforce planning difficult. A mechanism to capture workforce data from the self-regulated professions is being explored by HWA.

2.3 University educated clinical workforce

The majority of the clinical workforce is university educated. The health industry is dependent on the higher education system for the development of future clinicians. In return, the university sector is dependent on the healthcare industry which plays a vital role in the provision of clinical practice experience for clinical students. Despite this mutual dependency there is no formal mechanism for the healthcare industry to directly influence the university student intakes or curriculum.

The *Review of Australian Higher Education Final Report 2008*[5] has resulted in the establishment of a reform agenda to boost Australia's national productivity and performance as a knowledge-based economy through higher education and research[6].

The key reforms include incremental removal on the cap on over-enrolments, and a move to funding universities on the basis of student demand. This reform has further limited the opportunity for the health industry to influence the number of student places

[4] Professions include but not limited to audiologists, social workers, orthotic prothetists, orthoptists, sonographers, perfusionists, dietitans, exercise and sports physiologists, orthotics, and speech pathologists
[5] Commonwealth or Australia, December 2008: Review of Australian Higher Education Final Report.
[6] Commonwealth or Australia 2009: Transforming Australia's Higher Education System.

in health education programs, and may potentially lead to an over or under supply of graduates in particular professions.

2.4 Vocationally educated and trained clinical workforce

The vocationally educated and trained (VET) health workforce also plays a key role in the provision of healthcare services, particularly in aged and community care sectors but also in acute care. The health and community vocationally trained workforce is the fastest growing workforce in Queensland[7].

Between 2005 and 2010, the number of VET health graduates in Queensland more than doubled from 1500 to almost 4000[8]. VET sector health students now represent approximately 34 per cent of all students enrolled in a higher education health program in this state[9]. It is clear that VET training is a pathway to university, with approximately seven per cent of university health students in Queensland entering on the basis of a VET qualification[10]. The Community Service and Health Industry Skills Council oversees the development of the training packages in collaboration with the industry for vocationally trained workers.

2.5 National health industrial arrangements

There is limited consistency amongst the Australian states and territories with regards to industrial arrangements, salaries, and other terms and conditions of employment. Further, states and territories are often seeking to compete with each other, creating a costly and unsustainable 'leapfrogging' of wages and entitlements across the sector.

With regard to senior clinicians, the use of individual contracts in the private sector (in preference to award and agreement coverage) is the preferred instrument of employment for this highly paid segment of the workforce.

3. Workforce employed in the Queensland public health system

The Queensland public health system employed approximately 80,000 people as at December 2012 (Table 1).

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[7] Health and Community Services Council 2012: The Health and Community Services Industry—Building a stronger economy and fairer Queensland.
[8] National Centre for Vocational Education and Research. Historical time series (revised August 2012). www.ncver.edu.au/publications/2395.html. Viewed 24 January 2013.
[9] National Centre for Vocational Education and Research. Tertiary Education and Training in Australia 2010. www.ncver.edu.au/publications/2489.html. Viewed 24 January 2013
[10] Tom Karmel and Davinia Blomberg 2009. Workforce planning for the community services and health industry, National Centre for Vocational Education and Research, Adelaide, South Australia.

Health service delivery requires a diversity of skills. The extensive skills portfolio for health include, but not limited to:

- gardening
- catering
- cleaning
- clinical skills
- equipment procurement and maintenance
- legal advice
- management and administration
- record management
- human resource management
- financial management
- information technology management.

To manage this skill portfolio, Queensland's public health system has six awards, six industrial agreements, 189 human resource policies, various directives under the *Public Service Act 2008*,as well as other informal union arrangements. The six industrial agreements cover medical officers, visiting medical officers, nursing, health practitioners, general (administrative and operational) and building and engineering. These agreements have been negotiated centrally and apply across all HHSs, commercialised business units and the Department of Health.

Table 1: Queensland public health service workforce as at December 2012

December 2012	Occupied headcount	Occupied FTE
Managerial and clerical	14,738.19	13,272.08
Medical including VMO's	8,220.00	7,154.31
Nursing	32,684.25	25,859.38
Operational	13,051.97	10,607.05
Trade and artisans	433.00	431.63
Professional and technical (inc. health practitioners)	10,704.59	9,379.23
Total	**79,832.00**	**66,703.68**

Source: Queensland Health Human Resources Management Information System.

In December 2012, of the almost 80,000 workforce employed by the Queensland public health system, approximately 78 per cent were clinical professionals or those who provided direct clinical support. The Queensland public health system clinical workforce comprised approximately 62,229 headcount, these individuals' collectively filled 51,120 full time equivalent (FTE) positions. Approximately 42 per cent of operational officers and approximately 35 per cent of the administrative officers were considered to be within the clinical workforce.

4. Clinical workforce

4.1 Registered clinical workforce in Queensland

The clinical workforce are health professionals or support health professionals who spend the majority of their time working in the area of clinical practice and provide clinical services direct to the health consumer and/or provide indirect services that have a direct impact on health consumer care and clinical outcomes.

While some professional groups are more obviously identified in a clinical role (for example doctors), it is less clear when consideration is given to the diverse, complementary roles of other staff involved directly in achieving health delivery. These roles would include staff from both the operational and administrative officer streams such as Indigenous health workers, allied health assistants, clinical scientists and ward clerks who are integral to clinical service delivery.

Table 2: Queensland's registered clinical workforce as at 30 June 2012

Registered professions	Registrants
Medical practitioner	17,682
Nurse	57,491
Nurse and midwife	7,321
Midwife	321
Dental practitioner	3,728
Chiropractor	692
Optometrist	929
Osteopath	149
Pharmacist	5,187
Physiotherapist	4,379
Podiatrist	631
Psychologist	5,220
Occupational therapy practitioner*	N/A
Aboriginal and Torres Strait Islander health practitioner*	N/A
Chinese medicine practitioner*	N/A
Medical radiation practitioner*	N/A
Total	**103,730**

Source: Australian Health Practitioner Regulations Agency Annual Report 2011–12
*Occupational therapy, Aboriginal and Torres Strait Island health practitioner, Chinese medicine practitioner and medical radiation practitioners entered AHPRA on 1 July 2012. 2012 data was not available at time of AHPRA report.

It is noteworthy that the Queensland public health sector employs approximately 46 per cent of the total registered medical workforce of Queensland, approximately 47 per

cent of the registered nursing and midwifery workforce, and less than 35 per cent of individual allied health disciplines (other than radiation therapists)[11].

The remaining registrants, in general, work in the private and non-for-profit health sectors as well as other sectors, such as education and disability, which utilise a clinical workforce. In addition, some registered clinicians may remain registered but do not currently work as a clinician in Queensland.

4.2 Queensland public health system clinical workforce

4.2.1 Medical workforce

Queensland public health system medical workforce includes interns, junior and senior house officers (JHO and SHO respectively), principal house officers (PHO), registrars, visiting medical officers (VMO) and other medical roles. The latter encompasses senior medical officers, medical staff specialists, medical superintendents and medical officers with a right to private practice.

The medical workforce at December 2012 comprised 8220 people (headcount) making up 7154 FTE positions. Medicine comprised 16 per cent of the total clinical workforce. Registrars were the single largest medical workforce group both by headcount (2707) and FTE (2624) (Table 3).

The medical workforce is ageing with six per cent of Queensland public sector doctors aged 60 years of age and over. This group is considered to be at a high risk of retirement. A further five per cent were aged between 55 and 59 years of age and expected to transition to retirement in the next five years.

Approximately 10 per cent of the public health sector doctors were international medical graduates (IMG) who practise medicine under limited registration with the Medical Board of Australia (MBA). These are overseas trained doctors who are not yet eligible for either general or specialist registration.

Table 3: Medical workforce headcount and FTE as at December 2012

December 2012	Occupied headcount	Occupied FTE
Intern	645	645
JHO/SHO	1,190	1,177
Reg/PHO	2,707	2,624
VMO	788	229
Other[12]	2,890	2,479
Total	**8,220**	**7,154**

Source: Queensland Health Human Resources Management Information System.

[11] Calculated on 2011 data from the Australian Health Practitioner Regulation Agency and the Queensland Office of the Health Practitioner Registration Boards.

[12] Others' are defined by client support and reporting and include senior medical officers, medical staff specialists, medical superintendents and medical officers with a right to private practice.

4.2.2 Nursing and midwifery workforce

The nursing and midwifery workforce in the Queensland public health system comprises enrolled nurses (EN), registered nurses (RN), midwives and nurse practitioners. Nursing is supported by assistants in nursing (AIN) (Table 4).

Nurses and midwives form the largest clinical workforce group in the Queensland public health system with 32,684 headcount making up 25,859 FTE as at December 2012. Nurses and midwives comprised 63 per cent of the total clinical workforce headcount.

Table 4: Nursing and midwifery workforce headcount and FTE as at December 2012

December 2012	Occupied headcount	Occupied FTE
Enrolled nurse	3,920	2,927
Nurse practitioner	122	117
Registered nurses and registered midwives	25,997	21,109
Sub total	**30,039**	**24,153**
Assistants in nursing	2,645	1,706
Total	**32,684**	**25,859**

Source: Queensland Health Human Resources Management Information System.

Registered nurses were the largest group within the nursing and midwifery workforce, comprising 80 per cent of the nursing and midwifery headcount. Nurse practitioners represented the smallest group comprising less than one per cent of the nursing and midwifery headcount.

The Queensland public health system nursing and midwifery workforce is ageing. Nine per cent were aged 60 years of age or over and are considered to be at a high risk of imminent retirement. A further 11 per cent were aged between 55 and 59 years of age and are expected to transition to retirement in the next five years.

The midwifery workforce within Queensland has an older age profile than general nursing. Due to projected imminent retirement losses it is anticipated that there will be insufficient new entries into the workforce to match these losses. Non-urban areas of the state will be most affected because they have an older cohort than urban centres.

4.2.3 Allied health professions workforce

Allied health professionals working within the Queensland public health system have been defined to include the disciplines identified in Table 5[13].

Analysis of the allied health workforce at December 2012 identified 6566 headcount making up 5688 FTE, comprising 12.6 per cent of the total clinical workforce headcount. The allied health workforce is mostly a younger cohort and ageing of this workforce is not a concern. The largest allied health workforce groups were social workers, physiotherapists, occupational therapists and radiographers/medical imaging

[13] List of allied health occupational groupings provided by Allied Health Workforce Advice and Coordination Group.

technologists, with each comprising more than 10 per cent of the total allied health workforce when analysed by either FTE or headcount. These four occupational groups together comprised approximately 55 per cent of the total headcount across the allied health workforce.

Table 5: Allied health professions workforce headcount and FTE as at December 2012

December 2012	Occupied headcount	Occupied FTE
Audiologists	36	30
Breast imaging radiographers	85	56
Clinical measurement scientists and technicians	177	153
Dietitians/nutritionists	356	302
Exercise physiologists	11	10
Music therapists	10	7
Neurophysiologists/technicians	7	7
Neuro-psychologists	23	19
Nuclear medicine technologists	37	35
Nutritionists	58	49
Occupational therapists	870	748
Optometrists	4	2
Orthoptists	8	5
Orthotists, prosthetists and technicians	31	30
Pharmacists and technicians	655	580
Physicists	84	82
Physiotherapists	1,002	848
Podiatrists	66	55
Psychologists including clinical (excl. neuro)	561	476
Radiation therapists	256	241
Radiographers/medical imaging technologists	667	602
Social work associates	17	17
Social workers	1,019	896
Sonographers	134	110
Speech pathologists	365	307
Welfare officers	25	23
Total	**6,566**	**5,688**

Source: Queensland Health Human Resources Management Information System.

4.2.4 Oral health workforce

The oral health workforce comprises a range of professions/disciplines from dental specialists to dental assistants/aides[14].

At December 2012, dental officers (dentists) and dental specialists comprised 20 per cent of the headcount for the total oral health workforce. Dental assistants/aides represented 51 per cent of the total clinical oral health workforce headcount (Table 6).

Table 6: Oral health workforce headcount and FTE as at December 2012

December 2012	Occupied headcount	Occupied FTE
Dental prosthetists	16	15
Dental technicians	147	136
Dental therapists/oral health therapists	321	254
Dental officers	296	241
Dental specialists	28	19
Sub total	**808**	**666**
Dental officers—assistant/aide[15]	848	683
Oral health total	**1,656**	**1,349**

Source: Queensland Health Human Resources Management Information System.

4.2.5 Other clinical workforce

Other clinical workforce (Table 7) are identified as clinical health practitioners who are not defined as allied health professions or oral health practitioners, but are employed under the health practitioner, professional or technical streams. This workforce includes professional roles including scientists (i.e. medical and laboratory scientists), environmental health officers, and health promotion officers. It also includes the relatively new role of allied health assistants.

This group comprised 3331 headcount making up 3025 FTE at December 2012 or 6.5 per cent of the total clinical workforce headcount.

Table 7: Other health practitioners workforce headcount and FTE as at December 2012

December 2012	Occupied headcount	Occupied FTE
Other clinical workforce	3,331	3,025

Source: Queensland Health Human Resources Management Information System.

[14] To be consistent with the identification and analysis of workforce data relating to the assistant and technical workforce, the dental assistant/aides group was not included in the calculations for the total clinical workforce. On this basis, an analysis of the remaining oral health workforce shows that this group represented 1.6 per cent of both the total clinical workforce headcount and FTE as at December 2012.

[15] This group has not been analysed as a per cent of the total clinical workforce headcount as it is not included in the total clinical workforce numbers. Included in discussion of the operational clinical workforce.

5. The challenges

5.1 Geography and demographics

The health workforce in Queensland faces substantial challenges now and into the future. Some, like those associated with specific skills shortages and new technologies, are global challenges, while others are influenced by specific local issues such as geography or population demographics.

Queensland is the second largest state or territory in Australia and has a geographically dispersed population which is growing and ageing. It is projected that Queensland's population will grow from 4.1 million in 2006 to 6.1 million in 2026 and reach 9.1 million by 2056[16]. Most of the population growth will concentrate in the south-east corner and coastal areas. The number of people aged 65 years and over is projected to be four times greater in 2056 than it is was in 2006. It is anticipated that there will be an increased demand for health services which will also increase the demand for workforce.

The Queensland clinical workforce is ageing, with 16 per cent of the Queensland public health system clinical workforce aged 55 years and over. It is probable that a significant proportion of the current clinical workforce will exit the workforce in the next five to ten years. In addition, more people are working part-time. This means that several people may be required to fill a single full time position.

Based on population need, Queensland will continue to experience workforce shortages in medical practitioners, nurses and in some medical specialist roles. This is likely to be more pronounced in regional, rural and remote communities where attraction, recruitment and retention of the health workforce is already a challenge. Currently there is a dependence on international recruitment and the use of locums or agency services to fill relief and vacancies. Whilst reliance on locally trained clinicians is a long term goal, the ongoing recruitment of internationally trained clinicians will be required to meet service gaps in the foreseeable future.

5.2 Changing models of care

Models of care are changing. Rapid developments in technology and pharmaceuticals require the clinical workforce to adapt and quickly acquire new skills and knowledge. In addition, services are increasingly being delivered in a diverse range of settings, for example, same-day facilities, home services, multi-purpose ambulatory centres, virtual hospitals and Telehealth services. The clinical workforce will need to be able to adapt to changing skill requirements and ways of working.

It has been difficult to drive and embed the innovative changes required to meet the future demands of the health system in Queensland. However significant leadership development has occurred in recent years, targeting the current and future generation of clinician leaders. Management skills will also become increasingly important in a tightening fiscal environment.

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[16] Department of Infrastructure and Planning. *Queensland's Future Population 2011 Edition.* Queensland Government, Brisbane, 2008. (Source: Office of Economic and Statistical Research: www.oesr.qld.gov.au)

5.3 Industrial complexity and regulatory environment

Increasing competition between jurisdictions during industrial negotiations has led to a 'leapfrogging' of employment terms and conditions, with no national consistency. In addition, competition is increasing within the jurisdiction between public, private and not-for-profit organisations. Public sector enterprise bargaining in the Queensland public health system directly influences outcomes in the private and not-for-profit sectors. Private health and not-for-profit providers find recruitment in the health practitioner and nursing areas difficult if wages parity is not maintained.

The combination of six awards and six industrial agreements results in a possible 24,000 permutations of employee payments. Although there will always be differences where staff are employed on shifts (the majority of nurses and operational staff, and all junior doctors) and operate a 24-hour service, the awards and agreements are unnecessarily complex and prescriptive. Further, due to historical factors in the nursing and administration area, there are employees who perform exactly the same function at the same classification level but are subject to different pay and conditions due to different award coverage.

With regard to senior clinicians, the use of individual contracts in the private sector (in preference to award and agreement coverage) is the preferred instrument of employment for this highly paid segment of the workforce.

Traditionally, tie points were in place that maintained the relative work value across professions. Recent enterprise bargaining outcomes have resulted in the distortion in the relativities between professions. Bargaining has become the mechanism for seeking parity. This process is unnecessarily complex and expensive.

Other factors such as legislation regarding the administration of drug and poisons varies from state to state, resulting in differing workforce capability and scope of practices between jurisdictions.

5.4 Workforce participation

Staff turnover and reduced hours of work increase the amount of human resourcing effort required to cover service requirements. Each of the health workforce groups have different employment cultures, particularly in relation to workforce participation.

For example, in the Queensland public health system over 60 per cent of the medical workforce are temporarily employed. This reflects the contractual nature of employment arrangements for this workforce, particularly the employment of medical staff within training positions. Training positions usually experience annual turnover of incumbents. In contrast, 85 per cent of the nursing and midwifery workforce are permanent employees, while for health practitioner, dental, professional and technical workforce group over 83 per cent are permanent.

Most of the medical profession and health practitioners work full-time, approximately 78 per cent and 72 per cent respectively. In contrast, only 40 per cent of nurses work full-time. The impact is that increased numbers of individuals are needed to make up a full time equivalent position. However this flexibility may assist to attract and retain experienced personnel in the workforce.

Allied health professions on the other hand struggle with almost 15 per cent temporary employees. The high percentage of temporary employees is attributed to the backfilling of permanent staff on leave (including parental leave) requiring temporary appointments.

5.5 External workforce (locums)

External agencies can be used to fill workforce gaps and vacancies. The medical profession has the largest use of external agency staff at 2.8 per cent. The use of external staff for nursing and allied health practitioners are 0.7 per cent and 0.4 per cent respectively.

While external locum usage is a valid workforce tool, it is expensive and in some instances has become a core mechanism for service provision. Long term locum usage is fiscally unsustainable. Clinician distribution to areas of vacancy and need, particularly regional, rural and remote areas, remains a key challenge.

5.6 Developing the future workforce

A rapid increase in the number of students undertaking health education programs has placed additional burden on the Queensland health system for clinical education and training placements, and has increased the tension between service delivery and supervision and training. The Queensland public health system continues to provide the majority of clinical education and training for the medical, nursing and midwifery and allied health professions, yet it employs less than 50 per cent of these professions registered in Queensland.

The Queensland health workforce is fragmented and aligned into professional silos which are supported by professional culture and practice barriers as well as complex and inflexible industrial arrangements. Clinicians need to work to their full scope of practice. There is a need to challenge the myths and explore new ways of working to provide safe, cost effective care.

Aboriginal and Torres Strait Islander people are currently under-represented within the Queensland health workforce. This is significant as research indicates that Aboriginal and Torres Strait Islander people are more likely to seek healthcare when provided by their own people. To date, strategies implemented to promote and support entry of Aboriginal and Torres Strait Islander people into the clinical workforce have been slow to achieve significant change.

5.7 Funding the workforce

Finally, the impact of changing funding models is yet to be determined. However escalating labour costs over the last decade in the Queensland public health system are not sustainable within a constrained State budget. Over the seven years from 2002 to 2009, clinical workforce costs grew at an average annual growth (adjusted for inflation) of 11.1 per cent, while growth in FTE was approximately half that rate, with an

annual average growth of only 6.6 per cent[17]. This suggests that wage prices of the workforce have been the main driver for increasing labour costs, rather than growth in workforce numbers.

6. The Future workforce strategy for better healthcare in Queensland 2013–2018

The *Future Workforce Strategy for better healthcare in Queensland 2013–2018* provides the opportunity to harness the challenges and prepare the health system in Queensland for the future.

The strategy identifies five streams for the health workforce in Queensland over the next five years. The strategy is underpinned by a *Future workforce action plan*. The *Future workforce action plan* outlines the key actions that will be delivered under each strategy stream between now and 2018 to address the workforce challenges facing healthcare services across Queensland.

6.1 Stream 1: workforce regulation

Our industrial, policy and regulatory environment is easy to understand and our employment arrangements support workforce flexibility and local decision-making.

6.1.1 Key actions for stream 1

Key action 1.1: Identify and remove regulatory barriers to clinical reform and improved workforce flexibility.

Key action 1.2: Remove red-tape in the form of prescriptive human resource policies and directives which hinder flexibility and local decision-making.

Key action 1.3: Simplify industrial awards and entitlements to remove complexity and create flexible employment arrangements that allow HHSs to manage their business imperatives as statutory bodies.

Key action 1.4: Build a flexible reward and remuneration system.

6.2 Stream 2: workforce models

Our workforce structures and systems are contemporary and aligned with a service delivery environment that spans the public, private and not-for-profit health sectors.

[17] Data provided by Workforce Analysis and Research Unit, Queensland Health (2010).

6.2.1 Key actions for stream 2

Key action 2.1: Develop workforce models that support expanded practice roles for clinicians including the use of Telehealth.

Key action 2.2: Redesign workforce structures and systems to drive efficiency and effectiveness.

6.3 Stream 3: workforce capability

Our people have the right skills, knowledge, and capability and are employed in the right place at the right time across public, private and not-for-profit health sectors.

6.3.1 Key actions for stream 3:

Key action 3.1: Department of Health to work with HHSs, private, not-for-profit and other levels of government on workforce planning.

Key action 3.2: Build the next generation of clinicians and develop training strategies that support expanded practice roles for clinicians.

Key action 3.3: Build regional, rural and remote workforce capacity and capability and the use of Telehealth.

Key action 3.4: Improve occupational health and safety management and assurance systems.

Key action 3.5: Develop rostering and hours of work practices that increase capacity and savings.

Key action 3.6: Build HHS capability and capacity.

6.4 Stream 4: culture and work practices

Our culture and our work practices are aligned with a strong focus on customer service, high performance, innovation, and accountability.

6.4.1 Key actions for stream 4

Key action 4.1: Encourage a culture of leadership to drive reform of the health system in Queensland.

Key action 4.2: Manage whole of government initiatives to drive a lean, frontline focused organisation and embed a health system culture of customer service, high performance, innovation and accountability.

6.5 Stream 5: empowered workforce

Our leadership and health system stewardship enables devolved, front-line decision-making and an empowered workforce, creating permanent and sustainable change in the delivery of healthcare services.

6.5.1 Key action for stream 5

Key action 5.1: Drive clinician engagement.

7. Evaluation and review

The *Future workforce strategy for better healthcare in Queensland 2013–2018* is a key pillar of the structural and cultural changes that are being progressed to reform health services in Queensland. It is a key enabler to improving the performance of the health system in Queensland.

The clinical workforce aspects of the strategy and the *Future workforce action plan* implementation will be oversighted by the Clinical Workforce Board (CWB). The CWB will:

- assess the outputs/outcomes and effectiveness of the key actions within the plan
- prioritise effort and resources for the most effective output and outcomes
- review/refresh the action plan annually
- report decisions of the CWB to the Executive Management Team (EMT) through the chair of CWB.

The industrial actions and non-clinical workforce actions of the strategy and *Future workforce action plan* will be oversighted by the Chief Human Resources Officer, who will report the outcomes and outputs directly to the EMT.

The EMT will:

- assess the outputs/outcomes and effectiveness of the entire set of key actions within the plan
- prioritise effort and resources for the most effective output and outcomes
- will review recommendations relating to the review or refresh of the *Future workforce action plan* annually.

Reporting on deliverables of the *Future workforce action plan* will be aligned with internal and external reporting requirements of the *Blueprint for better healthcare in Queensland*.

The *Future workforce action plan* will be reviewed and/or refreshed annually.