National Health Workforce Innovation and Reform Strategic Framework for Action 2011–2015
National Health Workforce Innovation and Reform Strategic Framework for Action 2011–2015
'Innovation is change that creates a new dimension of performance.'

Peter Drucker
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The Framework sets broad parameters for the system as a whole, recognising that there are many contributors shaping future health workforce priorities for Australia.
As the Chair of the Health Workforce Australia Board, I am pleased to present Australia’s first National Health Workforce Innovation and Reform Strategic Framework for Action 2011–2015.

Health Workforce Australia (HWA) was established in 2010 as an initiative of the Council of Australian Governments to work across the health and education sectors and address the challenges of providing a skilled, flexible and innovative health workforce that meets the needs of the Australian community, now and into the future.

The National Health Workforce Innovation and Reform Strategic Framework for Action 2011-2015 (Framework) is a first for Australia – it is a national call to action for workforce reform that will involve and link the health and education sectors.

The health sector needs to focus on wellness, prevention and primary health care if it is to be sustainable in the future. Sustainability will require re-balancing many aspects of the current system: making decisions based on consumer and community need and focusing on the most cost-effective and efficient workforce arrangements to provide care. It will mean reconfiguring the workforce, and the education and training programs that prepare and support that workforce.

The Framework has been designed to provide an overarching, national platform that will guide future health workforce policy and planning in Australia. It sets out key priority areas and five essential domains that create the foundation for an integrated, high performing workforce fit to meet Australia’s health care needs.

The strategies within the Framework aim to attract and retain, and enable and enhance the productivity of the existing and future workforce to meet current and emerging demands.

The Framework sets broad parameters for the system as a whole, recognising that there are many contributors who will respond to Australia’s future health workforce priorities. It will guide the future work plan of HWA and in particular our Workforce Innovation and Reform program. With national partnerships and collaboration across sectors and professional boundaries, I am confident that implementation of the Framework will be successful.

I would like to acknowledge the considerable contributions that many Australians have made to inform the development of the Framework. Numerous individuals and organisations have participated generously in the consultation process.

I urge everyone – all levels of government, the private sector, non-government organisations, health professionals, educators and trainers, industrial, regulation and accreditation bodies, consumers and the community as a whole – to work with HWA to build a stronger health workforce. Together, this work will support a health care system that delivers better health for Australians in the decades to come.

The Hon James McGinty  
Chair HWA Board
Purpose

The National Health Workforce Innovation and Reform Strategic Framework for Action 2011–2015 is a national call for action for workforce reform across the health and education sectors.

The National Health Workforce Innovation and Reform Strategic Framework for Action 2011–2015 (Framework) is a national call for action for workforce reform across the health and education sectors. The Framework will help to reshape Australia’s future health workforce while supporting and enabling the productivity of the existing workforce. It aims to attract and retain a highly valued workforce and to expand the size and nature of the future workforce to meet current and emerging demands.

Health, education, regulatory and accrediting bodies, employers, health researchers, professional groups, industry and regulation bodies, across the private, public and not-for-profit sector, must collaborate in planning, implementation and evaluation of reforms that will result in a sustainable health workforce.

The Framework sets broad parameters for the system as a whole, recognising that there are many contributors shaping future health workforce priorities for Australia. It provides the platform for developing the workforce critical to achieve the desired outcomes of the National Partnership Agreement (NPA) on Hospital and Health Workforce Reform and other major national health priorities. These priorities include, but are not limited to, Closing the Gap in Indigenous Health, primary health care, mental health care, health promotion and illness prevention, rural and remote health initiatives and the implementation of the COAG Heads of Agreement on National Health Reform (February 2011).

This document will guide and inform the health workforce response and future work plans of:

- Health Workforce Australia (HWA)
- Commonwealth Departments of Health and Ageing (DoHA)
- State and Territory Departments of Health
- Private, not-for-profit and non-government health and aged care providers
- Aboriginal and Torres Strait Islander health and education providers
- Health education and training providers
The Case for Change

Australia's population is growing, ageing and living longer and health expenditure as a percentage of gross domestic product (GDP) is rising rapidly.

These issues are not unique to Australia. Health service provision is labour-intensive and the continued or future lack of appropriately skilled health professionals, and its possible negative impact on timely access to and quality of care, is a global concern.¹

A healthy population has enormous implications for a healthy economy, the nation's sustainability and its reputation as a civil society.² International comparisons show relatively good health outcomes for Australians overall.³ Yet for many Australians, especially Aboriginal and Torres Strait Islander people, wherever they live,⁴ and for Australians who live outside our capital cities, health outcomes are worse.⁵

National reports since 2006⁶ foreshadow growing burdens of chronic disease, higher numbers of people needing long term care and support, and higher community expectations from health services. It is not sustainable to use the current health workforce to deliver these same health services into the future. The size of the health workforce has never been larger, but, even to maintain the types of services that we currently have, numbers would need to treble.⁷ This growth would need to occur in a context of dynamic global and local labour markets, where health competes with all other career options. Australian health services rely heavily on overseas trained health professionals to meet shortfalls in workforce supply, especially in rural and remote areas. Social, economic and policy changes in source countries, together with broader ethical considerations of such a heavy reliance on imported health workforce, point to the need to move towards greater national self-sufficiency in health workforce. Private, not-for-profit and community-based health services are major employers and providers of health services in Australia. Planning and decision making that has been traditionally public-sector focused and concentrated on a handful of professions, must now be more inclusive of all contributors, all settings and all professions.

Generational changes mean that many providers are not working the same long hours or practising in the same way as their predecessors.⁸ The informal carer workforce currently providing much of the services to the aged⁹ is likely to diminish as people stay longer in the workforce and are less available to assist the aged and chronically ill to stay at home.

1. OECD (2004) http://www.oecd.org/document/36/0,2340,en_2649_201185_31938380_1_1_1_1,00.html.
The health sector needs to refocus on wellness, prevention and primary health care if it is to be sustainable in the future.

Larger numbers of health workers alone will not solve the existing problem of poor distribution of health providers across underserved communities. Nor will larger numbers solve future problems, if the types of skills available do not match community needs.

As recognised by major national health initiatives in recent years the health sector needs to refocus on wellness, prevention and primary health care if it is to be sustainable in the future. Sustainability will require re-balancing many aspects of the current system and making decisions based on consumer and community need and reflect the evidence of the most cost-effective, efficient workforce arrangements to provide care. It will mean re-configuring the workforce and the education and training programs that prepare and support them.

Failure to consider how new technologies, therapeutics and other discoveries might change the way health professionals work will mean perpetuating ways of working that are already unable to meet demand.

For many communities there is not a future crisis – the crisis is already here. People living in regional, rural and remote areas are more likely to die from preventable diseases, accidents, injury or suicide.

Nationally, there are areas of special need such as mental health and aged care that continue to suffer significant workforce shortages in the face of growing demand. As Australia seeks to develop the capacity to be self-sufficient in the provision of doctors, nurses and midwives by 2025, there are clear indications from recent HWA projections that challenges lie ahead. Without further action there is little doubt that too few nurses will be participating in the Australian health system to meet service demands over the medium to longer term.

While there are indications from baseline projections that the overall medical workforce will be sustainable to 2025 and beyond, there are signs that demand for certain specialities within the profession will outstrip supply in the future. Irrespective of concerns over the national availability of nurses and some medical specialities in the future, HWA’s analysis confirms that persistent variation exists in the distribution of the health workforce across Australia.

This is particularly evident in rural and remote communities where challenges in establishing and maintaining adequate numbers of health professionals in local service provision remain. It is unlikely that reliance on increased student intake will be sufficient. More innovative solutions will be required to support and reform the professions and encourage greater participation in areas of relative need. Without this, it is likely Australia will need to increasingly rely on the recruitment of overseas trained doctors and nurses to meet service demands.


13. AIHW 2010 p. 248, based on National Health Survey 2007-08.
The health status of Aboriginal and Torres Strait Islander people continues to be a national priority, with a whole of government commitment to Closing the Gap. Gains have been achieved, but the building blocks to reduce health inequalities for Aboriginal and Torres Strait Islander people need broad, system wide incorporation into health workforce planning and action. There is much at stake. The poor state of Indigenous health in this country is well known and poignantly evident in the gap in life expectancy between Indigenous and non-Indigenous people.

If we are to meet future need and better address long-standing gaps in services for all Australians, we need broader reform of the health workforce and we need to start the process now.

While health workforce action alone cannot deliver improved health outcomes or address inequalities, health workforce reform is an essential foundation for increasing access to services and providing preventive, early intervention and care services that are timely, consumer-focused and culturally appropriate.

There is an urgent need to systematically reform the way that the health and education systems work together to develop and support the Australian health workforce into the future. Efforts at the State/Territory level have often been constrained by jurisdictional and sectoral boundaries, funding complexities and political imperatives. Many health workforce strategies or reform initiatives have been local - at the micro-level of the system - and described by some as ‘tinkering around the edges.’

What is required is a paradigm shift in ways of thinking about workforce design and planning, one that works backwards from outcomes for communities, consumers and population need, versus the current thinking that is generally focused on working forward from the base of existing professions and their interests and skills, demarcations and responsibilities.

There is frustration at the slow rate of progress in system-wide workforce innovation and reform, especially in implementing competency-based education for health professionals, accommodating overlapping professional boundaries, or introducing new roles and extended scopes of practice that have been working effectively in comparable countries for decades.

The potential barriers to workforce reform are considerable and cannot be overcome by governments, sectors or service providers working in isolation. Sustainable innovation and reform will only be achieved through urgent and integrated national action.

For many communities there is not a future crisis - the crisis is already here.
If we are to meet future need and better address long standing gaps in services for all Australians, we need broader reform of the health workforce and we need to start the process now.

Failure to innovate and reform the systems that prepare and support the health workforce could mean that:

- the types of health professional skills available will not match the needs of communities, especially those in underserved areas
- the experience, supervision and mentoring provided by the existing health workforce will be lost to the system
- increasing numbers of aged and chronically ill people will be living without adequate care and support, often alone in single person households
- Aboriginal and Torres Strait Islander people will not have culturally appropriate services in urban, rural and remote areas
- regional, rural and remote areas will not have the workforce to provide services, especially to the increasing proportions of elderly living outside cities
- people from culturally and linguistically diverse backgrounds will not have services that meet their specific needs
- the potential of many young people will be lost to society when early detection, treatment and support could have changed their life course
- avoidable deaths or loss of functionality will increase
- existing inequalities in access to health services will worsen
- gaps in the life expectancy and quality of life of our most vulnerable communities will worsen
- workforce participation rates will drop, resulting in a shrinking taxation base to fund essential services and infrastructure.

Principles

The implementation of this Framework will be guided by the following principles:

- Work from a community, individual and carer needs perspective.
- Involve the community, consumers and carers in service system design, health workforce planning and evaluation.
- Align with the intent and actions of Closing the Gap in the planning and implementation of national health workforce innovation and reform.
- Address the expansion of existing roles or creation of new roles in ways that ensure the quality and safety of care is improved.
- Address workforce issues in ways that recognise Australia's social and cultural diversity and promote equity of access and outcomes across communities, geographic areas and age groups.
- Recognise the importance of informed personal choice and self management.
- Recognise and support members of the community, including volunteers and unpaid carers, in the provision and delivery of health services.
- Facilitate collaboration
  - across all levels of government and with regulatory bodies, accrediting bodies and professional associations
  - in partnership with education providers across the education continuum: schools, Vocational Education and Training (VET), universities, colleges and workplace based trainers
  - with the private sector, the not for profit sector and the community-controlled sector.
- Build health services research and evaluation into all workforce and service redesign initiatives.
- Build and disseminate the evidence base for successful health workforce innovation and reform.
- Ensure mechanisms for accountability and evaluation are planned and systematically undertaken to ensure progress towards the implementation of this Framework is monitored and reported.

Involve the community, consumers and carers in service system design, health workforce planning and evaluation.
Future outcomes

Workforce imbalances and regulatory, industrial and financing approaches create barriers that stifle health innovation and reform. A concerted national effort under this Framework will strengthen the ability to implement national health reforms and agreed national priority strategies which taken together will lead to the following future outcomes:

• a sustainable and affordable health system delivered by a committed and well supported workforce
• increased equality in access to services to support improved population and individual health outcomes
• sustainable partnership between health service providers and educators in preparing and developing the health workforce.

Intermediate outcomes
To achieve the outcomes defined above this Framework requires a concentrated effort in health workforce innovation and reform and effective coordination of national effort across all sectors. Intermediate outcomes will include:

• a workforce planned and distributed on the basis of consumer and population needs
• improved system wide workforce productivity, efficiency and effectiveness
• improved distribution of health workforce across regional, rural and remote areas and underserved communities

• improved retention of the current workforce
• increased career and role flexibility, adaptability, mobility and more efficient training
• reinforced generalist practice in all of the professions with more relevant skill mix
• increased numbers of Aboriginal and Torres Strait Islander people working in the health sector
• increased numbers and capacity of the personal care/support and assistant workforce
• increased interprofessional learning and practice
• increased critical mass of service level, clinical and research leaders
• improved capacity and cultures that support and promote change focused health professionals
• increased engagement of health professionals, consumers and communities in future workforce planning and reform initiatives
• authoritative, robust and needs-based planning and modelling capacity
• improved health system policy, employment and financing mechanisms that enable and support workforce reform and innovation
• streamlined, consistent industrial relations and regulatory approaches to support reform.

National priority strategies, taken together, will lead to sustainable partnership between health service providers and educators in preparing and developing the health workforce.
Australian health workforce

The broad social determinants of health (such as housing, diet, education, employment, safety, family and community stability) mean that many work roles and organisations contribute significantly to the health and wellbeing of the population. This is particularly so in regional, rural and remote areas, in underserved areas and in communities with high levels of complex co-existing chronic diseases and mental illness. Many non-government organisations (NGOs) employ a workforce that works with individuals and communities to address multiple aspects of their lives, health and wellbeing.

A holistic approach to health and wellbeing that is sensitive to the culture of local Aboriginal and Torres Strait Islander communities can extend beyond non-Indigenous concepts of health work. Collaboration with traditional healers and Elders is an important part of health care provision.

The boundary is often blurred between the work of health professionals and service providers and the work of partners who are outside the health sector. The important collaborative work of many social, community, philanthropic and faith-based groups, early childhood and school educators, police and corrections services, and service providers to the disabled, vulnerable households and vulnerable individuals is acknowledged. This workforce is not the focus of the Framework.

The current and future health workforce is complex. The health workforce that is addressed in this Framework is broadly conceptualised as consisting of the following, often overlapping, types of roles:

- clinicians and practitioners in various disciplines that may be nationally regulated, partially regulated, self-regulated or unregulated
- support workers in clinical and non-clinical roles
- preventive and health promotion workforce
- health service managers
- health planners, administrators and researchers
- health educators and trainers
- health students
- emerging health workforce
- consumers who manage their own care
- voluntary and unpaid carers.

The broad social determinants of health mean that many work roles and organisations contribute significantly to the health and wellbeing of the population.
Monitoring and evaluating the success of the framework

Evaluation is an essential element of service and workforce redesign and should be considered throughout the process. The Framework plans for the development of mechanisms to assist in monitoring, evaluating and reporting on progress of workforce innovation and reform nationally. It includes an approach to monitoring and evaluation that begins at the point where innovations are first considered.

The Framework promotes careful analysis of evidence in the design phase. It seeks to ensure that scarce resources are not wasted on projects that have little chance of success, or that have the potential to do harm or be more successful if designed and resourced differently.

The design, implementation, monitoring and evaluation of this Framework are occurring at a time of major reform in the health and education sectors: the COAG Heads of Agreement on National Health Reform19 and the Australian Government’s response to Transforming Australia’s Higher Education System (the 2009 Bradley Review).20

The National Partnership Agreement on Hospital and Health Workforce Reform (2008) includes benchmarks and key performance indicators (KPIs) for workforce innovation and reform, such as the development of national data collections, an increase in the uptake of extended scopes or new or redesigned roles and the roll out of successful workforce redesign programs.21

This Framework will need to be supported by a set of detailed KPIs relevant to its focus.

The implementation of the Framework and the subsequent workplan will involve many different agencies working collaboratively on the core objectives and strategies.

There will be times when this Framework seeks to:

- seed innovations and reforms not previously undertaken
- disseminate the successes and lessons learned from completed projects
- support networks, organisations or systems to scale up existing proven initiatives
- revisit ideas and initiatives that have been attempted before, where barriers or enablers have changed.

In recognition of the complexity and the interdependencies between the existing and parallel workforce development activities of health systems, universities, professional groups and the education sector, the Framework proposes significant investment in the development of a monitoring and evaluation framework that will:

- track the use of the resources allocated for accountability purposes
- develop consumer focused case studies
- capture and disseminate successes and lessons learned
- monitor and report on the achievements against KPIs agreed under the NPA
- provide real time data that will assist the health system to manage, listen to and learn from emergent responses, successes and resistance to change
- describe and provide advice on how to use the interdependencies between all stakeholders in health workforce development and between them and the broader health and education system reforms and restructures.

The monitoring and evaluation network framework will include:

- continuous monitoring of experience and evidence nationally and internationally
- cost effective use of existing data sources
- analysis of governance, regulatory and institutional arrangements that enable or block reform
- local evaluations of all investments under the Framework
- review and meta-analysis of local evaluations
- analysis and review of the monitoring and evaluation of other relevant strategies that are workforce focused or have significant workforce development components at jurisdictional, national and international levels
- primary data collection that allows for the tracking of agreed outputs, KPIs, intermediate and longer term outcomes; an analysis of contribution and attribution; and timely feedback for strategy review and refinement.

The implementation of the Framework and the subsequent workplan will involve many different agencies working collaboratively on the core objectives and strategies.
Domains for Action

A concerted national effort under this Framework will strengthen the ability to implement national health reforms.
Domains for Action

The key priority areas (Domains) in this Framework reflect the areas of innovation identified in strategic health workforce plans of Commonwealth, State and Territory governments and of the Aboriginal and Torres Strait Islander Community Controlled Health services sector.

Taken together, the national reforms and strategies seek to re-shape a health care system that has tended to operate as a disparate set of services, rather than an integrated health system. The national strategies aim to respond effectively to changing pressures and to coordinate services within and across the broader health system to meet the needs of consumers and their communities.

To ensure that the Framework targets activity towards the most urgent and pressing priorities in the next 5 years, HWA will work with Commonwealth, State and Territory governments and organisations to focus on those key workforce innovation and reform domains that will help address the nation’s highest priority health areas.

As outlined in the case for change, government reports, strategies and initiatives across Australia consistently identify the priority population based groups as:

- Aboriginal and Torres Strait Islander peoples
- older people
- people living with chronic diseases
- people living with mental health problems

The future workforce innovations and reforms will have an impact on all areas of the health system, and the emphasis on high priority areas will not diminish the need to explore other critical areas for reform.

The Domains in this Framework have been identified through examination of key international, national and State/Territory strategies and workforce planning documents and have been validated against the national and international literature.

As described in the national primary health care strategy, Australia’s health care system faces significant challenges due to the growing burden of chronic disease, an ageing population, workforce pressures, and unacceptable inequities in health outcomes and access to services.\(^\text{18}\)

This alignment of thinking regarding workforce innovation and reform with key directions in health service reform and priorities will ensure that national health workforce reform efforts complement and support major health system priorities and reform efforts already underway. Better understanding of how the workforce can be developed to meet need and improve the outcomes valued by consumers and carers will contribute to future innovation and reform strategies across the education and health sectors. These strategies will need to be implemented in a way that acknowledges the need for health and education systems to continue to deliver services, while at the same time moving towards new approaches.

The Domains are:

1. Health workforce reform for more effective, efficient and accessible service delivery
2. Health workforce capacity and skills development
3. Leadership for the sustainability of the health system
4. Health workforce planning
5. Health workforce policy, funding and regulation.

The Framework will have a focus on evaluation of the effectiveness of interventions to improve workforce capacity and productivity system wide.

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National Health Workforce Innovation and Reform Strategic Framework for Action 2011–2015

Domains for Action

**KEY DOMAINS**

1. **HEALTH WORKFORCE REFORM FOR MORE EFFECTIVE, EFFICIENT AND ACCESSIBLE SERVICE DELIVERY**

2. **HEALTH WORKFORCE CAPACITY AND SKILLS DEVELOPMENT**

3. **LEADERSHIP FOR THE SUSTAINABILITY OF THE HEALTH SYSTEM**

4. **HEALTH WORKFORCE PLANNING**

5. **HEALTH WORKFORCE POLICY, FUNDING AND REGULATION**

**OBJECTIVES**

1. Reform health workforce roles to improve productivity and support more effective, efficient and accessible service delivery models that better address population health needs.

2. Develop an adaptable health workforce equipped with the requisite competencies and support that provides team-based and collaborative models of care.

3. Develop leadership capacity to support and lead health workforce innovation and reform.

4. Enhance workforce planning capacity, both nationally and jurisdictionally, taking account of emerging health workforce configuration, technology and competencies.

5. Develop policy, regulation, funding and employment arrangements that are supportive of health workforce reform.
**DOMAIN 1**

**Health workforce reform for more effective, efficient and accessible service delivery**

Reform health workforce roles to improve productivity and support more effective, efficient and accessible service delivery models that better address population health needs.

**Context**

Successful planning and implementation of non-traditional roles and workforce models involves micro-level or local level organisational initiatives. Such activity has largely been the focus of Australian and International workforce innovation. Micro-level initiatives can include redefinition of roles, interprofessional collaboration, enabling professionals to work to their full scope of practice and creation of supporting technologies and information systems.

There has been significant work to develop micro-level initiatives that will support re-configured workforce roles and that aim to improve access to care, enhance the patient journey and improve health outcomes. At a national level it will mean taking a fresh look at what different groups of the workforce can do and how they can work together to maximise benefits for individuals and communities while maximising the cost-effectiveness of services.

The evidence shows that generalist, primary care is associated with a more equitable distribution of health in populations and with greater cost-effectiveness. Supporting professionals to practice in generalist roles, to be freed up to maximise their time spent providing care and to utilise all of their skills and training will be crucial. It will mean taking a fresh look at the balance of the generalist and specialist workforces, where required, to meet community need across all disciplines.

Despite the many similarities in the basic training programs of health providers globally, and the well-established health education structure in place in Australia, the pace of reform of health workforce roles and service delivery models has been slower here than in many other comparable Organisation for Economic Co-operation and Development (OECD) countries. There is an important role for activity at the national level to support and guide these micro-level reforms, including by enacting macro-level strategies.

Macro-level strategies include changes in educational approaches and changes in policy or regulation and these are dealt with in more detail in Domains 2 and 5. It is important that during a major period of health system and health workforce reform the current workforce and service delivery systems continue to be supported, and that duplication of effort across levels of government and organisations is minimised. Achieving efficiency gains, for example in improved uptake of advances in technology, will help to ensure that increased resources are available for future reform initiatives.

**Key findings from the literature and practice**

- Any gains in productivity, such as enabling health professionals to spend more time providing direct care to consumers, can effectively and immediately address skill shortages
- Innovative workforce models and work roles often arise at the local level in response to perceived needs at the front line and there is a critical need to identify and enable proven models that can be adapted for other locations or scaled up nationally
- Initiatives have a higher likelihood of success when time and support are provided for planning, change management and rigorous evaluation prior to implementation
- Connecting local initiatives, reducing duplication of effort and developing a coherent and consistent approach to funding evidence-based, sustainable, long-term workforce reform activities will provide more rapid and timely solutions.

The following strategies are designed to support and sustain micro-level workforce initiatives, which in turn support the development and implementation of local, regional and nationally relevant and sustainable service delivery models.
**DOMAIN 1 – Strategies**

**Health workforce reform for more effective, efficient and accessible service delivery**

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<tr>
<th>Strategies</th>
<th>Major lead</th>
<th>Collaborative partners may include:</th>
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| 1.1 Develop resources to assist the identification and national implementation of evidence-based workforce role redesign | HWA | • Accreditation Authorities  
• Regulators  
• Service providers across all sectors (public, private, NGO)  
• DoHA  
• State and Territory Health Departments  
• National Boards/AHPRA  
• VET, University and College educators |
| 1.2 Increase the productivity and retention of the existing workforce and enable all current health disciplines to work to their full or extended scope of practice, including options to better utilise the assistant and support workforce | HWA  
State and Territory Health Departments | • Professional associations  
• Regulators  
• Accreditation Authorities  
• VET and University educators  
• Employers across all sectors (public, private, NGO)  
• DoHA  
• Industry Skills Council  
• Industrial organisations |
| 1.3 Investigate models of workforce reform, policy and funding options that are inclusive of private and NGO providers and recognise their unique business and service delivery models | HWA  
DoHA  
State and Territory Health Departments | • NGO and private sector peak bodies  
• Health insurers  
• Professional associations  
• Industrial organisations |
| 1.4 Develop mechanisms and guidelines across all disciplines for the timely consideration of regulation of redesigned roles and expanded scopes of practice, and accreditation of the training programs to support them | State and Territory Health Departments  
National Boards/AHPRA  
Accreditation Authorities | • VET, University and College educators  
• Service providers across all sectors (public, private, NGO)  
• NGO and private sector peak bodies  
• DoHA  
• HWA  
• Consumer and carer peak bodies  
• Industrial organisations |
| 1.5 Develop a national communication platform for the identification of health workforce innovation and reform initiatives and dissemination to key consumer and workforce stakeholder groups | HWA | • Service providers across all sectors (public, private, NGO)  
• VET, University and College educators  
• Researchers and evaluators  
• Professional associations  
• Consumer and carer peak bodies  
• NGO and private sector peak bodies  
• Employers across all sectors (public, private, NGO)  
• Regulators  
• Industrial organisations |
DOMAIN 2
Health workforce capacity and skills development

Develop an adaptable health workforce equipped with the requisite competencies and support that provides team-based, interprofessional and collaborative models of care.

Context
Micro-level initiatives described in Domain 1 to improve service delivery also need macro-level strategic support for their success and sustainability. Significant national reform is required in both the health and education sectors to improve health workforce capacity and skills. Action is also required to better connect health and education workforce planning with the development of improved service delivery models (see Domain 4). There is a need for education and training providers and accrediting bodies to adopt forward-looking methodologies that go beyond delivering for today and using today’s concepts of workforce. There is also a need to move beyond multi-professional and towards interprofessional training and work practices, where two or more professionals learn with, from and about one another to improve collaboration and quality of care.

To attract and retain a sustainable health workforce we need multiple entry points to health training and careers, starting at school level with programs that will articulate through the whole education framework. It needs to be easy for trained professionals to move across or up the education pathway and to have career change options that will keep them in the health system. It needs to be easy to return to the health workforce after periods away, or to move into and across the health workforce from related fields. The education and health systems need to offer opportunities to acquire new skills and to work and train in new settings to maximise job satisfaction.

Preparation for health workforce entry can begin early. In all Aboriginal and Torres Strait Islander communities children and young people need to be equipped with knowledge, language, literacy and numeracy skills that will open up career pathways both in Indigenous contexts and in the broader health system. This has been identified in the Closing the Gap strategy.

Innovation in education will support broader workforce reform efforts. At a time when new levels of collaboration between the health and education sectors will be crucial, both sectors are undergoing major structural reform through the National Health and Hospitals Network (NHHN) and through the government’s response to the Bradley Review of Australian Higher Education. These factors will need to be managed sensitively and strategically if health workforce innovation and reform is to be successful.
Key findings from the literature and practice

- The mission, goals and drivers of education providers globally are not sufficiently aligned with health workforce challenges and there is a need to simplify processes that will accelerate progress towards developing and accrediting curricula that reflect the skills and competencies required to meet the needs of consumers and their communities.

- Concurrent national reform in health and education should involve a major shift towards common education platforms that will produce more providers delivering general services in expanded settings, with adaptable skills that can be built on and enhanced as needs and priorities change.

- A major shift is required towards interprofessional education and practice, where health professionals from different backgrounds learn with, from and about one another to improve collaborative team-based practice and the quality of care delivered.

The flow on effects of such a shift in health education and training would involve:

- major changes in training and curricula, especially moving towards outcomes based curricula and more competency based training approaches.

- building capacity in the educator and clinical supervisor workforces to support interprofessional practice and education.

- ensuring the depth of training to provide holistic care to meet complex health care needs.

A major shift is required towards interprofessional education and practice, where health professionals from different backgrounds learn with, from and about one another to improve collaborative team-based practice and the quality of care delivered.
## DOMAIN 2 – Strategies
### Health workforce capacity and skills development

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<th>Strategies</th>
<th>Major lead</th>
<th>Collaborative partners may include:</th>
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| 2.1 Accelerate the implementation of evidence-based interprofessional education, changes to scope of practice and emerging health disciplines by working with accreditation and regulatory bodies to develop appropriate and streamlined mechanisms | HWA | • National Boards/AHPRA  
• VET, University and College educators  
• Employers across all sectors (public, private, NGO)  
• State and Territory Health Departments  
• Professional associations  
• Industrial organisations  
• Consumer and carer peak bodies |
| 2.2 Improve productivity, retention and career pathways by the simplification of articulation, both horizontal and vertical, across education/training programs, enhancing recognition of prior learning and existing competencies, and increasing re-entry points to training and career paths | State and Territory Health Departments  
VET, University and College educators  
Employers across all sectors (public, private, NGO) | • National Boards/AHPRA  
• HWA  
• Professional associations  
• Industrial organisations  
• Industry Skills Council |
| 2.3 Raise awareness, promote health careers and build programs in schools and workplaces to increase participation and retention of Aboriginal and Torres Strait Islander people in the health workforce | School, VET and University Educators  
State and Territory Health and Education Departments | • NACCHO  
• Indigenous health professional associations  
• HWA |
| 2.4 Strengthen Aboriginal and Torres Strait Islander health service delivery and accessibility by ensuring education and training programs prepare the workforce to deliver culturally appropriate and safe health care in all settings | State and Territory Health Departments  
VET, University and College educators | • NACCHO  
• Indigenous health professional associations  
• Employers across all sectors (public, private, NGO) |
| 2.5 Facilitate the uptake of technologies that enhance workforce practice and productivity, with an emphasis on underserved communities and populations | State and Territory Health Departments  
Employers across all sectors (public, private, NGO) | • NEHTA  
• VET and University educators  
• HWA |
| 2.6 Expand clinical training placements in underserved and non-traditional settings to maximise learning opportunities and future career choices in these settings | HWA  
DoHA  
State and Territory Health Departments | • Service providers across all sectors (public, private, NGO)  
• Accreditation authorities  
• Regulators  
• VET, University and College educators  
• UDRH and other relevant health research and planning bodies  
• Professional associations  
• Private and community-based health services |
DOMAIN 3  
Leadership for the sustainability of the health system

Develop leadership capacity at all organisational levels to support and lead health workforce innovation and reform.

**Context**
Effective leadership is a crucial factor in successful innovation and reform and is vital when an organisation faces the need to mobilise a workforce in a new way towards a vision, a set of values, or changing work practices. Building a relationship between those who aspire to lead, and those who choose to follow is the essence of the leadership process. Key individuals, occupying all types of health roles as well as consumers and carers, play a major role in shaping and championing beliefs, behaviours, and a culture that will enable change. Local leaders need to be able to identify areas for change and need to be supported to act upon them.

Leadership and management are often confused. The purpose of leadership is to bring about movement and constructive change, while the role of management is to provide stability, consistency, order and efficiency. Involving, supporting and encouraging people to solve problems that will be associated with innovation and reform requires leadership. This leadership can come from anyone in the system.

There are also different concepts of leadership that need to be respected. It will be important to collaborate on health workforce issues with leaders in Aboriginal and Torres Strait Islander communities, health services and health professional groups in joint-decision making, priority setting and constant learning and reflection. Emerging leaders in the Indigenous health professions are relatively small in number and often carry community expectations of advocacy and representation, which can place heavy additional responsibilities on young shoulders. Leadership capacity in the Aboriginal and Torres Strait Islander health and education workforce must therefore be fostered and supported.

States and Territories have made considerable investment in leadership programs for the health workforce over many years. It will be important to build the leadership capacity of health system managers in all sectors to implement reforms and sustain productive work environments.

Many existing programs aim to develop senior clinical leadership, although this Framework’s concept of leadership for health workforce innovation and reform is broader and encompasses the entire health workforce and all levels of health service delivery. Continuing to develop clinical leaders will still be important in supporting, promoting and sustaining interprofessional practice and workplace learning and in leading adaptation of clinical governance for new roles, expanded roles and services delivered in non-traditional settings.

At the system level, leadership is needed across the health and education sectors in order to achieve the major shifts in education content and provision that are foreshadowed in Domain 2. Educators and teachers can play a crucial leadership role in influencing and embedding innovation and change methodology.

At the national level there are major structural reforms underway or foreshadowed, and strong leadership capacity will be required across all levels of the system to guide the workforce changes required to support these national reforms.

The purpose of leadership is to bring about movement and constructive change... It will be important to build the leadership capacity of health system managers in all sectors to implement reforms and sustain productive work environments.
Key findings from the literature and practice

Health care delivery and professional or clinical leadership needs to be supported by the system to authentically and consistently provide direction, based on community and consumer needs and quality and safety.

• At all levels of the health system, leaders will initiate and steer health workforce innovation and reform, particularly at the local level on the frontline of service delivery.

• Strong leadership can lift team performance and conversely weak leadership is identified as a major factor of systems failure.

• Leadership of a diverse workforce that values professional autonomy must include development of workplace cultures that match the locus and style of leadership to the patient journey and experience, with those best placed to lead clinically expected to and empowered to do so.

• Continuity of leadership is essential for the effective implementation and sustainability of innovations.

• Allowing and supporting people to manage, rather than avoid, risk within acceptable parameters is an essential component of leading innovation.

• Development of leadership competencies in the health workforce is necessary, and a national approach will improve consistency and reduction of duplication of effort.

• The right leadership can help to turn around deeply rooted institutional and professional cultures, organisational structures, and social dynamics that can act as barriers to adopting workforce innovation.

• There needs to be improved evaluation of the effectiveness of leadership programs and return on investment.

The following strategies are designed to support the development of leaders who have the vision and skills to lead and manage workforce and service delivery change, respond to emerging challenges and develop and implement proven models of care.

At the national level there are major structural reforms underway or foreshadowed, and strong leadership capacity will be required across all levels of the system to guide the workforce changes required to support these national reforms.
## DOMAIN 3 – Strategies
Leadership for the sustainability of the health system

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<thead>
<tr>
<th>Strategies</th>
<th>Major lead</th>
<th>Collaborative partners may include:</th>
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<tbody>
<tr>
<td>3.1 Develop a nationally consistent leadership competency framework for all health professions at all organisational levels and incorporate it into established, ongoing professional development requirements</td>
<td>HWA State and Territory Health Departments Professional associations Colleges</td>
<td>• Employers across all sectors (public, private, NGO) • Regulators • Accreditation authorities • National Boards • VET, University and College educators</td>
</tr>
<tr>
<td>3.2 Work with professional, regulatory, and accrediting bodies and educators to ensure leadership competencies are included in all education, training and continuing professional development programs</td>
<td>VET, University and College educators Regulators Accreditation authorities</td>
<td>• HWA • Professional associations • Industry Skills Council</td>
</tr>
<tr>
<td>3.3 Develop national health leadership training and capacity building mechanisms to drive innovation and reform and improve productivity</td>
<td>HWA</td>
<td>• DoHA • State and Territory Health Departments</td>
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<tr>
<td>3.4 Accelerate progress in achieving the goals of Closing the Gap by building and supporting the leadership capacity of the Aboriginal and Torres Strait Islander health workforce</td>
<td>DoHA State and Territory Health Departments</td>
<td>• HWA • Peak Indigenous service provider bodies • Indigenous health professional associations</td>
</tr>
<tr>
<td>3.5 Work with clinical leaders in all disciplines to support, promote and sustain interprofessional practice and workplace learning, and to adapt clinical governance procedures for new or expanded roles</td>
<td>State and Territory Health Departments DoHA</td>
<td>• Colleges • Professional associations • Service providers across all sectors (public, private, NGO)</td>
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Health Workforce Planning

Enhance workforce planning capacity, taking account of current and emerging health needs and changes to health workforce configuration, technology and competencies.

Context

To date the focus of planning has been on the existing health professions and the traditional settings and current models of care in which they work. In Australia, it is now recognised that workforce planning methodologies need to factor in new models of care; for example, the effect of policies which shift the focus of service delivery away from institutions to community-based care. National planning must consider the increased role of the private sector and NGOs in providing health services for these new models and the increased variations in payment and funding arrangements for these health practitioners.

There are substantial gaps and inconsistencies in the availability of national workforce data. This has been recognised, and the COAG National Partnership Agreement on Hospital and Health Workforce Reform has tasked HWA with a particular brief to address national health workforce data collection and planning methodologies. HWA will collaborate with agencies to collect improved data on professional groups, including with National Boards / AHPRA, in relation to nationally registered professions.

There are gaps in the existing coverage of workforce planning with inadequate linkages between public and private data. This has been acknowledged in most State and Territory workforce strategies, and a move towards planning that starts with community needs-analysis at the local level appears in most jurisdictional plans. These initiatives recognise the need for change, but under current circumstances, without rigorous national data sets and methodologies, the work will result in duplication of effort across different levels of the health system.

In order to effect real change, workforce planning needs to provide methodologies and tools for identifying and planning the types of health roles and models of service delivery that will best meet the needs of consumers. The new tools must be responsive to regional planning requirements, aware of new and emerging technologies, and factor in the multiple influences on the work participation decisions of the health workforce.

Strong partnerships across the health and education sectors will be critical to effectively plan the pipeline from education to work, especially clinical training placements that involve collaborative planning with service providers.

Key findings from the literature and practice

- There is currently significant variability in workforce planning methodology, tools and approach across the jurisdictions and sectors in Australia.
- There is room to improve existing methods of workforce planning and there is a need for data development to overcome significant national deficiencies.
- Skill-mix planning needs to start from specific analysis of the patient population in question and their current and future health needs in order to determine the type and mix of staffing required.
- There should be increased use of dynamic planning models that provide scenarios of the impact of alternative policies, the impact of new technologies and test policy mixes for their relative effectiveness.
- The capacity for workforce planning needs to be enhanced locally, whilst equipping central planners to use richer sources of information and new methodologies.
- It is essential to have strong operational links and a clear line of sight between educational institutions and other elements of the workforce planning system, and to reflect the responsibilities and authorities of each element through these links.

The following strategies are designed to enable effective workforce planning and modelling of future workforce configurations.
### DOMAIN 4 – Strategies

#### Health workforce planning

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<th>Strategies</th>
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<tr>
<td><strong>4.1 Strengthen a national approach to workforce planning by developing consistent and standardised consumer and needs focused methodologies and tools that can be applied at national, jurisdictional and regional levels</strong></td>
<td>HWA</td>
<td>• Professional associations&lt;br&gt;• Service providers (public, private, NGO)&lt;br&gt;• Regulators&lt;br&gt;• Accreditation authorities&lt;br&gt;• DoHA&lt;br&gt;• State and Territory Health Departments&lt;br&gt;• Skills Australia&lt;br&gt;• Universities Australia&lt;br&gt;• AIHW&lt;br&gt;• ABS&lt;br&gt;• Consumer Health Forum of Australia&lt;br&gt;• COTA&lt;br&gt;• Consumer and carer peak bodies</td>
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<td><strong>4.2 Develop an authoritative National Statistical Resource that brings health workforce related data and information from a variety of sources together at a national level to underpin future workforce planning across the system</strong></td>
<td>HWA</td>
<td>• National Boards/AHPRA&lt;br&gt;• DEEWR, DIAC&lt;br&gt;• Professional Colleges&lt;br&gt;• Professional associations&lt;br&gt;• DoHA&lt;br&gt;• State and Territory Health Departments&lt;br&gt;• AIHW&lt;br&gt;• ABS&lt;br&gt;• Service providers across all sectors (public, private, NGO)&lt;br&gt;• Skills Australia&lt;br&gt;• UDRH and other relevant health research and planning bodies&lt;br&gt;• Health devices, therapeutics and pharmaceutical industry peak bodies</td>
</tr>
<tr>
<td><strong>4.3 Equip workforce planners across the system to utilise and apply national tools to adopt more consistent, accurate and comparable approaches</strong></td>
<td>HWA</td>
<td>• DoHA&lt;br&gt;• State and Territory Health Departments&lt;br&gt;• AIHW&lt;br&gt;• ABS&lt;br&gt;• Service providers across all sectors (public, private, NGO)&lt;br&gt;• Skills Australia&lt;br&gt;• UDRH and other relevant health research and planning bodies&lt;br&gt;• Industry Skills Councils</td>
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<td>Strategies continued</td>
<td>Major lead</td>
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| 4.4 Develop collaborative planning approaches across the health, education and training sectors to more effectively plan and coordinate training responses to future workforce requirements within the context of a deregulated education sector | HWA | • DoHA  
• DEEWR  
• State and Territory Health Departments  
• AIHW  
• ABS  
• Service providers across all sectors (public, private, NGO)  
• Skills Australia  
• UDRH and other relevant health research and planning bodies  
• Industry Skills Councils |
| 4.5 Develop a Rural and Remote Health Workforce Strategy that addresses inequalities in service access | HWA | • DoHA  
• State & Territory Health Departments  
• Employers across all sectors (public, private, NGO)  
• DEEWR  
• Skills Australia  
• Consumer and carer peak bodies  
• Industry Skills Councils |
**DOMAIN 5**

**Health workforce policy, funding and regulation**

Develop policy, regulation, funding and employment arrangements that support health workforce reform.

**Context**

The Australian context provides decision and policy makers with a unique set of challenges and characteristics. These include the continuing inequity in health outcomes for Aboriginal and Torres Strait Islander people; the needs of underserved regional, rural and remote communities; a three-tiered system of government with a complex mix of public, private, not for profit and community-controlled service delivery. This complexity can give rise to inequities and a cogent example is the substantial variation in Aboriginal and Torres Strait Islander Health Worker wage levels that are dependent on geographical location, jurisdiction and sector of employment. Other health professionals in comparable roles often receive higher remuneration and this may be influenced by differences in factors such as training pathways and industrial award systems.

There is a myriad of employment, self-employment, small business, contracting and payment arrangements for the health workforce. This is compounded by multiple industrial instruments and other regulations that determine workplace roles and responsibilities.

These challenges require specific social and political choices about access to and delivery of health care before appropriate methods can be used to derive requirements for providers and services in particular populations, locations and sectors. Government has articulated many of these choices in national health plans and priority areas for action. Appropriate methods of identifying the service requirements of consumers, carers and communities have been suggested in the previous Domains of this Framework.

The principal policy levers available to governments to shape the health workforce include education, occupational regulation, and health care funding and organisation. It will be important to utilise relevant policy levers to appropriately balance generalist and specialist skills within disciplines to address equity of access and cost issues. This will be particularly important in regional, rural and remote areas and in underserved communities as health expenditure trends upwards. There are a range of financial, status and structural impediments to achieving the correct balance in many disciplines.

Important industrial and regulatory issues need to be addressed to realise fundamental changes in job design, scope of practice, professional demarcation and the creation of new roles. Close collaboration and information sharing between health and other government portfolios will be crucial, as will collaboration and information sharing between key agencies.

The objectives and guiding principles of the National Registration Accreditation Scheme legislation that is to be implemented by AHPRA support the intent of this Framework and include the following:

3.2.e – to facilitate access to services provided by health practitioners in accordance with the public interest and

3.2.f – to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by health practitioners. [Health Practitioner Regulation National Law Act 2009, p.26]

HWA and others will have the opportunity to work with National Boards, AHPRA and accreditation authorities to achieve the legislation’s objectives, guided by this Framework.

**Key findings from the literature and practice**

- Health care policy decisions, for example financing, can unintentionally impede health workforce innovation and reform. Policy formulation should take account of the potential implications for the health workforce.

- There are current regulatory barriers to ongoing reform of the health workforce.

- Industrial relations law and practices, and other legislation can impact positively and negatively on workforce reform.

- The policies and practices of professional accreditation bodies can be both enablers and barriers to workforce reform.

The following strategies are designed to support and inform policy development, regulation, funding and employment arrangements that are supportive of health workforce reform.
**DOMAIN 5 – Strategies**

**Health workforce policy, funding and regulation**

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<th>Strategies</th>
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<tr>
<td>5.1 Identify the system-wide changes required to achieve an effective balance between generalism and specialism in all disciplines to meet community need</td>
<td>HWA State and Territory Health Departments</td>
<td>• Professional associations&lt;br&gt;• Service providers across all sectors (public, private, NGO)&lt;br&gt;• Regulators&lt;br&gt;• Accreditation authorities&lt;br&gt;• Health insurers&lt;br&gt;• National Boards/AHPRA&lt;br&gt;• Consumer and carer peak bodies&lt;br&gt;• Industry Skills Councils&lt;br&gt;• Skills Australia&lt;br&gt;• Industrial organisations</td>
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<td>5.2 Identify policy, financial and non-financial mechanisms which enable the most cost-effective, efficient deployment of the health professional workforce</td>
<td>DoHA State and Territory Health Departments</td>
<td>• HWA&lt;br&gt;• Professional associations&lt;br&gt;• Consumer and carer peak bodies&lt;br&gt;• Industrial organisations</td>
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<tr>
<td>5.3 Maximise the retention of the clinical training supervisor workforce across disciplines in the public, private and community-based sectors by addressing policy, regulatory and other mechanisms</td>
<td>HWA State and Territory Health Departments</td>
<td>• Employers across all sectors (public, private, NGO)&lt;br&gt;• Peak bodies for self-employed health professionals&lt;br&gt;• Professional associations&lt;br&gt;• National Boards/AHPRA&lt;br&gt;• Industrial organisations</td>
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<td>5.4 Facilitate further legislative and regulatory reforms to allow for the appropriate mobility of the health workforce across professions and the implementation of expanded scopes of practice</td>
<td>State and Territory Health Departments</td>
<td>• DoHA&lt;br&gt;• State and Territory Health Departments&lt;br&gt;• National Boards/AHPRA&lt;br&gt;• HWA&lt;br&gt;• Accreditation authorities&lt;br&gt;• Industrial organisations</td>
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<tr>
<td>5.5 Support the articulation of training programs to improve the retention of health professionals and their career flexibility including through contemporary and responsive accreditation processes</td>
<td>Universities Australia&lt;br&gt;Australian Qualifications Framework Council&lt;br&gt;National Boards/ AHPRA</td>
<td>• Professional associations&lt;br&gt;• Industry Skills Councils&lt;br&gt;• Skills Australia&lt;br&gt;• TEQSA&lt;br&gt;• ASQA&lt;br&gt;• Higher education and training providers&lt;br&gt;• HWA&lt;br&gt;• Industrial organisations</td>
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<tr>
<td>5.6 Address legislative, regulatory, industrial and other barriers to minimise waste, inefficiency and duplication and to achieve greater workforce ability to respond to the health needs of the community</td>
<td>Commonwealth, State and Territory governments</td>
<td>• Regulators</td>
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<td>• Employers across all sectors (public, private, NGO)</td>
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<td>• State and Territory Health Departments</td>
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<td>• Industrial organisations</td>
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<tr>
<td>5.7 Address remuneration, payment arrangements and terms and conditions to support workforce models that increase accessibility, improve workforce retention and productivity and encourage interprofessional practice</td>
<td>State and Territory Health Departments DoHA</td>
<td>• Employers across all sectors (public, private, NGO)</td>
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<td>• Service providers across all sectors (public, private, NGO)</td>
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‘Reform – a change for the better’

Merriam Webster Dictionary
Glossary

**Aboriginal and Torres Strait Islander Community Controlled Health Services (ACCHS):** Aboriginal communities operate over 130 ACCHSs (sometimes called Aboriginal Medical Services or AMSs) across Australia. They range from large multi-functional services employing several health professionals and providing a wide range of services, to small services which rely on Aboriginal health workers and/or nurses to provide the bulk of primary care services, often with a preventive, health education focus. The services form a network, but each service is autonomous and independent of one another and of government.

**ABS:** Australian Bureau of Statistics.

**Accreditation Authorities:** professional and statutory bodies that approve or recognise specific education and training programs in the context of the requirements for professional qualification. These organisations may also have a prescribed statutory responsibility to approve or recognise programs and/or determine the academic standards and professional and vocational components of such programs.

**ACTU:** Australian Council of Trade Unions.

**AHMC:** the Australian Health Ministers’ Conference consists of all Australian Government, State, Territory and New Zealand Ministers with direct responsibility for health matters, including the Australian Government Minister for Veterans’ Affairs.

**AHPRA:** Australian Health Practitioner Regulation Agency. The term AHPRA is used throughout the document to denote the activities of the National Health Professions Boards and the National Health Professions Councils.

**AiHW:** Australian Institute of Health and Welfare.

**ASQA:** Australian Skills Quality Authority.

**Assistant:** An assistant works to, and under the supervision of a health practitioner, takes on less complex treatment or care tasks, and/or performs administrative or other tasks that would otherwise reduce the time available for more complex direct care by more highly trained practitioners.

**Bradley Review:** a 2008 Government-initiated Review of Higher Education to examine the future direction of the higher education sector. The review was conducted by an independent expert panel, led by Emeritus Professor Denise Bradley AC. The Government’s response was a series of reforms contained in its 2009 *Transforming Australia’s Higher Education System* report.

**Carer:** someone who has a caring role for a person with a health problem or illness. Carers could be family, friends or staff of an organisation who are paid or unpaid. The role of the carer is not necessarily static or permanent, and may vary over time according to the needs of the consumer and the circumstances of the carer.

**Clinical:** related to the diagnosis and treatment of health conditions within established health care guidelines and therefore primarily describing health care workers.

**Clinical governance:** policies or frameworks that addresses those structures, systems and processes that assure the quality, accountability and proper management of an organisation’s operation and delivery of service.

**Clinical leadership:** formal and informal leadership within a service to improve service quality and approach and to set direction.

**Clinical placement:** provides opportunities in a relevant professional setting for the education and training of health sector students for the purposes of: integrating theory into practice; familiarising the student(s) with the practice environment; and building the knowledge, skills and attributes essential for professional practice, as identified by the education institution and/or external accrediting/licensing body. During clinical placements the provision of safe, high quality patient care is always the primary consideration. It is recognised that a clinical placement may be conducted in any number of locations, including non-healthcare settings for some allied health professions, and that the setting and/or location of a placement will necessarily vary both within and across professions.
**Clinical supervision:** Clinical supervision involves the oversight by a clinical supervisor of professional procedures and/or processes performed by a student or a group of students within a clinical placement for the purpose of guiding, providing feedback on, and assessing personal, professional and educational development in the context of each student’s experience of providing safe, appropriate, and high quality patient care.\(^\text{22}\)

**Clinical supervisor:** an appropriately qualified and recognised professional who guides students’ education and training during clinical placements. The clinical supervisor’s role may encompass educational, support and managerial functions. The clinical supervisor is responsible for ensuring safe, appropriate and high quality patient care.

**Closing the Gap:** the Prime Minister’s February 2009 report to Parliament, *Closing the Gap on Indigenous Disadvantage: The Challenge for Australia*, outlined the evidence on which the Government’s closing the gap commitments are based. The Australian Government is working with the States and Territories to remedy the long-term systemic failures that have marginalised Indigenous Australians. The COAG National Indigenous Reform Agreement:

- commits all jurisdictions to achieving the Closing the Gap targets
- defines responsibilities and promotes accountability among governments
- provides a roadmap for future action
- commits significant funding through National Partnership Agreements to assist in meeting the targets.

The National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes is one of five National Partnership Agreements.

**COAG:** the Council of Australian Governments is the peak intergovernmental forum in Australia, comprising the Prime Minister, State Premiers, Territory Chief Ministers and the President of the Australian Local Government Association.

**Colleges:** postgraduate education, training and professional development bodies in the health sector. These include nursing colleges, specialist medical colleges and similar bodies for other health professions. Colleges may or may not have a role in setting standards and accrediting education programs.

**Commonwealth:** Australia is a federated system, consisting of states, territories and federal government. The term Commonwealth denotes federal (national) level departments or legislation.

**Competencies:** the abilities needed by graduates, where specific elements of knowledge, skills and attitudes are the components of a given specific ability. Adapted from Frank JR, Snell L et al (2010). *Competency-based medical education: theory to practice*. Medical Teacher 32(8): 638–645]

**Competency based education (CBE):** an approach to preparing the health workforce for practice that is oriented to developing abilities. CBE is organised around competencies. These competencies are derived from an analysis of community and individual needs. CBE assesses the readiness of the health practitioner based on his/her demonstration of competence, rather than completion of required time in training.

**Consumer:** a person who uses or has used a health service.

**Cultural competence:** A set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals and enable that system, agency or those professionals to work effectively in cross cultural situations.

Cultural safety: an environment, which is safe for people; where there is no challenge to or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning together with dignity, and truly listening. Adapted from Williams R (1998) http://www.ruralhealth.utas.edu.au/indigenous-health/RevisedCulturalSafetyPaper-pha.pdf]

DEEWR: Commonwealth Department of Education, Employment and Workplace Relations.

DIAC: Commonwealth Department of Immigration and Citizenship.

Discipline: a body of knowledge and approach to assessment, treatment and support.

DoHA: Commonwealth Department of Health and Ageing.

E-health: health services or information delivered or enhanced through the Internet and related technologies. E-health platforms can also facilitate professional training for the health workforce and secondary consultations between health professionals.

Future outcomes: the ultimate goals of the reform program.

GDP: Gross domestic product.

Generalism: an approach to the practice of health care in all disciplines that provides holistic care of a person over time; managing a range of conditions, mindful of the impact of external and societal factors on health, and referring to specialists or other services as and when required.

Generalist: a health professional whose practice is not oriented to a specific specialty, specific disease or specific part of the body, but instead covers a variety of health problems.

Health insurers: the term denotes organisations that provide health care insurance to individuals for costs related to their treatment and to organisations that provide indemnity insurance to health practitioners.

Health promotion and prevention: the process of enabling people to increase control over and to improve their health. Prevention covers measures not only to prevent the occurrence of illness, but also to arrest its progress and reduce its consequences once established.

Health student: a student or trainee who is enrolled in a health-related education or training program and who works in a health service setting as part of his or her training or registration requirements.

Holistic: considering the whole person and all aspects of a person’s health and wellbeing: physical, mental, environmental and social.

Industrial organisations: organisations that represent the interests of employees or employers and are registerable under the relevant State/Territory legislation or under the Fair Work (Registered Organisations) Act 2009.

Industry Skills Councils: government-funded bodies, governed by independent industry-led boards that provide information and advice to Skills Australia and State and Territory governments. The Councils also work to assist Registered Training Organisations on specific programs. The Community Services and Health Industry Skills Council is of particular relevance.

Intermediate outcomes: specific changes in systems, organisations, and personnel that result from the program and contribute to achieving its ultimate goal.

Interprofessional learning, training, practice or collaboration: where two or more professionals practice and learn with, from and about one another to improve collaboration and the quality of care.

Jurisdiction: technically, an area with a set of laws under the control of a system of courts which are different to neighbouring areas. In these documents, ‘jurisdictions’ refers to the Commonwealth, State and Territory governments of Australia.

KPI: Key performance indicator.
Multidisciplinary teams (MDTs): an integrated team approach to health care in which professionals from different disciplines consider all relevant treatment options and develop collaboratively an individual treatment plan for each consumer, based on the body of knowledge, approach and contribution of their respective professional/discipline groups.

Multi-professional learning: where two or more professionals learn side by side.

NACCHO: National Aboriginal Community Controlled Health Organisation, the national peak Aboriginal health body representing Aboriginal Community Controlled Health Services throughout Australia.

NEHTA: National E-Health Transition Authority, established by the Australian, State and Territory governments to develop better ways of electronically collecting and securely exchanging health information.

NHHN: National Health and Hospitals Network, established as the governments’ implementation response to the NHHRC, through National Partnership Agreements in 2010 and 2011.


Non-clinical: health care related work other than that described in clinical (above). Non-clinical work may include, but is not limited to, assistance with daily living and rehabilitation, health education, laboratory or research roles, logistical and administrative roles.

Non-government organisations (NGOs) in the health sector: private, not-for-profit, and community-managed organisations that provide care or support services for people affected by illness and their families and carers. NGOs may promote self help and provide support and advocacy services for people who have a health problem or an illness, and their carers, or who have a physical or psychosocial rehabilitation role.

Not-for-Profit: organisations that do not operate on a commercial basis. These may include community sector, faith-based or philanthropic organisations or trusts.

NPA: the National Partnership Agreement (2008) was an inter-governmental agreement of COAG (see above) to contribute $3.042 billion to improve efficiency and capacity in public hospitals through the following four reform components: (a) introducing a nationally consistent funding approach; (b) improving health workforce capability and supply; (c) enhancing the provision of sub-acute services; and (d) taking the pressure off public hospitals.

The NPA (2010) was a subsequent inter-governmental agreement of COAG providing funding to support the implementation of structural reforms under the new NHHN.

Nurse practitioner: registered nurse educated to function autonomously and collaboratively in an advanced and extended clinical role. The scope of practice may include, but is not limited to, the direct referral of patients to other health care professionals, prescribing medications and ordering diagnostic investigations.

OECD: the Organisation for Economic Co-operation and Development, which was established in 1961 and has a mission to promote policies that will improve the economic and social well-being of people around the world. It has a membership of 34 countries, including Australia, China, India and Brazil and developing economies in Africa, Asia, Latin America and the Caribbean are not currently members of the OECD.

Peak bodies: representative bodies for a number of organisations or groups with common interests or scope of activity.

Primary health care: essential health care made accessible at a cost a country and community can afford, with methods that are practical, scientifically sound and socially acceptable. Primary health care services often constitute the first point of contact for people experiencing a health problem and their families. Primary care services include general practitioners, emergency departments and community health centres.
**Private:** non-government enterprises, small businesses or private practices that deliver health services on a commercial or fee-for-service basis, with or without subsidisation from the public health system.

**Productivity Commission:** Australian Government’s independent research and advisory body on a range of economic, social and environmental issues affecting the welfare of Australians.

**Professional associations:** organisations that represent the interests of members of the same professions, with activities ranging from standard setting, accreditation of education and training programs, information sharing, professional development, advice to government and the public on areas of policy, or advocacy on behalf of members. Professional associations may or may not operate as industrial organisations (see above).

**Professionals in health:** refers to members of the workforce who are specifically trained in health and are expected to work to particular standards and/or meet registration requirements.

**Regulated professionals:** professionals subject to regulatory controls, either through statutory regulation (nationally or partially – only in some states and territories) or self-regulation where the profession regulates itself, often through a professional association.

**Regulators:** bodies responsible for exercising authority over individual or institutional activity in the provision of health services, for example in permitting health professionals to register for practice, determining the scope of practice of professions, or determining requirements for staff numbers in service settings. e.g. National Boards.

**Retention:** keeping health professionals working in a health service or, more broadly, in the health system, for as long as possible.

**Scope of practice:** the range of activities that a practitioner in an occupation or discipline may practice. Scope of practice is usually limited to that which legislation allows for specific education and experience, and specific demonstrated competencies.

**Secondary consultation:** a service delivered to a professional from another agency or service provider about a specific client of that other agency. In contrast to primary consultation, in secondary consultation the client may or may not be present during the consultation. A secondary consultation may involve discussion about a number of clients of the other agency or service provider.

**Self-regulated professionals:** professions where the assessment of an individual’s suitability to practice is conducted by peers, rather than by an independent agency or government. In such cases, regulation processes may be conducted by a professional association or similar body.

**Skills Australia:** an independent statutory body, providing advice to the Minister for Tertiary Education, Skills, Jobs and Workplace Relations on Australia’s current, emerging and future workforce skills needs and workforce development needs.

**Specialism:** a devotion or restriction to a particular branch of study or practice.

**Specialist:** a health professional who, within a discipline, focuses on specific health problems, conditions or parts of the body.

**State and Territory Health Departments:** each Australian State and Territory has a department responsible for health. Titles of departments may vary between jurisdictions.

**Student:** For ease of reference, this Framework uses the term student to refer to the person undertaking education or training in a clinical placement within the health sector. The term is intended to encompass anyone undertaking education or training across the spectrum of those being supervised in a clinical placement – inclusive of the VET sector, professional entry level to postgraduate students and vocational trainees in medicine, nursing and midwifery, dental and the allied health professions.
Support workers: although often used interchangeably with assistants in some contexts, for the purposes of this document support workers denotes a broad range of health care roles they may or may not require training or qualifications.

Technologies: devices, therapeutics, imaging, simulation and communication technologies and other supports that complement the work of health professionals in providing care, learning, or training and supervising others.

Telehealth: the delivery of health-related services and information via telecommunications technologies.

TEQSA: Tertiary Education Quality and Standards Agency, an independent body with powers to regulate university and non-university higher education providers, monitor quality and set standards. At the time of writing, an interim TEQSA has been established.

UDRH: University Departments of Rural Health, established with Commonwealth funding with a brief to provide programs to encourage students of medicine, nursing and other health professions to pursue a career in rural practice by providing opportunities for students to practise their clinical skills in a rural environment; and to support health professionals currently practising in rural settings.

Underserved: populations that do not have adequate access to health care.

Universities Australia: the peak body representing Australia’s 39 universities.

Unregulated professionals: health care professionals who do not require registration in order to be employed in a particular role or to practice.

VET: Vocational Education and Training.