Notes: This document was prepared by the Policy and Planning Group during 2011 for the purpose of assessing how key external factors have affected the Health and Community Services industry since 2007. It is not intended to be exhaustive. The Community Services and Health Industry Skills Council (CSHISC) is the industry skills council for this industry. This brief draws strongly on the CSHISC Environmental Scan 2011, which in turn focuses strongly on workforce development issues facing the sector given industry growth and labour shortages in Australia. Given the strength of the industry in Australia, this brief excludes a consideration of global health trends or research.

Overview and Rationale

The Health and Community Services Industry in 2006-2007 (as outlined in original IES) - Why was this industry selected?

In 2006-07 the industry was the third largest industry in Australia and a major employer, with more than half a million Australians employed in the health sector alone. RMIT had research, and learning and teaching strengths in Health and Community Services education and training. The industry was mostly concentrated in government funded services, with greater fragmentation in allied and complementary health and an overall trend towards greater individual contribution. Key factors affecting the industry (and demand for services) included an ageing population, increases in chronic ‘lifestyle’ diseases, mental illness, e-health and a changing health workforce.

The Health and Community Services Industry in 2011 – Summary (Why should RMIT continue to focus on this sector?)

The Health and Community Services sector is now Australia’s largest employer (DEEWR), employing 11.4 per cent of the total Australian workforce (CSHISC). The long and short term employment outlooks are strong, buoyed by demographic changes and an ageing workforce. Skills shortages persist in key areas and it remains a key priority for both State and Commonwealth Governments, for example through public health spending and through research priorities.

Significantly, given the workforce growth and funding challenges facing the industry, state and federal government focus is on improving workforce productivity through changing the skills mix of the workforce in addition to increasing supply. Other factors affecting the industry include changing technology and greater use of technology in education and training, new health business models, IT, changing patient and community roles and greater cross-skilling. A key pressure relates to maximising the value of the public health dollar and finding new more efficient ways of addressing (or preventing) health issues. These factors also create opportunities for training providers to work with the sector and develop new and innovative ways to deliver services.

Industry Snapshot

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Government spending on health (SM-Cth and State)</td>
<td>69,510 (AIHW)</td>
<td>84,789 (09-10) (AIHW)</td>
<td>Employment</td>
<td>1 million approx (ABS)</td>
<td>1.3 million approx (ABS)</td>
</tr>
<tr>
<td>Share of population with private health insurance</td>
<td>42.7% (2005-06)</td>
<td>45.3% (2010-11) IBIS (citing Private Health insurance administration council)</td>
<td>Non-government spending on health (5m) (AIHW)</td>
<td>102,391 (AIHW)</td>
<td>121,355 (09-10) (AIHW)</td>
</tr>
</tbody>
</table>

Economic Economic factors include economic growth, interest rates, exchange rates and the inflation rate. These factors have major impacts on how businesses operate and make decisions.

Industry performance

The industry is experiencing strong growth. There is strong demand for services (see sociocultural) and a strong demand for workers (see below at employment). Modelling to 2025 predicts continued growth in community services and health (CSHISC). Health is an essential service and despite the global economic slowdown, attendances at GPs and hospitals for routine matters remaining constant throughout 2008 and 2009 (IBISWorld). Public spending has also remained steady, albeit with some reduction in private spending (IBISWorld).

Increasingly complex client needs and a greater integration between services and enhanced focus on client choice and participation (CSHISC) are changing modes of delivery. General hospitals (which contribute 47.8 per cent of health...
services revenue) are expected to grow by 4.7 per cent pa (IBISWorld) with increasing outsourcing of other services such as pathology and diagnostic imaging (IBISWorld) continuing to create opportunities for other health industry businesses. There has been a rise in the number of smaller firms offering niche services, although overall numbers are stalling (IBIS 6). There are signs of increased competition, both overall and increasingly between different sub-industries (IBISWorld). Mergers are likely to continue (IBISWorld).

Other indicators which point to industry growth (over the period and into the future) include:

- Strong public health funding and recent health care reforms (see below at political) increase public funding.
- There is a trend towards greater individual contribution towards health care which also increases private funding.
- Demand for disability services is growing at a rate of approximately 7.5 per cent per year (CSHISC).
- Strong growth in alternative therapies such as acupuncture, homeopathy and naturopathy (IBIS 6) with the number of complementary therapists in Australia growing by 61 per cent (to 23,400) between 2003 and 2008 (CSHISC).
- Community services industry and workforce is predicted to grow significantly over the next 15 years to meet increasingly complex client needs, changing demands and more integrated services (CSHISC).

**Employment and Workforce**

Continued strong growth in the industry and predicted future demand places increasing pressure on the industry for employment, recruitment, retention and wages. Health and community services provision is labour intensive and skills shortages in the industry have been persistent over most of the past decade (see further below at skills and productivity) 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 (HWA, citing OECD).

Pressures on the Australian health and community services workforce include:

- Employment rose 8.6 per cent between 2009 and 2010 (CSHISC). Employment growth is expected to be strong across all eight specific Health Care and Social Assistance sectors over the next five years (ABS).
- The average industry annual employment growth over the last decade (3.7 per cent) is higher than the all industries average (2.1 per cent) (DEEWR).
- Approximately 56.5 per cent of revenue in 2011-12 is expected to go to wage costs, up from 54.5 per cent a decade ago (IBISWorld), with wage growth exceeding increases in revenue and employment in alternative therapies (IBISWorld).
- The push for wage parity between community services and health services workforce (CSHISC).
- Nearly half of the existing workforce is over the age of 45.
- Generational changes mean that many providers are not working the same long hours or practicing in the same way as their predecessors (HWA Action Plan).
- Australian health services are relying heavily on overseas trained health professionals to meet shortfalls in workforce supply, particularly in rural and remote areas (HWA Action Plan).

Combined, these factors mean that the workforce needs to grow, while replacing retiring workers and finding more efficient ways of meeting the need, such as through multi-skilling, and the industry faces significant workforce reform. However, achieving the reform is more challenging as the industry has “a myriad of employment, self-employment, small business, contracting and payment arrangements for the health workforce...compounded by multiple industrial instruments and other regulations that determine workplace roles and responsibilities” (HWA).

(See further below at COAG reforms)
Socio-cultural factors are a very strong driver for the industry. Similar to most developed countries, Australia's overall population is ageing due to sustained low fertility and increasing life expectancy. Life expectancy is now 84 for females and 79 for males (CSI, quoting AHW), with the median age increasing by more than five years over the last two decades, although life expectancy at birth differs among population groups and is significantly lower for the Aboriginal and Torres Strait Islander community (ABS). The ageing population increases demand for health and community services as (despite increasing life expectancy) poor health, chronic disease and disability increases with age. For example, in 2010 it was estimated that 1.5 million people required help with core daily activities and the number of people with this high level of disability is expected to increase to almost 2.3 million by 2030 (CSHISC). This growth in disabilities – and the economic and social impact of caring for Australians with a disability – is leading to further reform in this area (see further below at political).

Other socio cultural and demographic changes affecting the industry include:

- By 2026, more than one quarter of people aged over 80 in Australia will be from culturally and linguistically diverse backgrounds (CSHISC).
- Family sizes are decreasing and there is an increase in single or divorced people, leading to a decrease in the number of informal carers (CSHISC).
- Client needs are becoming increasingly complex – e.g. people may have contact with criminal justice system, substance abuse issues, disabilities health workers may need to engage community services.
- More people are retaining their teeth (which continues the need for oral health services) (CSHISC).
- Approximately 7 million Australians (46 per cent) have literacy levels lower than required to participate fully in life and work (CSHISC, citing Adult Literacy and Life Skills Survey, 27). This can affect the support needs of clients and also the workforce/skills needs of industry employees or potential employees.
- Increasing consumer choice and greater access to information are creating a more savvy client base.
- Increasing obesity and excess body weight among Australian children.
- People living in the major cities are generally less likely to die from preventable causes than people in country areas, regardless of socioeconomic levels (State of Australian Cities).

Technological factors include R&D activity, automation, technology incentives and the rate of technological change. They can determine barriers to entry, minimum efficient production level and influence outsourcing decisions.

This is a high technology change industry, with new or enhanced technology changing the way services are provided directly (such as through medical diagnosis or treatment) and indirectly, such as in the area of health information and documentation technology. Broader reforms (such as the trend to service integration) also change the way services are offered. Increasing technological advancements “consistently increas(e) costs and minimis(e) profit growth” (IBISWorld).

Key technology trends identified by the Industry Skills Council include:

- Assistive and communications technologies important for the aged care and disability sectors (26).
- Better information technology to improve reporting and coordination requirements.
- Technology to enable people to stay in their own homes. The Medical Technology Association of Australia proposes that $3.1 billion in health care spending can be saved “through the use of products such as implantable cardiac devices that wirelessly transmit data, and other devices that monitor trends and trigger alerts” (CSHISC).
- Creation of simulated learning environments.
- New education and training products (such as online learning and assessment strategies and products) and real-time online video links for providing health and community services.
- Telephone-based health services (e.g. communications technology to provide advice through roles including health coaching, counselling, service coordination and case management).
Health Workforce Australia also notes that e-health platforms can also facilitate professional training for the health workforce and secondary consultations between health professionals (HWA, Action Plan). Enhanced IT applications in health care can also be seen in hospital administration, with systems applications for patient administration, financial management, clinical information, medication prescription management, incident management, patient tracking, medical equipment, surgical equipment and devices (IBISWorld). Potential growth in online medicine can improve service efficiencies with very strong applications in rural and regional areas (IBISWorld).

**National Research Priorities**

The National Research Priorities are unchanged since 2002 and ‘Promoting good health and well being for all Australians’ remains a national research priority in its own right. Venturous Australia recommended that public sector innovation priorities should include population health and applications to utilise broadband infrastructure (especially in health, education and public data access). Additionally, “frontier technologies for building and transforming Australia” can have applications in the industry. The HWA action plan includes activity to encourage uptake of technologies, particularly in underserved areas (HWA). Research Australia has found that the Australian health and medical research sector performs well at an international level, but that there is a need for increased investment to maintain Australia’s position at the international level as health and medical research spending only represents 3.4 per cent of the total Australian Government spending on health (Research Australia).

Other analysis of Research Australia also point to strong R&D opportunities:

- The medicine industry invests over $1 billion in research and development every year and total annual revenue is estimated to be in the order of $7.6 billion for 2009-2010.
- Philanthropic investment is estimated to be $800 million to $1.4 billion per year.
- The National Health and Medical Research Council (NHMRC), the major national vehicle for Australian Government funding for health and medical research, has experienced a five-fold increase since 1995.
- Victoria receives the largest proportion of NHMRC grants (39.80 per cent), followed by NSW at 26.80 per cent.
- There has been strong growth in funding for public health, health services and clinical research.

**Political factors**

Political factors are how and to what degree a government intervenes in the economy, including tax policy, labour law, environmental law, trade restrictions, tariffs, and political stability.

The industry is heavily regulated. Responsibility is split between state and federal governments, however, the health care reforms implemented over the period are changing responsibilities. Australian Government spending on health has overtaken growth in GDP each year in the past decade (Research Australia). Evidence of continued and sustained investment into the industry over the period includes:

- Commonwealth policies continue to support Medicare and the Pharmaceutical Benefits Scheme.
- In 2008, the Council of Australian Governments (COAG) agreed to specific timeframes for overcoming Indigenous disadvantage by achieving six Closing the Gap targets.
- Commonwealth stimulus packages during the period include some encouragements for people to spend on elective procedures such as dentistry (IBISWorld).

However, Australia’s ageing population creates challenges for government sustaining this investment into the future, not only due to increased health care costs but also as the ratio of working age people to retirees will reduce. This is likely to increase focus on preventative care, efficiencies and requiring greater private contribution towards the costs of health care. For example, the Medicare Levy Surcharge (MLS) (introduced in 1997), the Lifetime Health Cover (introduced in 2000) and the Private Health Insurance Rebate (introduced in 1999) are Commonwealth policies which encourage private health insurance uptake and minimise pressures on the public health system.

**Health Care Funding and Reforms**

Growth in healthcare funding and spending is relatively constant, with government revenue for health care consistently increasing in line with GDP and often faster (IBISWorld). Australian government spending on health is projected to rise,
based on the ageing population and also expected technological advancements in health and demand for higher quality health services by people of all ages (ABS).

In February 2008, the new Labour Government announced the establishment of the National Health and Hospitals Reform Commission, which reviewed health system arrangements and made recommendations. In February 2011, the National Partnership Agreement on Hospital and Health Workforce Reform was signed, detailing new funding arrangements for public hospitals including a new funding pool and administrative arrangements. On 2 August 2011, COAG finalised the National Health Reform Agreement which sets out funding and management responsibility for key aspects of the industry, with, for example, the Commonwealth taking lead responsibility for GP and primary health care and full funding and program responsibility for aged care and the States to take the management of the public hospital system and have joint responsibility with the Commonwealth for funding public hospital services.

**National Disability Scheme**

During 2011, the Productivity Commission reviewed long-term care and support scheme for people with disability in Australia, which:

- Found that the current disability support arrangements are "inequitable, underfunded, fragmented and inefficient and give people with disability little choice".
- recommended a National Disability Insurance Scheme to provide all Australians with insurance for the costs of support if they or a family member acquire a disability.
- recommended a National Injury Insurance Scheme to provide no fault insurance for anyone who suffers a catastrophic injury (FAHCSIA).

The Commonwealth has signalled that it supports the reform vision proposed by the Productivity Commission and stated that it “will work to lay the foundations for reform with states and territories, who currently deliver and have primary funding responsibility for disability support services, consistent with the recommendations of the Productivity Commission” (FAHCSIA). The Commonwealth has initially provided $10 million to support technical policy work, although longer term implementation of the recommendations will require significant additional funding from state and federal governments.

**COAG Workforce Reform**

The workforce challenges noted above require a multi-dimensional and coordinated approach to health workforce issues across government. In 2006, COAG agreed to a significant national health workforce reform package (AHWO). In November 2008 COAG announced $1.1 billion of Commonwealth funding over four years for health workforce and infrastructure initiatives.

The package includes funding streams for supervision training and simulated learning environments, and a non-recurrent allocation of $130 million for the development of capital infrastructure. In 2010 Health Workforce Australia was established to facilitate implementation and carry out activities spanning policy and research, clinical training, innovation and reform of the health workforce and recruitment and retention of international health professionals (CSHISC). In 2011, HWA has released the National Health Workforce Innovation and Reform Strategic Framework for Action 2011-2015 which sets out "key priority areas and five essential domains" to create the foundation for “an integrated, high performing workforce fit to meet Australia’s health care needs” (HWA). An implementation plan is currently being developed which is likely to guide future reform and activities. The Domains for action include health workforce reform, skills development, leadership, planning and funding and regulation (HWA).

**Regulatory Changes**

The Australian Health Practitioner Regulation Agency (AHPRA) was established in July 2010 to implement the National Registration and Accreditation Scheme across Australia (AHPRA). Other specific regulatory changes include:

- National Compact and Not-for-Profit Sector Reform Council to strengthen partnerships and collaboration. The council is charged to drive reform and consider scope of a national ‘one stop shop’ regulator.
• AHPRA has increased the International Language Testing System (IELTS) score required for health profession registration (CSHISC).
• From 2014, holders of certificate IV enrolled and division 3 nursing qualifications will not be eligible for registration (CSHISC).
• The National VET Regulator is due to appoint a community services and health case manager.

Other select key government policy and initiatives over the period include:

**National**
- Children’s Services Policy Agenda: including a new National Quality Framework, and development of a national early childhood strategy (CSHISC)
- Productivity Commission study -Caring for Older Australians
- Creation of Local Hospital Networks and Medicare Locals, intended to support community role

**Victorian**
- The Better Skills, Best Care strategy seeks to encourage health services to explore new and redesigned work roles and provide support to pilot and roll out initiatives.

As noted above, the health workforce faces significant reform and the demand for workers is strong, which creates education and training opportunities into the future. High technology change, the changing nature of service delivery and client needs in turn require new ways of teaching and learning, with increasing focus on to whom, what and how the workforce is taught and a need for an adaptive workforce with a more complex array of skills. Changing roles and the growth required also creates general skills needs for workforce planning (not currently widely available in community services and health, CSHISC) along with policy and advocacy skills to support IR change and workplace reform. Consumer-directed care is seeing an increase in case manager, informant and advocacy roles (CSHISC).

**Training Products and Delivery**

The Skills Council believes that “(n)ew and better-quality education and training products will enable the training of more people and the formation of new education and training work roles” (CSHISC). Similarly, Health Workforce Australia has examined curricula across health professional education providers and identified common areas for delivery through simulated learning environments and is undertaking other activities including a major workforce development project that aims to identify how the Aboriginal and Torres Strait Islander health workforce can be strengthened (CSHISC). Simulated learning environments will be available for the development of both VET sector and university-trained worker roles. Ongoing workforce and training reform, however, also creates challenges to support wage growth commensurate with skill level. For example, the rise of multi-skilled staff and/or staff with associate degrees can challenge traditional career pathways and wage rates.

**Clinical placements:** Clinical placements play an important role in preparing health students ready for the workforce. However, there have been reports from education and training providers that there are difficulties finding enough clinical placements for all students (Victorian Government). In 2007, the Victorian Government released *Clinical Placements in Victoria* to help establish a statewide approach to supporting placements. Similarly, $993 million of the joint Commonwealth/State National Partnership Agreement on Hospital and Health reform is to fund entry-to-practice
Clinical training and a key program of activity for HWA focuses on the improving and expanding access to quality clinical training for health professionals in training across the public, private and non-government sectors through funding programs which expand capacity, improve quality and delivery and offer diversity in learning opportunities (HWA).

**Skills Shortages**

Shortages of health professionals have been persistent over most of the past decade. DEEWR identifies multiple occupations within nursing, social professions and health diagnostic and therapy professions as being in shortage. HWA notes that skills shortages can be particularly evident in rural and remote communities (HWA 4). Table 1 in the attachment highlights national skills shortage areas. Persistent skills shortages include medical diagnostic radiographer, physiotherapist and sonographer, podiatrist and child care occupations. Widespread shortages of nurses (both registered and enrolled) over the past decade speed workforce changes, for example, registered nurse shortages are seeing enrolled nurses take on enhanced roles and nurse practitioners are increasingly being employed (CSHISC). 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 (HWA).

**Business Skills, Administration and Planning**

The health care funding reforms change the way the sector will be managed and administered. The shift to activity based funding models creates new demand and an enhanced roles for information managers and clinical coders (CSHISC) with likely greater demand for people with coordination, information and advocacy skills, with planning roles shifting from the public sector, decision making “must now be more inclusive of all contributors, all settings and all professions” (HWA). Health Workforce Australia also notes trends towards an increased use of dynamic, scenario based planning models that test policy mixes for their relative effectiveness (HWA), which further changes the skills mix and professions of the workforce.

Similarly, increased competition, mergers and changing modes of interaction create a need for health and community managers with strong change management and administrative skills, particularly given the growth and importance of IT systems in health and community services administration. Similarly human resource management is critical given the need to attract and retain skilled staff. Trends towards mergers, and more integrated, client-centred models of delivery may require changes to business models and human resources policies to compete for staff in a strong market. This can create opportunities for business and strategy skills.

**Other Tends/Issues**

Other trends or issues which might could affect the workforce and skills needs include:

- **Insurance**: Policies encouraging private health insurance (and potential greater need, given pressures on public health system) can create demand for different insurance retail products.
- **Design**: supporting people stay in their own homes, and growth in aged care facilities.
- **Language, Literacy and Numeracy**: a need to support more people into the health workforce may require increased focus on building these skills.
- **Raising workforce profile and supporting retention**: Improved management practices to support workforce retention (eg aged care, CSHISC) Marketing and branding: need to raise the profile of the industry CSHISC).
- **IT**: Emerging roles are developing that involve the operation and maintenance of assistive technology (CSHISC) the growth of online medicine, with telecommunications services and increased integration also create a need for enhanced IT and design skills.
- **Language and design**: client-centred modes of delivery also create opportunities for multi-lingual and culturally sensitive staff.
- **Quality and consistency**: The Industry Skills Council is also a strong advocate for stronger quality and consistency across education and training for the sector and sees the moves towards an integrated tertiary sector and the establishment of national regulators (ASQA and TEQSA) as an opportunity (CSHISC) with their proposed merger as an opportunity to support better articulation between the sectors.
References

ABS Life Expectancy Trends – Australia 4102.0


IBISWorld, Health Services in Australia 2011, October 2011.


## Skill shortages – summary table

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Rating</th>
<th>No of years in national shortage in past decade</th>
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<tr>
<td><strong>Health diagnosis and therapy professions</strong></td>
<td></td>
<td></td>
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<tr>
<td>Medical diagnostic radiographer</td>
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<td>Medical radiation therapist</td>
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<tr>
<td>Nuclear medicine technologist</td>
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<tr>
<td>Sonographer</td>
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<tr>
<td>Optometrist</td>
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<tr>
<td>Pharmacist</td>
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<tr>
<td>Chiropractor</td>
<td>Employers seeking chiropractors who have skills in specialized techniques or with paediatric experience have difficulty recruiting</td>
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<tr>
<td>Dentist</td>
<td>Shortage in regional areas</td>
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<tr>
<td>Occupational Therapist</td>
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<td>Speech pathologist</td>
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<td><strong>Nurses</strong></td>
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<tr>
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<tr>
<td>Child care worker</td>
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