

The state of health workforces

Alliance members report workforce problems across the system. It is well known that the extent of these problems correlates with socio-economic pressures with rural, remote and Aboriginal communities being the least-well served

What is less understood in government is that health workforce issues spill over across specialisations. For example, where there is inadequate medical expertise, the pressures on nursing resources will increase, creating conditions where nurses may see their task as hazardous, over-pressured and unattractive. In a town where there is no access to specialist services, the local GP will find themselves exposed to the demand to provide a broad range of services, or to act without the benefit of full information, involving legally onerous responsibilities. In a community where a doctor or nurse is not available, a local pharmacist or paramedic (if available) may end up being the main treatment service provider, by default. Whenever these workforce issues arise, the absence of specialist human resources results in increased demands on unpaid carers, and on those in need of care. In a growing range of Australian communities we face a vicious cycle of health workforce deficiencies, and this cycle is accelerating.

What is happening in nursing? Increased work, fewer workers.

It is reasonable to talk in terms of a 'nursing crisis'. Older, more experienced nurses are choosing to leave and not return. Aged care nursing is increasingly characterised by under-qualified para-nurses supervised by a small number of qualified staff, and entry into nursing training and training completion rates are less than is needed. Nursing specialisations such as mental health are suffering pronounced problems, and the international market for nurses is increasing the pressures for export of skills.

In 1995/96 there were 45 hospital separations per full time equivalent (FTE) nurse in the public sector. This increased to 49 separations per FTE nurse in 1998/99. There were 205 occupied bed days per FTE nurse in 1995/96. This increased to 208 in 1998/99. Conversely, the number of FTE nurses per 100,000 population decreased from 1171.1 nurses per 100,000 population in 1989 to 1032.7 in 1999³. The AIHW report that the number of full time equivalent nurses employed in acute public and psychiatric hospitals fell by 2.8% between 1995-96 and 1998-99 while the number of patient separations increased by 7.4%⁴.

The long term effects of these decisions will not only be felt by the health and aged care systems, but will also impact on the individual nurses by, for example, reducing their present standard of living as well as their future retirement benefits.⁵

³ AIHW 1999 Nursing Labour force 1998 AIHW Canberra.

⁴ *ibid.*

⁵ Page 5, Australian Nursing Federation Submission to Senate Community Affairs References Committee Enquiry into Nursing, July 2001.

What is happening in medicine?

The rural medical crisis is far from the complete extent of the medical workforce issue. The recent problems of indemnity have added to the pressures, and it is reported that a growing number of doctors are considering early retirement or (particularly with specialists) overseas practice options.

In recent years, based mainly on studies by the Australian Medical Workforce Advisory Committee (AMWAC), the orthodox view has been that Australia has an overall surplus of GPs, but a shortage in rural and remote areas. The primary findings of this investigation are that, contrary to this 'conventional wisdom', there is currently an overall shortage of GPs in Australia as well as a maldistribution;

- Shortages of GPs are by no means confined to rural and remote areas but are increasingly apparent in outer urban areas. Inner urban areas generally have an adequate supply, with only very few areas in surplus;
- These findings are supported by the GP Workforce Survey (conducted by Access Economics for the AMA in 2001), by a substantial body of anecdotal evidence and by the Access Economics GP Workforce Model;
- While the Australian community continues to express its support for Medicare, patients' expectations of access to GP services are not being met;
- Unless workforce policy settings are changed, the overall shortage of GPs will get worse. If that is allowed to happen, it will prove even harder to resolve the maldistribution of GPs and

A physiotherapist in rural NSW recently reported that it took five years to recruit a physiotherapist despite widespread advertising. Another in Queensland received no applications for an advertisement and says that every year it has become worse. The story is the same all around the country: typical quotes from physiotherapists include:

- "We received a very low level of applications for a Grade one position", - public sector, Melbourne.
- "I have had to downgrade services because I can't find enough experienced physiotherapists. This has led to reduced opening hours and an inability to send speakers to schools" - private sector, Perth.
- "Finally after nine months we received one application for a senior cardiac position" - public sector, NSW.
- "We have been intermittently advertising a position since July. We will take somebody full-time or part time and still we can't fill the position", - private sector, Melbourne.
- "Mid-year vacancies are common. The consequences are increased workload for remaining staff and compromised patient care" - public sector, Perth.

Pers. comm., Australian Physiotherapy Assoc.

to meet community expectations⁶;

Physiotherapy workforce shortfalls

There is a national shortage of physiotherapists, with a shortage of specialists in NSW, Victoria and South Australia.⁷ The Department of Employment and Workplace Relations has identified:

- Difficulties recruiting experienced physiotherapists in metropolitan areas and general difficulties in rural areas in South Australia;
- Overall shortages in Western Australia;
- Widespread shortages in Victoria, particularly in the following specialities: paediatrics, cardio-thoracic, gerontology, oncology and palliative care, and generally in rural areas. These shortages are increasing.
- State wide shortages in Tasmania and NSW; and
- A shortage of experienced physiotherapists across Queensland, with supply of locum and part-time workers critically low.⁸

The causes of these problems can be partly traced to the vicious cycle noted above, with adverse staff ratios leading to stress and injury, further exits as a result, exacerbating the original problem and creating unattractive conditions to recruit replacements.

- A staggering 1 in 6 physiotherapists change their profession as a result of a workplace injury⁹, many of which result from people trying to do too much because there are not enough staff.
- Rehabilitation sites have physiotherapist : patient ratios at 50% or more above Australian Federation of Rehabilitation Medicine guidelines - due to inability to fill positions, not budget constraints.¹⁰
- 52% of physiotherapists who resign from physiotherapy positions in our public hospital leave the profession¹¹.
- 35% of all advertised public hospital physiotherapy positions in 2001 received no applications.

Specialisations are under workforce pressure

One could be led to believe that whilst there may be problems with general practice, the more prestigious areas of the medical workforce are thriving. Whilst some areas of specialisation are providing very attractive, this is not the case across the board.

⁶ An Analysis of the Widening Gap between Community Need and the Availability of GP Services: A report to the Australian Medical Association by Access Economics Pty Ltd Canberra ACT February 2002

⁷ Department of Employment and Workplace Relations 2002. National and State Skill Shortage Lists.

⁸ Research undertaken by the State Labour Economics Office of the Department of Employment and Workplace Relations, 2002.

⁹ Cromie JE, Robertson VJ and Best MO (2001): Occupational health and safety in physiotherapy: Guidelines for practice. Australian Journal of Physiotherapy Vol 47: 43-51

¹⁰ Unpublished survey data

¹¹ Unpublished survey data

A crisis in pathologist person-power has been identified by the Australian Medical Workforce Advisory Committee. There are approximately 70 full time equivalent pathologist positions vacant nationally with a shortage overseas to compound the problem of replacement. It has also become apparent that the number of new fellows is not keeping up with retirements and increased demand for pathology services. In the public sector a large number of training posts have disappeared or been subsumed by other medical disciplines.

Gastroenterology, geriatric medicine, haematological oncology, medical oncology and thoracic medicine have now been added to the specialities failing to attract sufficient interest from trainees. A report by the Royal Australasian College of Surgeons has also flagged a need for 50% more surgeons by the year 2020.

As noted, with the indemnity crisis has come a morale problem in many areas of medical specialisation. There is a risk that this factor, coupled with high international demand, may place increased pressure on some highly specialised parts of the medical workforce.

The pharmacy workforce is under pressure

Pharmacists provide a low cost point of access for basic health services, as well as providing dispensing capacity. As other sources of services have come under cost and workforce pressure, this role of pharmacy has increased. Australia faces a growing shortage of pharmacists as the demand for pharmacists continues to outstrip the available supply. This is the major finding of a study¹² into the demand and supply of pharmacists.

The patterns within the pharmacy workforce reflect those in other healthcare workforces – ageing, a change in the sex mix, a high rate of exit from practice in the early years, and difficulties in recruitment.

Unpaid care: the release valve?

The strains in the professional system spill over into the unpaid carer community. For many, this role is far from voluntary. It comes with a very high cost to carers and to society. These costs include loss of earnings (and therefore carer's retirement incomes), stress and physical injury, and social isolation. This sector of the workforce continues to grow, reflecting the strains in the rest of the system.

Australia's 2.3 million carers have a dual role in our community and economy. As family and friends of people needing care, they contribute to maintaining and enhancing the social capital of our community which provides for richer relationships and enables people to be cared for in their home environment. In economic terms, this unpaid care for adults alone was estimated to be worth at least \$18.3 billion per annum in 1999 (AIHW, 2001), based on the cost of providing alternative paid care. In contrast the Australian Government's budget estimates for 2002-03 for spending on community care and support for carers and welfare payments totalled \$2.547 billion. These figures illustrate

¹² Health Care Intelligence "A Study of the Demand and Supply of Pharmacists, 2000-2010", Third Community Pharmacy Agreement, February 2003.

just how reliant governments and taxpayers are on the unpaid care of family and friends in supporting our system of community care that we value in Australia¹³.

Unlike other parts of the health workforce, carers are often unable to reflect their dissatisfaction and disadvantage by leaving the health workforce, but too often these burdens result in them having to downgrade their own careers, and incur health and other costs themselves. They highlight, through the Carers' Association and other groups, the fact that their basic needs are not being met, and that the rewards and resources available to them are far from sufficient to meet their needs.

The rural and remote community challenge

The vicious cycle is apparent across most workforces and most parts of the health system but it is pronounced in rural and disadvantaged communities.

Despite the special programs in existence for rural and remote health, the situation of the workforce is currently very serious. When there are generalized shortages of health professionals, rural and remote areas will always be most seriously affected. There is currently low morale among many in the rural and remote health workforce. Incomes in nursing (particularly in the aged care sector) are low. Access to information technology is poor. There are the long-standing effects of staff shortages: little time off, poor access to locums and mentors, insufficient access to CPD [Continuing Professional Development]. In remote areas there are particular issues with staff safety. On top of all of this, doctors, midwives and a number of health facilities, including private hospitals, are now affected by difficulties with indemnity¹⁴.

Stress, anger, sick days, decreased patient care, low morale because there isn't time in the day to give basic care. Feeling of 'we're drowning'. I just can't believe the government won't allocate more nurses to our hospital. I go home wanting to cry, out of frustration, not feeling that I've done a good days work. Working in a small remote hospital you constantly shoulder so much responsibility, loads of overtime and on call, can't get leave when you want it and get tired and burnt out¹.

Australian Nursing Federation Submission to Senate Community Affairs References Committee Enquiry into Nursing. July 2001. Page 44

A failure of incentives to deliver health

The Federal government engages in financial negotiations with the healthcare professions over medicare, PBS and other issues. Each profession is addressed in a separate agreement at a separate time. The focus of the negotiation is primarily the direct payment for service, and the form of service for which payment will be received. Some ancillary issues like research may also be addressed.

¹³ Carers Australia Pre Budget Submission 2004-05 October 2003 Page 1

¹⁴ National Rural Health Alliance pers. comm.

This silos-based approach pervades the institutional structures and budget approach of government. It ignores the interdependence of issues, and the broader needs of the people who make up the workforce. It discounts the extent to which perceptions of health system robustness impact on morale and career attractiveness, and the disincentive effects of inefficient administration, role confusion, or resource conflict. The approach limits the opportunity to restructure some of the fundamental 'drags' on the system (such as the transaction costs of the federal/state health relationship, or the costly burdens of inefficient administration). It reduces the opportunities to consider broader systemic reform (such as greater experimentation with service models tailored to different situations) and 'cross-agency' efficiencies (such as increasing investment in one area of health to realise values in other budgetary areas like age or disability pensions), or productivity improvement for non-health workforces. Ultimately these institutional failings are reflected at the coalface.

Doctors, nurses, physiotherapists, other allied health service providers, pharmacists and unpaid carers, all respond to a mix of incentives and disincentives. If the healthcare system is under excessive pressure, it will generate many disincentives. These include:

- Poor morale and emotional stress, particularly associated with concerns about the future of the system, one's career and the patients that one cares for;
- Conflicts, as service providers struggle to access basic resources;
- Adverse outcomes, reflected back upon the service provider as liability risk, criticism, and self-blaming;
- Skills decline, as service providers lack the incentive and the opportunity to enhance their capacity.

The relative attractiveness of a health career is impacted by much more than the short-term salary. Lifestyle and work environment are important.

... the economic incentives of medical practice operate in a complex broader environment with strong influences on the decisions of individual doctors about where to practise. These include the personal influences of family, social and professional ties, commitments and ambitions; geographic location of upbringing; and lifestyle preferences. In the health system, regional and local health service management often includes administrative and structural impediments to improvements in the distribution of the medical workforce¹⁵.

Intelligent, well-educated professionals make career choices based on economic values, but also on the basis of less tangible considerations such as professional status. Consistent downgrading of status will result in declining participation in that workforce.

¹⁵ Australian Medical Workforce Advisory Committee and Australian Institute of Health and Welfare (1998), Medical Workforce Supply and Demand in Australia: A Discussion Paper, AMWAC Report 1998.8, AIHW Cat. No. HWL 12, Sydney

The only way to ensure that the escalating exodus of nurses from the profession stops is an improvement in the conditions under which they are forced to work. Decrease the patient/nurse ratio, increase time for handover periods and provide mentors for newly registered or re-registered staff. Until my fellow nurses and I are treated with respect by the (employers) and not just as the main drain on the hospital's budget, nurses like me will continue to leave the profession at great cost to the economy¹⁶ (Mary Elgar)¹⁷.

These problems are most pronounced in rural areas. A professional workforce may once have been attracted to the country lifestyle and the opportunity for a close relationship with a community, but with declining work conditions and declining social conditions, this appeal is diminishing. It will not be repaired without major investment.

Incidence and ranking of problems identified by dissatisfied GPs*					
Problem	Rank as % of total				Total
	1	2	3	4	
Relatively low remuneration	43.1	16.1	11.4	8.3	19.7
Conflict with family responsibilities/desires	10.7	15.3	18.7	18.8	14.6
Long or inconvenient working hours	11.0	23.4	14.4	12.4	14.0
Inability to take leave, find staff or locums	8.9	15.7	15.7	12.7	12.4
Administrative or management problems	7.5	10.5	12.5	14.9	11.6
Difficulty selling, retiring or changing job	3.3	4.2	7.1	10.2	7.1
Being on call too frequently	4.3	5.2	7.1	8.7	6.9
Social/professional isolation or lack of amenities	2.7	4.0	6.8	8.0	6.0
Under employment	1.4	1.4	1.9	1.8	2.5
Other	7.2	4.2	4.2	4.1	5.3
TOTAL	100	100	100	100	100

* GPs who ranged their satisfaction as 1 to 7 in the 2001 AMA GP survey Question 8

Work intensity—The AMA Survey revealed that GPs frequently perceive huge disadvantages in country practice, many from the point of view of hindsight. They view the long hours, especially after hours, on-call hours and lack of holidays, with lack of locums or relief—‘never off duty’—as a fundamental difficulty, causing stress and burnout. Greater work intensity is also due to the greater diversity and skills challenges of rural work, with emergency and hospital work particularly stressful. There is limited hospital, specialist, technological and allied health back up, generating problems of professional and personal isolation, which increase with remoteness. Many GPs view rural or remote work as underpaid relative to the responsibility, with a 120% loading on top of the current rural remuneration rate required to attract the average urban GP to the bush¹⁸.

Family conflicts and costs—Partner's career, children's schooling and lack of family support are big issues, markedly so for single mothers. As children grow older, there is a substantial problem with education, in terms of the cost of boarding school (around \$15,000 p.a.) and university accommodation (‘running two houses’), as well as family separation. At this stage, many GPs move back to the city. Discontentment of partners is also often seen as

¹⁶ Australian Nursing Federation Submission to Senate Community Affairs References Committee Enquiry into Nursing, July 2001 page 2

¹⁷ Elgar M 2001 Letter to the editor The Australian 9 July 2001.

¹⁸ An Analysis of the Widening Gap between Community Need and the Availability of GP Services, A report to the Australian Medical Association by Access Economics Pty Ltd Canberra ACT February 2002, Page 12

'unsustainable', necessitating a move back to the city. Separation from extended family and friends can be a problem for young or single people. These issues were mentioned in two thirds of responses to the survey and were non-negotiable—'wouldn't go for any money'.

Business difficulties—Small business administration (often without IT or other support), difficulty getting partners or selling a business, higher practice costs in many cases, lack of capital appreciation and red tape (eg Trade Practices Act) are also barriers to rural GP supply. Medical indemnity insurance premiums (and associated anxieties) are increasingly prohibitive, especially for obstetric and rural procedural work. Maintaining the required variety of skills is difficult given the cost of travelling (and lack of access) to continuing medical education (CME) and other training.

Lifestyle and other factors—Many GPs perceive the rural lifestyle to be lacking in social choices, amenities, and peer interaction—isolated, parochial (the 'small town' mentality), yet lacking anonymity (the 'goldfish bowl' syndrome). This is particularly true for minorities¹⁹.

Improving the health workforce requires systemic strategies

When such conditions persist, it should not be surprising to see both early exit and failures to enter the health service professions. We are seeing a repeated pattern of:

- Professionals electing to leave the profession, or limiting the scope of their services to areas that are less frustrating or less vulnerable;
- Students completing (wholly or partially) expensive qualifications, but after a taste of the realities of practice, 'voting with their feet' and leaving the profession; and
- Difficulties in filling available training positions, or attracting students of the calibre required.
- The load falling increasingly on those who are unable to avoid it – unpaid carers, and the less advantaged.

It is of great concern to the ANF that nothing is being done to prepare for future nursing shortages following the retirement of older nurses over the next 10-15 years. Experienced nurses, many of whom will have specialist qualifications, will be exiting in large numbers but there is inadequate succession planning and no national planning to ensure that enough nurses are entering and staying in the health and aged care systems to replace either the numbers, the experience or the specialist qualifications. In the ten years 1986 to 1996, the number of nurses aged 25 and less decreased from 20.9% in 1986 to 5.9% in 1996. On the other hand, during the same period, the number of nurses aged greater than 45 increased from 18.9% in 1986 to 31.0% in 1996¹.

Jill Iliffe Federal Secretary Australian Nursing Federation
Australian Nursing Federation Submission to Senate
Community Affairs References Committee Inquiry into
Nursing
July 2001, Page 6

¹⁹ Page 14 ibid

A national health workforce strategy is needed, not a series of profession or problem specific band-aid interventions. It will not be possible to create such a strategy until we have far greater clarity about the health services model that will be required in the future. In turn this will not be possible whilst the planners and politicians fail to recognise two basic things – that healthcare is an investment, the returns from which depend largely on system effectiveness, and that the key to this effectiveness is the quality, motivation and empowerment of the workforce. Healthcare is a person-driven enterprise, where human motivations and human needs are what generate economic effectiveness. Taxation and government expenditure issues are important, but are a deficient starting point or end point for developing this strategy.

Healthcare is an area where unpaid work by carers is a significant contributor to outcomes. Both equity and economic efficiency require that we look to the needs of carers when considering how to maximise the benefits from health investment. They too need to be supported, and to be at the table when healthcare strategies and policies are designed. It should be borne in mind that there is a productivity cost (as well as a high personal cost) when carers foregoing their own careers. Reducing this cost is a relevant consideration in ensuring the future wealth of Australia when we can expect that there will be more care needs with an aging population.

We finish this discussion with comments arising from two of the workforces that will be important to an effective health system that provides a high return on that investment.

- Doctors

Furthermore the economic incentives of medical practice operate in a complex broader environment with strong influences on the decisions of individual doctors about where to practise. These include the personal influences of family, social and professional ties, commitments and ambitions; geographic location of upbringing; and lifestyle preferences. In the health system, regional and local health service management often includes administrative and structural impediments to improvements in the distribution of the medical workforce²⁰.

- Carers

The point that Carers Australia stresses is that people of all ages who need care and support to stay in their own homes must rely on the informal care of their family and friends and community care services. The availability of this unpaid care should not be assumed. For family and friends to fulfil a caring role there is a public and personal cost for what can be a constant, unrelenting and stressful job, depending on the individual situation. Therefore if the caring situation is to be sustainable, carers too must have adequate economic and social support, education for their care responsibilities and access to carer focussed services that are sufficiently resourced²¹.

²⁰ Australian Medical Workforce Advisory Committee and Australian Institute of Health and Welfare (1998), Medical Workforce Supply and Demand in Australia: A Discussion Paper, AMWAC Report 1998.8, AIHW Cat. No. HWL 12, Sydney

²¹ Carers Australia Pre Budget Submission 2004-05 October 2003, Page 9

The future

With an older workforce, we will have to spend more on health.

There are two issues to note with the future demand for GP services of an ageing population. First, elderly people consume more services per head of population, so the number of services required grows faster than [the] population. Second, elderly people present with more complex health problems and with more chronic conditions that require management. Hence, consultation times are longer than for younger people. Combined with the larger number of services for elderly people, this means that average consultation times of all GP services are increased. Therefore, the total supply of GP services, expressed in terms of hours of service, grows faster than the nominal growth in the number of services²².

That is unavoidable, unless we are to condemn our society to decline. What is more a matter for choice is whether we invest in productivity, or manage health as if it were an unproductive cost.

We are faced with two scenarios for our ageing population. The first will arise if we under-invest in healthcare, or if we waste the investment through ineffective management and high transaction cost administration. This scenario speaks of an ageing population accompanied by declining workforce productivity. Within this scenario there are many inequities and potential conflicts, and serious erosion of our social capital. This is the path that is most likely if we continue our present trajectory of inadequate and fragmented investment in healthcare, if we continue to fail to harness the goodwill and knowledge of those who work within the health system, and if we continue to try to manage health in a piecemeal fashion.

The vast majority of older people are healthy, active and independent. Only approximately 7% live in residential care, and this percentage is not expected to increase over time. The ageing population is accompanied by improving health and well-being amongst older people as a result of the sound public health policies which have been pursued over many years in Australia, access to a universal health care system, and improving medical technology. Further developments in geriatric medicine are likely to have positive impacts.

Healthy ageing is likely to lead to more people remaining in the workforce for longer. Early retirement is likely to diminish, and as the demand for staff increases due to falling numbers of younger workforce participants, older people will remain in, or re-enter the workforce, making a contribution to the economy through their productivity and payment of taxes.

Page 9, Council on the Ageing (Australia)
Long Term Strategies to Address the Ageing of the Australian
Population over the Next Forty Years
Submission to the House of Representatives
Standing Committee on Ageing
November 2002

²² An Analysis of the Widening Gap between Community Need and the Availability of GP Services: op. cit.
Page 17

The second scenario is that our healthcare system is upgraded to make it more effective. Under this scenario reform is focused upon maximising the value created, whilst minimising the costs of creating that value. Reform is based on harnessing the knowledge of all of the system participants, and on creating system-wide improvement. There is a focus on reducing unproductive elements such as jurisdictional re-bargaining and financial game-playing. Innovation is a central focus of reform. This is the path that the National Healthcare Alliance believes must be followed if Australia is to remain strong and productive even as we age.

HEALTH – AN INVESTMENT IN PRODUCTIVE AGEING

There is a strange myopia in the way in which Australia's government has addressed health, wealth and ageing in recent times. It is exemplified in the Intergenerational Report, but is also evident in other policy papers about workforce participation and GDP.

The argument that is developed goes something like this:

- a. we have an ageing population, which will typically mean a decline in economic productivity per person (on average) due to lower workforce participation, (and perhaps some decline in productivity per person).
- b. At the same time, we will have higher healthcare costs.
- c. Therefore we need to:
 - i) Increase workforce participation through such measures as altering industrial law, or retirement pension arrangements; and
 - ii) Control the costs of healthcare.

The myopia is this. The argument identifies the pivotal importance of workforce productivity to future wealth, but it treats healthcare only as a cost. This of course flies in the face of logic and experience. At its heart, health spending is an investment: in the ability to keep working (and playing, socialising and loving); in the maintenance of your productive capacity such as eyesight, hearing and movement; and in continuance of an independent and fulfilling life.

The other side of the story is also a well-known part of the human condition. The inability to secure healthcare services results in wealth-diminishing effects: the loss of skills and capacity (reducing productivity as well as satisfaction); the inability to participate fully in work; the redirection of effort into self care or care for dependent others, and the redirection of resources into non-productive expenditure. The Department of Health and Ageing's commissioned study

The longer a person is unemployed, and the earlier they retire, the greater can be the adverse financial effect of unemployment. People unemployed later in life are less able to increase savings to make up the shortfall in expected retirement income and this loss is greater the earlier a person retires. Unemployed people also have a greater usage of health services, such as higher hospital admissions, doctor and outpatient visits and higher use of pharmaceuticals, than employed people....

Access Economics has found that ensuring that mature age workers are not encouraged out of the workforce simply as a result of their age – as opposed to their competence – has the potential to raise the income of all Australians. Experts agree that average per capita income of Australians will be lifted if as few as 10% of people between the age of 55 and 70 years remain in the workforce instead of leaving.

The Hon. Bronwyn Bishop MP
Minister for Aged Care
Population Ageing and the Economy
January 2001
Commonwealth Department of Health and Aged Care

from Access Economics highlights the economic importance of mature worker participation.

The evidence suggests that tax reform may add somewhere in the region of 2.5 per cent to the annual national income of Australians, and that promoting national competition policy may add 5.5 per cent to the national income. The desire to ensure mature workers are not encouraged out of the workforce simply as a result of their age – as opposed to their competence – has the potential to raise the income of all Australians by a similar amount. Average per capita incomes of Australians could be lifted by 4 per cent if workforce participation by 55–70 year olds rose by just 10 percentage points.

The relativities are revealing. They suggest that, on published estimates, the benefits to national income of later retirement rank somewhere above those of tax reform and below those of promoting competition policy. Such estimates are imprecise at best, but they are a timely reminder of the importance of an issue that will grow with the passing of time²³.

A more complete understanding of health and wealth²⁴ suggests a positive attitude to healthcare investment strategy is well justified.

Health care investments not only lead to longer and more productive working lives on an individual basis; properly targeted public health care investments can also provide countries with a competitive advantage. According to the Canadian Council of Chief Executives' submission to the Commission (2002, 2), "Canada's business leaders have been strong supporters of Canada's universally accessible public health care system" because it provides a "significant advantage in attracting the people and investment that companies need to stay competitive." Indeed, the "big three" automakers (Ford, General Motors and Daimler-Chrysler) recently signed joint letters with their largest union, the Canadian Autoworkers, expressing support for Canada's publicly funded health care system and noting that it provides an important competitive advantage to the Canadian auto and auto-parts industries relative to their American counterparts. In short, it is more economical for the employers to pay taxes in support of medicare than to be forced to buy private health insurance for their workers.

²³ P 19. Access Economics, Population Ageing and the Economy January 2001 Commonwealth Department of Health and Aged Care

²⁴ Extracts from: Commission on the Future of Health Care in Canada: Building on Values: The Future of Health Care in Canada – Final Report Commissioner: Roy J. Romanow. November 2002 pp 41-43

It is also true that health care is what economists call a superior good in that, as individuals, we tend to spend progressively more on health care than other goods and services as our incomes go up. Based on a series of international studies summarized by Gerdtham and Jönsson (2000), higher income is the single most important factor determining higher levels of health spending in all countries (see Figure 1.34). Indeed, the more economically developed the country, the more pronounced the effect (Scheiber and Maeda 1997).

According to Reinhardt et al. (2002, 171), per capita GDP is without doubt "the most powerful explanatory variable for international differences in health spending."

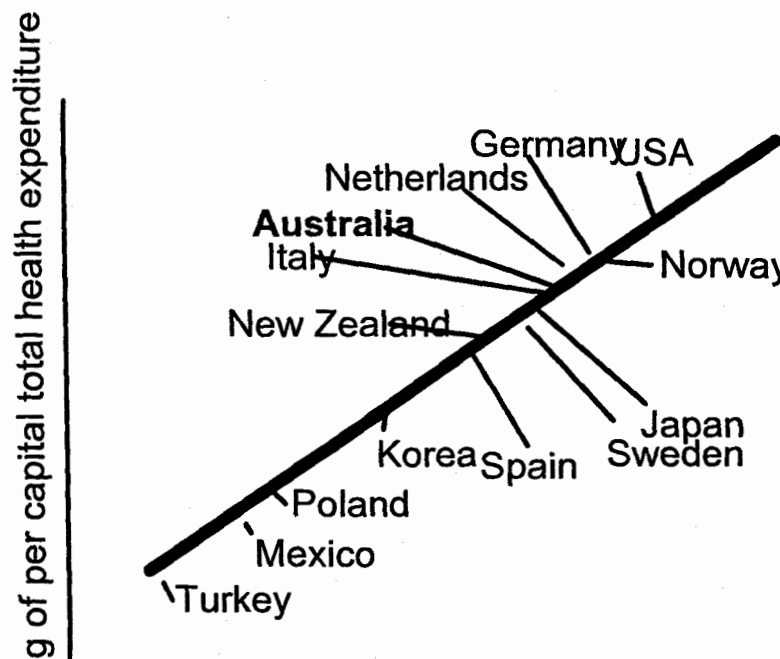
The correlation between a nation's preparedness to spend on health, and its GDP, is strong. This suggests that health investment is wealth producing, the

rich nations know that this is the case, and they invest accordingly. It certainly does support the view that the appropriate perspective on health expenditures is to consider them within a paradigm of investment return, not merely cost control.

One aim of health policy should be to optimise wealth production, through wise investment, reduction of systemic failings and transaction costs, and through resource building to ensure the returns are achieved. Any investment strategy which counts only the cost will fail, for it will always suggest disinvestment regardless of potential return. Our fear is that this is the error which has arisen from the policy myopia about of the nature of health in an ageing society.

One economic picture of the future Australia is dismal- unemployed ageing Australians struggling to make ends meet, with their health needs barely met through a depleted health system, and a reduced taxation base. To focus excessively on the costs of health will make this self-fulfilling. This is not the forecast that is justified by the facts, nor is it a sensible basis for health or

Ratio of Total Health Expenditures to Economic Growth Among some OECD Countries, measured in purchasing power parity, 2000



social policy. A focus on the investment value of health as the key to workforce participation and productivity leads to a different future.

The slowdown in workforce growth is not matched by an equivalent slowdown in demand for goods and services. Baby boomers will retire with large financial assets. If the shortage of labour is not addressed through higher participation rates among mature Australians, the current account may widen, wages may take off and returns to the owners of capital may fall.

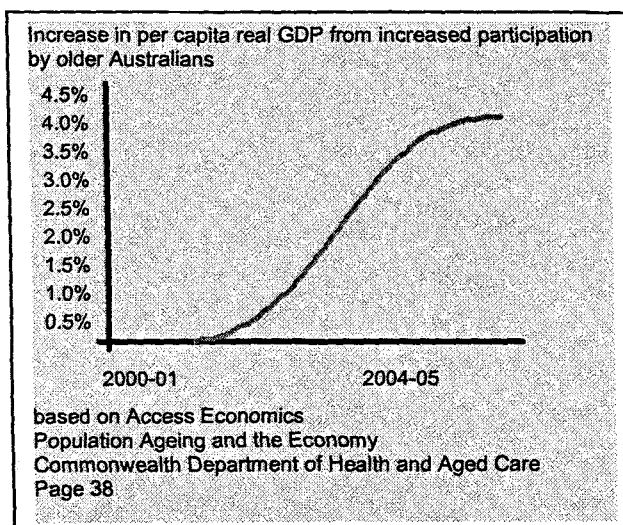
On current trends the workforce will grow slowly over the next twenty years. However, demand growth for goods and services will not fall off to the same extent. The baby boomers will retire with savings and superannuation providing disposable income far greater than previous generations of retirees. There will be plenty of demand for goods and services from a fast growing retired population. It will need to be provided by a slow growing workforce, as the population of consumers will grow much faster than the population of producers²⁵.

The key to this benign future is to control the dependency ratio: the number of people in work who are supporting the needs of those who are no longer able to work, or who wish to live off their accumulated wealth. The key to this, in turn, is to ensure the highest possible quality of healthcare throughout the community.

Data available to date would suggest that, in addition to economic factors, poor occupational and population health outcomes have played a significant part in the declining workforce participation rate of older workers. Further investment in, and coordination of, disease prevention and health promotion strategies across jurisdictions will be important to arrest this trend and to sustain older workers' productivity and participation leading into the 2020s and beyond.²⁶

This basic understanding of the role of health in economic productivity has been identified by the European Foundation for the Improvement of Living and Working Conditions, (though they too are mainly focused upon industrial laws and superannuation issues, making the assumption that the basic health needs will be met through other largely unspecified means than health investment).

The economic success of any policy to raise the retirement



²⁵ Population Ageing and the Economy January 2001 Commonwealth Department of Health and Aged Care, P 32.

²⁶ Commonwealth Dept of Health and Ageing Submission to the House of Representatives Standing Committee on Ageing January 2003 Page 18

age or to reintegrate older workers depends on their being healthy and productive enough to contribute meaningfully²⁷.

There are many illustrations of the centrality of health issues in economic activity. Often the enormous value of health investment is not seen in the 'big picture' of workforce participation, but in the accumulation of relatively scattered benefits that together become a major contribution. Such is often the case with eyecare.

The social cost of loss of freedom and amenity that comes with reduction or loss of vision, including aged care costs that arise from loss of capacity for independent living. According to the Department of Health and Family Services in its Annual Report 1997-98, each place in an aged care facility has a direct cost to the Commonwealth of approximately \$30,000 per annum. Commonwealth expenditure on blindness pensions and related social security costs in 2001-02 amounted to \$2079 million.

There is a growing trend worldwide to evaluate disease and disability prevention on the basis of costs incurred and benefits accrued. Public health interventions to prevent blindness are particularly revealing in this respect, as cost savings and return on investment accrue, because of the avoided rehabilitative costs, on the one hand, and the gains in productivity on the other.

In 1990, the aggregated cost of blindness to the federal budget in the United States was estimated to be approximately US \$4.1 billion. A minimal federal budgetary cost of a person-year of blindness (vision less than 6/60 in the better eye) for a working-age adult was estimated to be US \$11,896.

More importantly, it has been estimated that in the USA, if all the avoidable blindness in persons under 20 and working-age adults were prevented, a potential saving of US \$1.0 billion per year would accrue to the federal budget.

In a study in the USA, the annual cost of welfare benefits per patient with severe visual loss caused by diabetes was estimated to be nearly seven times the cost per patient per year of vision saved. The same study concluded that prevention programs aimed at improving eye care for diabetic patients result in substantial federal budgetary savings and are a highly cost-effective health investment for society.

By preserving vision, good eye care can help to keep people in the workforce thereby mitigating to some extent the effects of loss of revenue to the Commonwealth and reducing welfare expenditure predicted in the Intergenerational Report.

The economic costs, including health care costs that come from accidents such as falls or automotive or industrial accidents arising from defective vision. In 1995-96 the cost of falls in the elderly in Australia was estimated to

²⁷ Page 14 New Approaches to Improve the Health of a Changing Workforce Dr. Richard Wynne & Dr. Robert Grundemann, European Foundation for the Improvement of Living and Working Conditions Luxembourg: Office for Official Publications of the European Communities, 1999