



UNIVERSITY OF  
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Vice-Chancellor's  
Centre of  
Public Ideas

CoPI AUSTRALIAN FUTURES NO. 1

# Getting planning for the health and social care workforce right

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**Stephen Duckett**

SEPTEMBER 2026

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*The Vice-Chancellor's Centre of Public Ideas (CoPI) at the University of Canberra was established in 2026 to explore how historical analysis can inform and develop the practice of contemporary politics, and restore long-term thinking to policymaking for the national good. Based in Canberra, Australia's national capital, and devoted to applied politics and history with a contemporary Australian focus, CoPI recognises the critical role universities play as civil institutions and knowledge-creators, supporting an inclusive and engaged citizenship and well-informed, democratic decision-making. CoPI works with students, academics, community, government, industry and civil society, providing opportunities for stimulating open debate on the most pressing questions facing Australia and the world.*

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**Note:** The paper was written before Stephen Duckett was appointed a Commissioner of the Australian Tertiary Education Commission (ATEC). The views expressed in this paper are not necessarily those of the ATEC.



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## Key points

National workforce planning is demonstrably ineffective, with notable failures in rural and remote Australia and looming shortages everywhere.

The expansion of tertiary education required to meet future skills needs must bring new cohorts into tertiary education. One way to facilitate this outcome is for universities to adopt 'earn and learn' models, which give students an opportunity to work in related fields while studying.

Workforce planning must become more local/regional, linking the health and social care providers with university and vocational educational providers. These partnerships should produce documented 'compacts' to achieve their shared aspirations.

*“Workforce planning is apparently imbued with magical properties, with the assumption that a plan or strategy is all that is required to bring demand and supply into alignment.”*

# Introduction

Workforce planning for health and social care in Australia needs to change, in line with changes to health and social care. But that introductory sentence presupposes we have something which could be called workforce planning. We don't. We have documents aplenty, 121 according to a recent count (Topp et al. 2025b). We have strategies, policies, frameworks, funding programs, and we've had them for decades, but they are fragmented, disconnected and ineffective. There is 'no national health workforce policy, nor a national coordinating body for health workforce policy and governance' (Topp et al. 2025b: 459).

The evidence speaks for itself. There are shortages of health and social care workers in rural and regional Australia, and in parts of metropolitan areas. We have looming shortages of almost every type of health and social care worker, almost everywhere. At the same time, we have an oversupply in some medical specialties in salubrious suburbs, with the specialists enjoying excessive incomes (Murphy 2025).

Workforce planning is apparently imbued with magical properties, with the assumption that a plan or strategy is all that is required to bring demand and supply into alignment.

Is workforce planning, like strategic planning, an oxymoron (Mintzberg 2023: 83), because formulation is separated from implementation? Certainly, the absence of a serious effector arm or arms is one of the issues with health and social care workforce planning in Australia.

Anderson's comments about workforce planning in the UK equally apply to Australia:

*To supply a sustainable, skilled, and fit-for-purpose health and care workforce for the UK, a radical, integrated, and long-term strategic vision is needed. To date, this vision has been lacking. Roles and responsibilities for different components of the workforce strategy have been distributed between various national and local stakeholders with no overall ownership or oversight. Workforce planning has been inconsistent and often undertaken in professional silos (Anderson et al. 2021: 2005).*

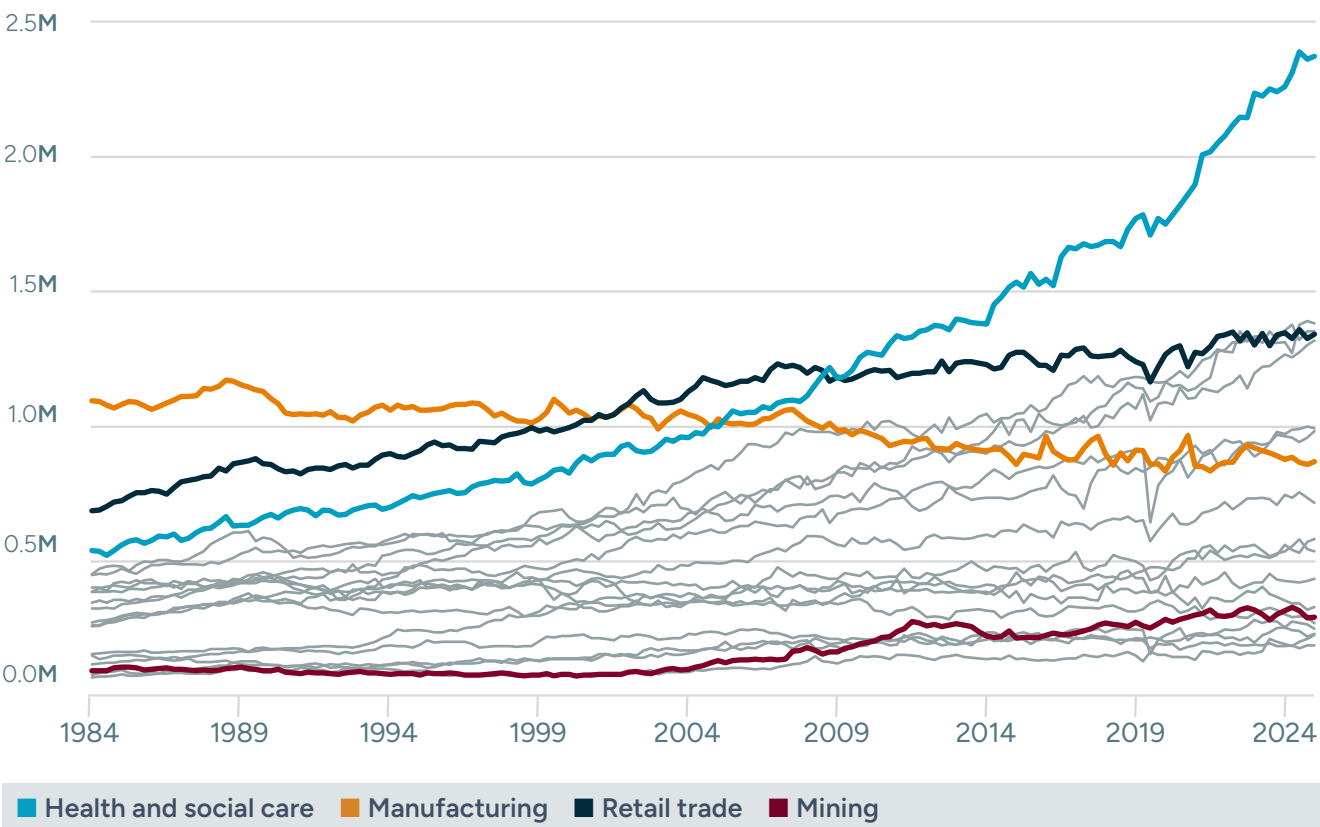
The first part of that quote – about a vision being needed – will simply add to the compendium of documents. But it is the latter part, about the need to reconnect responsibilities and establish ownership and oversight, which has particular relevance. In Australia, national oversight – and national plans – are disconnected from implementation, resulting in workforce planning as 'a very sterile and barren activity (because it is) not viewed integrally with acting and doing', as Amara (1979: 2) said about planning in another context.

In this paper I propose a new effector: regional health and social care compacts, to be jointly developed by health and social care employers (led by public sector health employers and larger aged care employers), and public education providers – both universities and vocational education providers. This effector will be a key mechanism for achieving change rather than just admiring the problem.

# The context

The health and social care sector has been the fastest growing employment sector for many years, outpacing growth in every other sector as well as population growth (see Figure 1).

**Figure 1: Total employed persons, by industry sector, 1984-2025, seasonally adjusted**



**Source:** Australian Bureau of Statistics. 6291.0.55.001 Labour Force, Australia, Detailed, Table 04. Employed persons by Industry division of main job (ANZSIC).

About one in every six people is employed in the sector, which in turn means that, just to keep that rate constant, one in every six school leavers will need to choose to work or train for the sector. Australia’s health sector employment has grown faster than other countries’ in recent years (Reserve Bank of Australia 2025: 42).

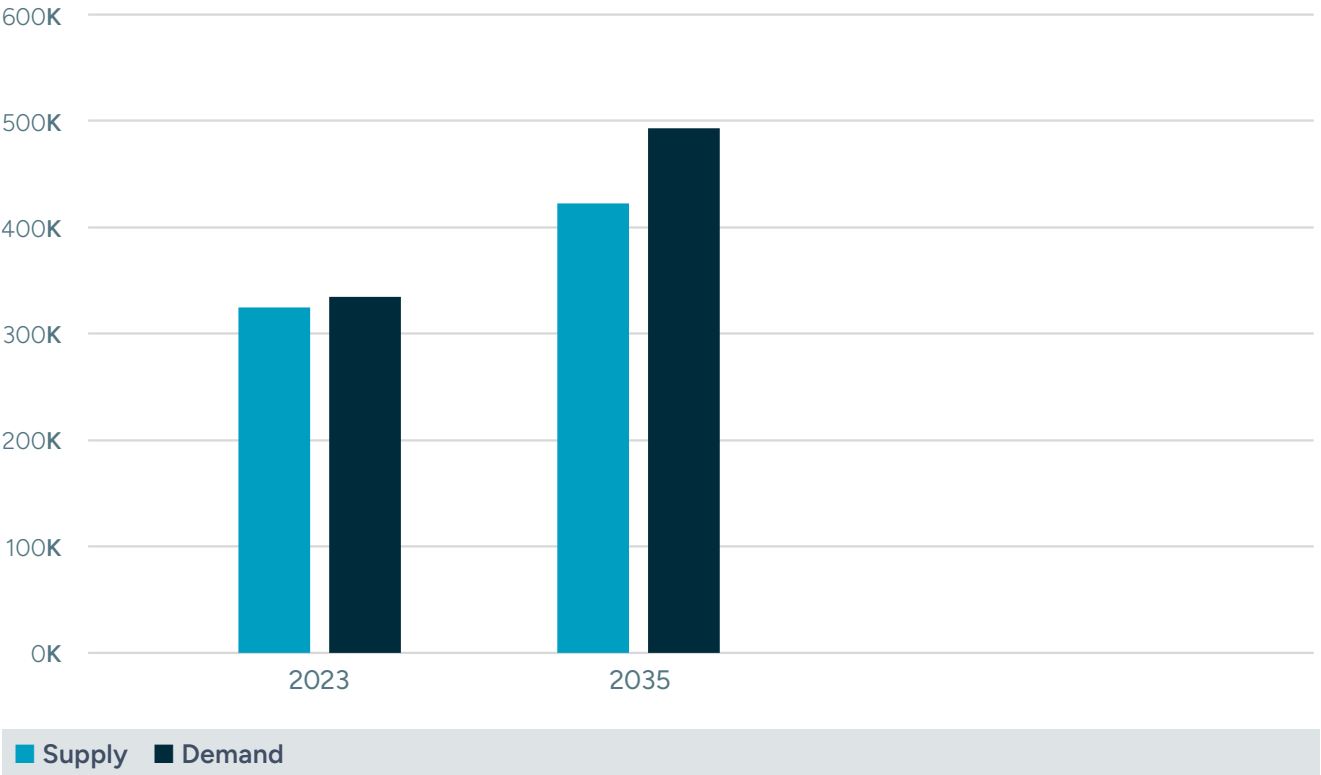
Late 2009 marked the crossing point when health and social care became Australia’s largest sector

by employment, overtaking retail. For many parts of the country, healthcare alone is the largest employer. In South Australia, for example, the health sector is the largest employer in most parts of Adelaide and in the state overall (South Australia. Health Performance Council 2026). But this change in the positioning of the sector has not led to a mindset change in how we think about the sector, nor how we plan for future workforce needs.

*“The workforce planning status quo must not continue, lest the dire projections come to pass.”*

The growth shown in Figure 1 will continue and apparently credible sources are projecting massive shortages of key personnel. The Commonwealth Department of Health and Aged Care, for example, has projected a shortage of more than 70,000 nurses by 2035 (see Figure 2), a shortfall of 17 per cent in 2035 compared to 3 per cent in 2023.

**Figure 2: Nursing demand and supply, 2023 and 2035**



**Source:** Department of Health and Aged Care (2024c).

A labour market study of the care workforce has predicted a workforce gap of 211, 430 full time equivalent staff in 2049-50 (National Skills Commission 2021).

To date, shortages had been most noticeable in rural and remote areas, despite 35 current workforce reports and strategies about the rural workforce (Topp et al. 2025b). If the gap cannot be ignored or defined away, it will mainly be filled by a very heavy reliance on importing health professionals trained overseas (Tran et al. 2024) or paying ludicrous amounts for short-term locums or agency staff. Neither strategy is sustainable in the long term. The former is unfeasible for ethical reasons (Joshi et al. 2023), the risks associated with the rise of anti-immigrant far-right populism (Droogan and Hutchinson 2024; Petter et al. 2026), and changing patterns of preferred destinations for nurses themselves (Gouveia et al. 2026). The latter needs to be avoided because of costs: a recent South Australian report shows growth in agency staff costs in rural Local Health Networks of around 45 per cent per annum (South Australia. Health Performance Council 2026).

There are problems in metropolitan areas too, with cyclical shortages of general practitioners (GP), nurses, and other personnel reported. Mental health personnel are seen as in short supply across the country (Department of Health and Aged Care 2022). Anecdotal reports suggest that many employers serving clients outside the National Disability Insurance Scheme (NDIS) cannot match the NDIS’s current prevailing terms and conditions, resulting in a ‘gravitational pull’ away from other sectors (Butler 2026).

The workforce planning status quo must not continue, lest the dire projections come to pass. Workforce planning is hard, so failures in workforce planning for the health and social care workforce are to some extent inevitable, but that does not mean we should not persevere and attempt to make our planning better.

# Why health workforce planning is hard

*“Most workforce planning is still for a single profession or ‘silo’ ...”*

Predicting supply of professionals is superficially easy: numbers graduating minus exits (including those changing hours worked at current terms and conditions) plus imports. But what is needed is not about projecting supply of professional group A, but rather supply of people with skill X who can do Task or Function Y working Z hours at times of the day and days of the week A, B, and C. This is not the same thing at all, and much harder to achieve, partly because of failures in our own imagination. Especially in Australia, location matters, so all this must be done by region (Argus et al. 2026).

Predicting demand for health personnel is hard.

Firstly, things change between when the projection is done, and the current reality. The world changes, different options are available for students and skill mixes. The result? ‘Forecasts are unlikely to ever get it right’ (Scott et al. 2011: 10). The basis for workforce planning is the workforce of today, but the end point of planning is the workforce of the future, and they are very different, perhaps unimaginably so. Harper (2026) described the workforce transformation contemplated in England:

*(The model of today) is labour intensive, hospital-centric and built around managing high levels of immediate demand. The (model of the future) assumes greater digital maturity, stronger community infrastructure, more integrated neighbourhood working, increased automation, improved prevention and different professional boundaries. The gap between those two positions is enormous.*

If we believe the rhetoric in policy documents and strategies, the same could be said of Australia.

Secondly, the health sector is essentially government funded: over 70 per cent of health spending is from government (Australian Institute of Health and Welfare 2025), and similarly for aged care and disability. Some of the funding is open-ended in that more demand leads automatically to more funding (funding for medical services under the Medicare Benefits Schedule (MBS)

can be described this way), but growth in funding is capped in other sectors, public hospital funding being an obvious example.

This capping means effective demand – that is, demand for which someone will pay – does not necessarily increase in line with demographic or epidemiological projections. Most projections assume that funding follows ‘need’, which is obviously not the case. There is a cost to the economy of a mismatch here. Education providers may have expanded intakes to meet expectations of ‘need’, only for new graduates to be unable to find employment matched to their skills. This is more of a problem in less powerful professions such as nursing than in those with more sway such as medicine. In the latter, stakeholder pressure is generally effective in ensuring that all graduates get jobs, at least to complete their registration.

Thirdly, the relative attractiveness of employment in health and social care compared to other sectors causes volatility in demand for personnel (and supply). If jobs in mining become plentiful and wages in that sector are high, that industry will draw personnel from other sectors, including health and social care. Demand from the health and social care sector will increase to fill those vacancies. The reverse side of the cycle can also occur, reducing demand from the mining sector for personnel, and increasing supply of health care professionals now available to work in the health and social care sector. The last few years have seen the health sector draw employment from other sectors (Reserve Bank of Australia 2025: 43), although there is no reason why that should continue forever.

Fourthly, other economy-wide effects also have an impact on health and social care sector demand. In times of economic downturn, retention might increase as health and care sector personnel defer retirement or increase their regular part-time hours, reducing demand for new graduates.

Finally, a more fundamental problem relates to the modelling itself, particularly the interplay between planning for profession A versus planning for skills, tasks, and functions.

Most workforce planning is still for a single profession or ‘silo’, to use the term from Scott et al. (2011), with separate strategies produced or in development for the medical workforce (Department of Health 2021), the nursing workforce (Department of Health and Aged Care 2024b), nurse practitioners (Department of Health and Aged Care 2023), maternity services ([www.health.gov.au/our-work/national-maternity-workforce-strategy-2026-2036](http://www.health.gov.au/our-work/national-maternity-workforce-strategy-2026-2036)), and allied health personnel (Department of Health and Aged Care 2024a). This makes incorporation of issues such as substitution and recognition of alternative ways of achieving the same outcomes for patients, clients, or communities that much harder. There is also a separate workforce strategy for the Aboriginal and Torres Strait Islander workforce (Department of Health 2022), and a ‘labour market study’ for the care workforce (National Skills Commission 2021). Mono-disciplinary planning characterises state and territory workforce planning (Topp et al. 2025a). Almost inevitably, these plans will ‘ignore inter-relationships between the health professions, in particular substitution possibilities and the development of complementary skills’ (Bloor and Maynard 2003: 17)

Even where cross-cutting workforce strategies have been developed, they quickly slip into siloed professional thinking. The National Mental Health Strategy, for example, refers to working to top of scope, and the importance of team working, but the very first recommendation is about individual professions: ‘Address critical medical, nursing and allied health workforce shortages with an initial focus on priority professions as agreed in the National Agreement – psychiatry, psychology, mental health nursing, and other relevant allied health professions’ (Department of Health and Aged Care 2022). A follow-up study of the psychologist workforce, which predicted a shortfall of more than 7,000 psychologists (28 per cent of workforce) by 2038, did not mention substitution or workforce redesign and simply assumed current patterns of provision into the next decade (Department of Health Disability and Aged Care 2026b, 2026a). In contrast, the Psychology Board of Australia, the registration body, in a consultation paper on registration pathways, raised the possibility of an explicit pathway for ‘psychology assistants’ (Psychology Board of Australia 2026). A 475-page report on the care workforce also did not mention the word ‘substitution’ once (National Skills Commission 2021). Professional advocacy about workforce shortages almost inevitably talks about more of the same, and rarely mentions alternatives such as workforce substitution e.g., Wong et al. (2022).

Mono-disciplinary workforce planning typically assumes that the conversion from professional hours into care needs is fixed – that is, there will be no change in productivity – and it is appropriate to plan for a fixed ratio of workers per head of population. To some extent history is on the side of that assumption: there has been very limited change in roles over decades and Baumol’s disease – that productivity in the care sector is inevitably ‘stagnant’ partly because ‘quality is, or is at least believed to be, inescapably correlated with the amount of human labor devoted to their production’ (Baumol 1993: 20) – possibly characterises the Australian health and social care economy. But whether this continues – and indeed whether it was ever true (Atanda et al. 2018) – is an open question. Recent evidence suggests that, with appropriate measurement, productivity in the (English) National Health Service (NHS) appears to be increasing (Warner and Zaranko 2025). Not surprisingly, better, more contemporary, workforce planning models do not assume unchanged productivity and no skill-mix reform (Asamani et al. 2021; Lee et al. 2024; Sutton et al. 2023; World Health Organization 2025), but these developments seem to have passed by Australia’s health and care workforce planning.

We are entering the fourth industrial revolution (Philbeck and Davis 2018) – or perhaps it is the second digital revolution – where artificial intelligence (AI), AI-assisted healthcare, and other digitisation innovations exhibit much potential, albeit a potential mostly not (yet) realised (Organisation for Economic Co-operation and Development 2026). But increasingly there are frameworks about adoption, including overcoming the very human concerns associated with increased use of AI, such as trust and ethics (Abdelwanis et al. 2026; pwc 2026). The risks of AI have been known since early in the development path, and the identified risks then are still much the same today (Bender et al. 2021).

The Irish AI strategy identified five domains of potential benefits: equipping patients with self-service tools for greater health service access and engagement; analysing medical output to improve diagnostic accuracy; synthesising complex data to accelerate the transition towards personalised treatment; automating routine manual processes to free up staff time; and using predictive and preventive models to anticipate population needs (Ireland. Department of Health and Health Service Executive 2026). Most of these domains have not seen applications at scale and evaluations

involving humans yield poorer results than evaluations of AI with written scenarios (A. M. Bean et al. 2026). Further, there are few randomised controlled trials demonstrating the benefits of AI in clinical practice (Han et al. 2024) and there is an increasing literature about the risks of AI, including potential deskilling (Heudel et al. 2026) or worse, ‘never-skilling’ (Ke et al. 2026 (in press)).

As AI develops, and we move from AI augmenting existing jobs to stepping back and redesigning jobs in the light of what AI can do – its impact in health care is likely to increase. It will be potentially transformative to shift the focus from the impact on specific tasks to the impact on roles, and, more importantly, on redesigned roles (Bessen 2016; Demirer et al. 2026), including sharper distinction between health and care ‘support’

*“... even if we get projections of demand and supply right, there is another key gap in health workforce planning: converting words to deeds.”*

We are still in the ‘hype greater than delivery’ phase with AI, but AI’s potential and capability – and its energy consumption – is increasing rapidly (Li et al. 2024; Maddox Thomas et al. 2025; Morone et al. 2025; Sahoo et al. 2025; Teo et al. 2025). Amara’s Law probably applies here: we overestimate the short-term impacts of an innovation and underestimate its long-term effects (Amara 1988).

But we are already seeing signs. AI doc bots are better at clinical reasoning and diagnosis, at least on written scenarios, than medical practitioners (Breda et al. 2026; Brodeur et al. 2026) and more empathetic than humans (Howcroft et al. 2025). On the latter, there are proposals to build engines which are better at ‘artificial wisdom’, including ethics, empathy and values alignment, potentially generating a better mental health chat bot (Jeste et al. 2026). Application of AI in surgery is growing rapidly (Kenig et al. 2024), robots can now be programmed to perform procedures (Kim et al. 2025), and about one in seven Australians trust AI-guided users can perform procedures as well as medical practitioners (Edelman 2026). Double reading of mammograms with one radiologist and AI is better than two radiologists (Abeelh et al. 2025). The United States Congress has before it a proposal to allow autonomous AI prescribing (Gilbert et al. 2025). In another week or two the list will be longer, despite the protective effect of some characteristics of health and social care jobs: they are protected by regulation, they are often relational, and they are commonly physical (Richmond 2026). Extensive use of AI, though, may adversely affect clinical skills acquisition (Ke et al. 2026; Keren et al. 2026) creating concerns about appropriateness of current use when judged in terms of dynamic efficiency.

and the ‘professional’ component (Massenkoff and McCrory 2026). Importantly for health care in rural and remote Australia, specialisation might decrease. Despite the policy direction towards expanded roles for almost every health profession (Scope of Practice Review (Reviewer: Mark Cormack) 2023), workforce planning underestimates issues of human-human task or role substitution (in addition to the potential human-capital or human-computer substitution discussed above).

It is very difficult to predict future demand for teams, rather than individual professionals. What proportion of a GP’s mental health contacts could be done by a psychologist or other mental health professional, noting that 71 per cent of GP contacts included ‘psychological factors’ as one of the three main reasons for the visit (Royal Australian College of General Practitioners 2025)? What proportion of mental health needs could be met by counsellors or social workers rather than psychologists (Bloch-Atefi et al. 2021)? How many specialist consultations could be done by a GP appropriately supported with pathway software or, more traditionally, ‘phone-a-friend’ capacity? To what extent can a physiotherapist reduce demand for orthopaedic (Melman et al. 2025; Oldmeadow et al. 2007; Raymer et al. 2024; Vedanayagam et al. 2021) or GP consultations (Gallotti et al. 2023; Walsh et al. 2024)? What about the expanding role of pharmacists (Ali et al. 2024; Nissen et al. 2017) and nurses (K. Kilpatrick et al. 2024)?

A further transformation is in the locus of care. St Vincent’s Hospital recently announced an aim for half of its care to be provided in the home by 2030 (St Vincent’s Health Australia 2025). Implementing this policy will inevitably shift some care from paid workers to unpaid, at least for

the care they provide, as the families and other carers in the home will add this role to their others. This in turn will affect projections for paid care personnel.

The problems of planning are complicated further by the training lag. A person entering the workforce in 2026 – when we see the current mix of roles – entered training in 2023 or earlier and made their choices in 2020 or earlier. Their educational preparation may not have prepared them for the roles and team-working that now exist.

But even if we get projections of demand and supply right, there is another key gap in health workforce planning: converting words to deeds. There is a disconnect between the planners and the planned for.

Health workforce planning is often the preserve of health departments: state, territory or federal. Apart from the territories, health departments are rarely the employers, which are the local health districts or networks. The connection between perceived need in the documents is attenuated at each link in the chain. Information is lost at each point, so that in the end there is no link between the pious intentions in the national documents at the top of the chain and the parlous workforce situation on the frontline. We end up with the situation where national workforce planning produces innumerable glossy documents without any thought to the need for a connection between the document and the decisions of employers or educational providers. For example, the demand estimates do not necessarily translate into decisions of educational providers, who continue to be engaged in a cat and mouse game with health care providers about finding clinical and other professional placements for any program expansion.

Former Speaker of the US House of Representatives, Tip O'Neill, famously said 'all politics is local' (O'Neill and Hymel 1994). Health workforce planning in Australia is almost the reverse; all health workforce planning is national. The words about the workforce in the recently signed National Health Reform Agreement are almost all about national workforce planning with only the briefest aside about 'collaborating at the region or local level with key sector stakeholders' (First Ministers 2026: Paragraph G4), and not much about the sorely needed workforce redesign (Gregg et al. 2026).

Yet the reality is that national workforce planning has not delivered. The delivery failure is not surprising as the federal health department is not the key employer, nor the key provider of education. The disconnect

between planning and implementation has to stop and this can only occur if health workforce planning becomes local, or at least regional.

Internationally, there is recognition that the changes in and pressures on health systems require workforce planners to 'renew their thinking around the fundamentals' of how health and social care workforce planning is done (World Health Organization 2025). The answers in Australia are only partly technical. What is required here is for all stakeholders in workforce planning and *delivery* in a region to be around the table and do the planning at a meaningful level, testing assumptions about workforce design and workforce need, and with power collectively to implement what is required (Bloom et al. 2012; Duckett et al. 2012).

Contemporary workforce planning recognises that '[w]orkforce requirements are derived from anticipated changes in care pathways, acknowledging that system performance depends as much on how care is organised as on how many workers are employed' (Campbell and Correia 2026). It also requires strong links with employers (S. Kilpatrick et al. 2011). All stakeholders have to make commitments, including commitments to future students, who must be able to trust these commitments. Thinking has to change from institution-orientation – by both health/ care and education providers – to population-orientation, serving the health and social care needs of a region.

*“We end up with the situation where national workforce planning produces innumerable glossy documents without any thought to the need for a connection between the document and the decisions of employers or educational providers.”*

# Consequences if projections are partially right

Even if all the potential errors in projections and projection approaches are considered, there is a fairly wide credible interval around future projections of demand (and supply). Even assuming an outcome of the future imbalance at the lower end of the band, an increasing proportion of school leavers will need to choose the health and social care professions over other employment or study options. An increasing proportion of non-school leavers returning to study will also need to choose health and social care as their chosen field.

Following the Report on the Australian Universities Accord (Australian Universities Accord Review Panel (Chair: Mary O’Kane) 2024), government has recognised the importance of growing tertiary enrolments to meet Australia’s skills needs – aiming for 80 per cent of the population to have tertiary qualifications (university or vocational education) by 2050 and potentially foreshadowing a doubling of tertiary education enrolments over that period (Crowe et al. 2024; Warburton 2025). This will mean that cohorts of school leavers and non-school leavers who previously missed out on higher education – particularly rural students and lower socioeconomic status students – will need to elect to study rather than work, with the target only achievable if participation rates across all cohorts move closer to parity (Persson and Singh 2025).

There are two basic strategies universities and vocational education providers can adopt to change their student mix: change the student or change the university/education provider. They are not alternatives, but more policy attention has been devoted to the former than the latter.

A high profile ‘change the student’ strategy has been about changing student aspirations. Many universities, including prestigious ones, now embark on outreach to schools which enrol students from lower socioeconomic backgrounds to ensure that the option of tertiary study enters into the mindset of post school choices, so the effect needs to start well before year 12 to ensure appropriate choice of prerequisites (Coffey-Oates and McNaught 2026). Evaluating these programs is difficult, and results have been equivocal (Robinson et al. 2025). A more intense variant is to provide an in-school enabling program, building student capacity and guaranteeing entry to the university on successful completion (Ramos et al. 2025).

Another variant of the ‘change the student’ model is to provide additional support to students once they enter tertiary education such as additional study skills, counselling, and other supports. However, as Barnes et al. (2024: 8) argue, ‘(e)ffective university student support services are determined by a university’s willingness to adapt itself to its students’ needs rather than forcing students to adapt to university dictated systems’ and so the more comprehensive the student support, the more it aligns with a ‘change the provider’ model. Government has recognised the importance of both these types of initiatives through provision of needs-based funding.

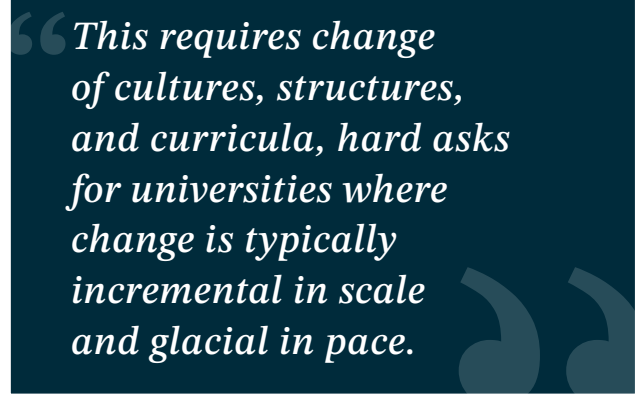
The deficit-framing of the ‘change the student’ strategies is endemic to equity programs in higher education (Burke et al. 2023) and causes the least discomfort to universities and their *modus operandi*. The option which is more challenging for providers is to look in the mirror and change themselves: a ‘change the provider’ approach. As Persson and Singh (2025) argue: ‘We (universities) must do the hard work to help design a system with the student at the heart, creating and supporting more seamless transitions and options for a more diverse student cohort’. This requires change of cultures, structures, and curricula, hard asks for universities where change is typically incremental in scale and glacial in pace.

Change of this kind might involve resetting cultural expectations of staff – both academic and professional – adjusting their expectations about the consequence of the sometimes chaotic nature of student lives, where family responsibilities, domestic violence, and job demands all conspire to make requests for late submission of assignments or missing classes more likely. Staff are up for this, many recognising the value of flexibility and adjusting accordingly (S. Macqueen et al. 2023). Additional institutional environmental supports may also be required, the most obvious being on-campus child care (Navarro-Cruz et al. 2023).

But structural/curriculum change might also be required. Victoria University in western Melbourne – which primarily serves a lower socioeconomic status population – has famously restructured its curriculum to a ‘block model’ (Jackson et al. 2022; Tangalakis et al. 2024). Under this approach, students complete one subject at the time in a four-week block, rather than three or four subjects simultaneously. The same number of subjects is completed in a year but in sequence rather than in parallel. Block mode provides a simple structure for students and reduces the consequences of failure in one subject if repeat in the next block can be arranged.

RMIT University and a number of other Australian institutions are pioneering an English import, the ‘earn and learn’ model (M. Bean et al. 2023; Canavan and Lilly 2023), the Australian transformation of the English ‘degree apprenticeships’. Here students, rather than undertaking part-time employment in hospitality or retail alongside their studies, *integrate* relevant employment with their studies. A typical design might embed a vocational education qualification in the first year (e.g., in allied health or nursing assisting) and then provide employment alongside a student’s latter study (Kenny et al. 2021; Lusk 2024). The education provider has pre-arranged employment, so the student does not have to hunt around for whatever employment they can find themselves.

The ‘earn and learn’ model helps address a critical structural barrier for low-income students or those with family/carer responsibilities by providing an income alongside their study, where the work is valorised and recognised as part of that study. It also provides reinforcement of the academic study. Such an approach requires a strong two-way relationship between the education and health providers to ensure the initial educational preparation is right so that the health provider can find relevant jobs for the student consistent with their study.



*“This requires change of cultures, structures, and curricula, hard asks for universities where change is typically incremental in scale and glacial in pace.”*

# Linking tertiary education and health and social care providers

As well as workforce challenges related to the number of future personnel, there are critical challenges to distribution. What we know about the medical workforce is that students who went to school in a region, and then did their medical training in that region, are more likely to work in that region (I. T. MacQueen et al. 2018; Sen Gupta et al. 2018). The same is probably true for other health professionals. The more even distribution of the nursing workforce is probably the result of a historic more even distribution of nurse education opportunities in rural and regional Australia.

New educational technologies now make it possible to adopt more distributed forms of education, making *in situ* provision of a broad range of educational opportunities more feasible. Lectures, especially, can be watched in real time in multiple locations or recorded and watched individually at a convenient time. As we have all experienced, smaller group discussions are possible through Zoom, Teams, and other platforms. Artificial intelligence will also create a transformative effect on education through individualised learning on a scale we cannot imagine at present.

## *The health provider role is critical.*

In the past, for many universities, students could only gain access to the university by going to the university campus. This was not the case for every university, with some having a proud history of taking university education to the student through what was originally called correspondence courses, then distance education, and now online study (Stacey 2005; White 1982). Almost every university is now dipping its toe in the online waters.

And here I want to link technological changes back to 'earn and learn'. If we are to expand opportunities dramatically and bring new cohorts into tertiary study, be they rural or low socio-economic status, we need to change the university and make it easier for those cohorts to study. Making it easier to study will inevitably involve making it easier for them to live while studying— that is, to earn money to support themselves. Importantly, making it easier for them to study does not mean reducing standards. Rather, it might mean increasing them if there is more reinforcement in practice alongside the academic study, than there is now through serendipitous employment which is in competition with their study.

Already about 30 per cent of school-leaver students work part-time (Australian Bureau of Statistics 2025). Those who do work alongside study think it makes them

more employable, and reinforces their learning (Brosnan et al. 2024). 'Earn and learn' models, which will not be for everyone, can build on that and might improve the likelihood of students entering the relevant workforce on graduation. For low socio-economic students in cities and regional centres, 'earn and learn' will still be about going to the bricks and mortar university campus, but also working at the same time in the bricks and mortar aged care facility and hospital, or in a modern mobile in the home service.

In rural settings, it will involve studying remotely for some of the time and coming to the university occasionally for a day of labs, simulations, and other high interaction education which might only be available face to face. But the bulk of their experience might be in a small group in a rural university hub (James and Keenan 2026), a local health facility, or using the resources of the local vocational education provider. The cohort experience, still a key part of university experience for many, can be retained. And all this can be achieved in quite small towns, helping ensure the future workforce for the health and social care services in those places as well as others.

The fate of universities and health and social care providers is inextricably linked in their joint endeavour of creating the next generation of health personnel. Their dance is the most complex form of interdependence, labelled 'reciprocal interdependence' by Thompson (1967). The outputs of the university (graduates) are the inputs of the provider (new employees) but the university requires inputs which are outputs from the provider in the form of clinical and professional placements. They have to work together better to meet burgeoning needs.

The way universities structure their curricula influences the skills, knowledge and attitudes of health and care sector employees to the future. Failing to teach students about how to work in modern teams with rotating leadership (Katzenbach and Smith 1993, 2008), and about the roles of other professionals, makes teamwork in employment harder. Worse, hidden curricula about relative health professional status hierarchies make sensible multidisciplinary team working well-nigh impossible.

The health provider role is critical. Finding suitable settings for professional placements is hard and placement provision is often the rate limiting factor in expansion of health professional education. Health providers bemoan the lack of graduates three or so years after they refused to provide placements to allow expansion of enrolments. Similarly, in an 'earn and learn' model, the health provider is the earn partner, the *sine qua non* of this partnership.

# Making workforce planning real

This brings us back to the need to transform health and social care workforce planning. Planning needs to involve the reciprocally interdependent health, social care, and education providers. A revitalised health and social care workforce approach will mean that recommendations of the plan become real, with words and deeds in alignment.

The current disconnected health and social care workforce planning system, with its 'fragmented policy architecture' (Topp et al. 2025a), needs to change and is ripe for renewal. The stars are for once in alignment: the Universities Accord process provides funding for universities (and, in parallel, vocational education providers) to expand, and the 'earn and learn' innovation makes it possible for underrepresented cohorts to participate in study. What is missing is the effector arm: who will do what and where? This is not to say that all national workforce planning should be junked, but rather there is a better incremental cost effectiveness ratio in investing in doing things regionally rather than talking or producing documents nationally.

A recommendation to increase nursing enrolments to address the looming shortage has no effect unless universities and vocational education providers are funded to increase their intakes. State policies to pay Higher Education Contribution Scheme (HECS) debts for nursing students have a minuscule impact on workforce supply unless there is an increased intake.

University funding is the preserve of the education portfolio which may or may not sign up to the health department's workforce plans. Universities, who make the decisions to change intakes, are rarely engaged in plan preparation. Commonwealth policies in the past have capped student enrolment. The good news, however, is capping of enrolment is coming to an end, at least for 'equity cohorts', as governments realise the importance of growth in the percentage of people with tertiary qualifications to meet future skills needs, an issue discussed further below.

A key failure in the national approach to workforce planning is the inability to address distributional issues. As Scott and Brooks (2025) conclude:

*After 25 years it is difficult to see any positive outcomes so far regarding the distribution of the health workforce across geographies, specialities and types of health professional. Patients continue to be harmed by shortages and surpluses and are not able to wait another 25 years to see evidence of change.*

One way forward is to create an explicit regional tertiary education health and care sector partnership (Duckett 2009), what I have referred to in this paper as the 'effector arm'. National workforce planning will set the environment and context for regional planning partnerships.

The anchors for such a partnership will be the key university (or universities) and the public vocational education providers to a region on the one hand, and the key health and social care providers on the other. In some cases, the key educational provider may be located outside the region. Aboriginal Controlled Community Health Organisations should also be partners in some regions.

The aim here is to go beyond the simple placement contract approach which characterises much of the 'partnership' now. It goes beyond the teaching hospital/clinical school arrangement where senior clinical staff might be given university titles or university staff might be based in the provider. It becomes a much closer relationship where both are involved in priority setting, both plan the size of the intake, and both are involved in designing the curriculum. It therefore involves sharing of power, uncomfortable for all concerned.

The term region here has been left undefined but ideally it should be large enough to be net self-sufficient for the key health professions; net self-sufficiency should be achievable for populations of about 300,000-500,000, with regions at the lower end of this scale only being net self-sufficient in larger professions.

Net self-sufficiency as a goal recognises that inflows and outflows are positive: not all specialty training might be available in every region, and people travel and relocate. But the aim is for inflows to balance outflows. At present rural and remote Australia is nowhere close to this situation, especially for medical practitioners where unethical reliance on internationally trained medical practitioners

is not a bug, but a feature. The words of a recent UK Parliamentary report are true here too: ‘International recruitment is not a marginal feature of the system – it is structural’ (All-Party Parliamentary Group on Global Health & Security (Sir Andrew Mitchell MP Inquiry Chair) 2026: 6).

The concept of ‘region’ is easiest to operationalise where there is a defined population and where educational providers identify with their region. Rural and regional Australia is like that, but so too are some regions within metropolitan areas. It is recognised that net self-sufficiency is an ambitious long-term goal, even at the national level (Buchan et al. 2011), but unless the goal is set, the current ramshackle and expensive locum, agency and international recruitment arrangements will be forced to continue as an entrenched part of the future rather than be consigned to the dustbin of history as an example of poor past planning.

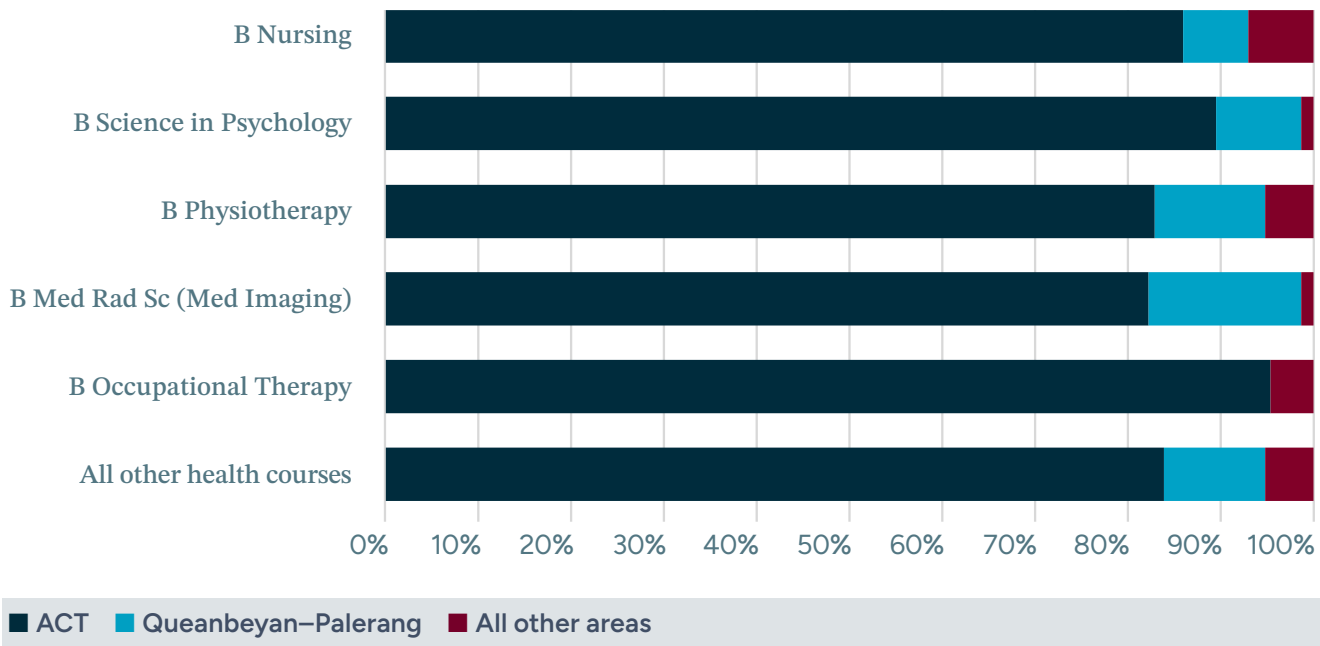
The regions’ composition should be informed by data, in particular relevance and commitment indexes, concepts derived from hospital planning (Griffith 1972). The commitment index can be calculated from a university’s own data and measures what percentage of its admissions are from that area. In the case of the University of Canberra, for example, 84 per cent of its health enrolments come from the ACT, and a further 11 per cent from Queanbeyan and surrounds (see Figure 3).

From the University of Canberra’s point of view, the first priority might be for a formal partnership and compact with ACT Health and related organisations, with its second priority for one with health and care organisations serving the Queanbeyan-Palerang Regional Council area, although a Queanbeyan region would probably be too small to achieve net self-sufficiency.

But, to some extent defining the boundaries of the compact areas using the commitment index misses the point: to sharpen the focus on community needs and secure a workforce to meet those needs. Here, the second index comes to the fore: the relevance index that measures the percentage of all offers/students which go to the relevant university. This requires comprehensive data from the Universities’ Admission Centre about where students in each area say they want to study.

Grouped into ‘all other areas’ in Figure 3 are offers made to residents of Goulburn-Mulwaree, Snowy Monaro, Upper Lachlan, and Yass Valley. It may be that the University of Canberra is the main supplier of health and social care education to those areas and so the compact ought to be developed incorporating those areas as well.

**Figure 3: Sources of offers for University of Canberra health courses, 2026**



The first task of a new regional health and education partnership will be to agree on the goal (Rees et al. 2025). Is 'net self-sufficiency' achievable in this region? If it is, can all participants sign up to that goal? Too often, health workforce planning founders because of lack of clarity of what the aim is, moving too quickly to the technical issues and avoiding normative issues (the goal) which may make planners uncomfortable. But with an agreed goal, one can negotiate the time frame. Here, quick is not always best: nurturing relationships, taking time to engage, being clear about intermediate steps, and recognising the inherent lags in education should be the order of the day, eschewing the adrenalin rushes of 'announceables' in favour of 'slow policy making' (Robertson 2026).

Once a broad goal is agreed, then the technical work starts with projections of healthcare workforce demand. This should encompass not only demand for the public health care sector partners but also demand for the whole health and social care economy. Demand projections should be realistic in the context of projected future health and social care funding.

The next step is to sort out how projections of demand for necessary skills/roles can best be met. This might involve simulating various options, workforce mixes and role changes (Scott et al. 2011). Facilitating new rural-specific workforce models – involving multi-skilling or generalist models (Barker et al. 2021; Dymmott et al. 2024) – might be part of the compact discussions recognising that city-based models of highly specialised health and social care provision may not be viable in small communities. The tertiary education providers in the partnership might facilitate workforce redesign by designing and providing bespoke, but nationally certified, programs.

If a domestic supply expansion is required, again options might be explored about which educational providers might be best placed to expand supply. This may be partly a process of negotiation among free agents, and partly a market process as care must be taken not to indulge in anti-competitive behaviour.

*“... local flexibility can lead to local innovation and responsiveness.”*

Where expansion in supply is required and agreed, health and social care providers must then commit to provide the necessary clinical and professional placements. Hopefully, this will increase the availability of placements locally, reducing 'placement poverty', the consequences of the cost to students of undertaking placements (Beks et al. 2024; Lambert et al. 2024; William et al. 2024).

Where 'earn and learn' models are to be developed, the health and social care providers must commit to the earn component and articulate their prerequisites for that employment. Health and social care providers must also commit, save for *force majeure* provisions, to employ in the range of 60-80 per cent of all graduates from programs covered by their negotiations. The percentage will be based on historic data or projected experience for new programs. It will probably be at the higher end of that range in rural regions, and at the lower end in metropolitan suburban regions.

These arrangements should all be underpinned by a new health and tertiary education 'compact' for the region agreed to by all parties and officially documented. This agreement will parallel but be separate from the 'compacts' being negotiated with universities under the Accord process.

Under this model, health and social care workforce planning becomes much more real. The aim is for each region to become net self-sufficient, providing enough opportunities for local students so they are not forced to study elsewhere, and in turn, increasing the likelihood that they will stay local after graduation. Workforce planning can become directly linked to locally codesigned workforce redesign. Health and social care providers will be able to see an end to expensive agency and local arrangements, and their pursuit of international recruits. Universities and vocational education providers will see their graduates getting jobs.

Students from lower socio-economic status backgrounds will now have a real potential to enter the health and social care workforce, especially with the expansion of 'earn and learn' models. The delivery of the government's commitment to meet skills needs in the future will be more feasible, with specific strategies to expand the cohorts who otherwise miss out on education. The regional health and social care workforce compact itself would fit nicely into a framework of rural health and social care planning and strengthening regional self-sufficiency in health and social care provision.

This model is clearly not 'one size fits all'. What it would look like in rural regions will be quite different from what it will be in the western suburbs of Sydney or Melbourne. There will be differences among rural regions too (e.g. coastal areas with high population growth vs inland); in some places it may work better at a smaller scale (Champion et al. 2025). Some universities, especially those in central metropolitan locations with state or national catchments, might not be squeezed into the model at all. But that is a strength; local flexibility can lead to local innovation and responsiveness.

In some regions where the model ought to work, it will not. Cooperation and power sharing is hard. The cultures of universities and health services providers are quite different, with the speed of decision making often glacial in the former and merely slow in the latter, with my hypothesis being it is related to differences in average lengths of stay measured in years in universities and hours/days in hospitals. Personalities may inhibit collaborative working. Organisational commitment, communication and availability, and the use of social capital, will facilitate the success of the new relationship (Thune 2011). Critical, though, is agreement that there is a problem to be solved, and that all need to work together to solve it.

Once there is a true partnership documented in a compact, it can become a vehicle for other opportunities and a vehicle to revitalise what Boyer (1996) has referred to as the 'scholarship of engagement', facilitating local value creation (Cao et al. 2026). It can play the central part in bringing the goals of the educational provider and the health system into alignment, consistent with a contemporary vision for the future of 'academic medicine' (sic) (Saxena et al. 2025).

This proposal has mainly focused on one role of universities, that of preparing the future health and social care workforce. Universities' roles are broader than that, and so too, the compact can be broader than initial education preparation. The health and social care workforce needs to be upskilled and retrained on a regular basis as new knowledge comes into the workplace. As staff grow in their capabilities, they might need to be supported with management training and other skills. Close partnerships through the compact may make bespoke training that much easier.

The partnership might also involve setting joint research priorities, including clinical and health services research and facilitating the translation of research done in other locations to its application locally, emphasising a 'scholarship of application' (Boyer 1990). The research program might also involve a program evaluation component to serve local system development.

Finally, the compact might be a vehicle for joint engagement of the education and health providers on the one hand and the communities served by both on the other. In addition to the expected benefits from better decision making, an engaged community might lead to greater local interest in health and social care sector employment. This local focus might be further strengthened by increasing community involvement in selection for graduate entry programs and prioritising local students, to increase the likelihood of local retention (Hay et al. 2017).

To some extent what is proposed here is not new. It builds on industry partnerships in the vocational education sector and joint curriculum and need planning in that sector over decades, allowing that the history in that sector is somewhat checkered (Condon and Rickard 2009; Smith 2025). It sits nicely alongside reforms to the university sector that will involve 'mission-based compacts' setting out how each university might be able to grow its enrolments. It is also consistent with a principle identified in Jobs and Skills Australia's regional roadmap that seeks to ensure local communities are supported to develop and deliver solutions (Jobs and Skills Australia 2025).

# Conclusion

What passes for health workforce planning in Australia is essentially a litany of failure over decades. Planning has become synonymous with document production, save for occasional forays in medical student expansion.

The documents produced have read well but have not ensured that Australia has the health and social care workforce it needs. And enormous amounts of energy have been expended on medical workforce planning which has left rural regions a black hole of need and GPs in short supply everywhere. Estimates of nursing, allied health and social care workforce shortages in the tens or even hundreds of thousands boggle the mind.

Good workforce planning requires attention to two interfaces: a 'workforce–community interface, capturing how societal, economic, and security conditions shape workforce motivation, performance, and retention, and the workforce–governance interface, reflecting how institutional arrangements, policies, and decision-making processes enable or constrain workforce system responses' (Onvlee et al. 2026). Workforce policy in Australia is weak on both these necessary interfaces.

Health and care workforce policy needs to be top down and bottom up, with the realities of local employer needs linked seamlessly to education providers, within an overarching framework. Australia has a surfeit of the national bits, and a massive gap in translating that into meaningful responses in terms of addressing needs and gaps. I have argued that health and social care workforce planning is technically hard, but I am not pessimistic. It requires a new approach, though, a hard slow slog, emphasising engagement and advancing with small steps rather than the drama of a big change (Robertson 2026). The huge changes necessary to achieve net self-sufficiency will be tough but achievable, if we recognise that scale and pace are two separate variables: that big scale can be achieved at a slow pace if we set and adhere to the direction (Tuohy 2018).

A goal of net self sufficiency for Australia or any region is very ambitious. For some professions in some regions more than half the workforce comes from outside Australia. But intermediate goals can, and should, be established for ten or twenty year or longer horizons. If we don't set such goals, the response to health and social care workforce crises will remain simply more reports, more talk, and more hand-wringing.

What I have proposed here – regional health and social care sector workforce partnerships and compacts – is a way of operationalising and documenting what the healthcare workforce of the future should look like, and how we will get from the current state to that future state. The main barrier to achieving this nirvana is an unwillingness to cooperate, talk, and commit. Hopefully, cooperation and commitment in the future will be as plentiful as workforce planning documents have been in the past. If that is the case, we can all be very optimistic.

*“What passes for health workforce planning in Australia is essentially a litany of failure over decades. Planning has become synonymous with document production ...*

*Hopefully, cooperation and commitment in the future will be as plentiful as workforce planning documents have been in the past. If that is the case, we can all be very optimistic.*

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