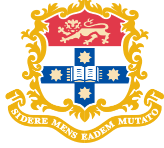

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19th July 2005

Productivity Commission
Health Workforce Commissioned Study

This submission is made on behalf of the Faculty of Health Sciences, University of Sydney. The Faculty has approximately 6000 undergraduate and postgraduate students and produces graduates in the following allied health disciplines:

- Orthoptics
- Rehabilitation Counselling
- Speech Pathology
- Exercise & Sports Sciences
- Health Information Management
- Diagnostic Radiography
- Radiation Therapy
- Nuclear Medicine
- Medical Sonography
- Occupational Therapy
- Leisure & Health
- Physiotherapy
- Indigenous Health Sciences

The Faculty is one of the largest of its type in the world, and we produce over one third of the starting practitioners in the NSW health workforce, as well as many interstate and internationally.

The Dean of the Faculty, Professor Gwynnyth Llewellyn, and the Pro-Dean, Dr Alastair Davison, appeared with other University of Sydney colleagues, before Commissioner Robert Fitzgerald on 4th July. At this hearing the Commissioner stressed that many issues and problems in health had been well identified, and what they were seeking were practical actions and strategies that would address the problems. In this vein, this submission does not seek to argue in detail the validity or priority of the issues addressed here, but presents possible solutions to key problems we face particularly in educating allied health practitioners and assisting the improvement of health service delivery.

<u>Models of Health Services Delivery</u>

Designing health sciences curricula which are accredited by state, national and international bodies is problematic, but complicated further because the day one expectations of and by new graduates varies considerably depending on location. The models of health services delivery in place across Australia differ and often lead to a serious mismatch of expectations when our graduates, who are trained with an emphasis on evidence based practice, and interdisciplinary and team based delivery of care, take their place in the workforce. They are too often faced with discipline centric care and workforce staff that are resistant to new trends. The consequent frustrations are counterproductive for all involved and lead to significant attrition. These problems can be reduced by having national professional accreditation systems, but still leave the State based workplaces with different attitudes.

It is proposed that COAG should adopt, promote and progressively implement a unified model of health services delivery for Australia. Whilst we clearly would advocate an interdisciplinary problem based model, the overriding need is for a consistent national approach. It is recognised that it will take a considerable amount of time to implement such a model nationally, but this action would engender a sense of common purpose, and enable health educators and professionals to be better synchronised.

Any unified model of health service delivery must be cognoscente of the increased emphasis on and rapid development in the information infrastructure with various eHealth advances including the electronic health record. The model should bear in mind the skills and expertise that the health workforce need to work within the changing environment in relation to information and communication technology.

A *brave* Federal government might see the advantage of taking the relative isolation of the Australian Capital Territory as an opportunity to pilot a new health services model as a proof of concept to be adopted nationally.

Clinical Education

Given the critical shortages in the health workforce, most education institutions are finding it increasingly difficult to provide sufficient clinical placements to meet the course and accreditation requirements. In some disciplines, students have had their graduation delayed because it has not been possible to provide the required clinical exposure during the normal course duration.

Clearly there is a growing tension between workplace staff shortages and the increased number of students. The education institutions, the professions and the accrediting bodies have a responsibility to develop innovative approaches which will be more efficient and flexible, and much good work is being done. The critical problem is to better identify and manage workforce capacity to provide clinical placements.

In nursing, medicine and dentistry the provision of clinical placements in hospitals is well established and typically underpinned by identifiable and funded clinical schools. This is not the case for allied health disciplines where the arrangements are organised using ad hoc and local arrangements, with little coordinating infrastructure and funding. Some Universities have established coordinating committees to make agreements on the timing and sharing of placements where ‘territories’ overlap. These agreements have varying success and are increasingly being broken due to the shortage of placements, competition between institutions and the hurried introduction of new programs.

These difficulties are further exacerbated by the fact that allied health practitioners rarely have clinical placement supervision built into their job description. This means it is typically on top of their already high service load, and is often the first thing to go when work pressure becomes too high. It increasingly leads to a poor relationship between student and practitioner, and a perception that students are a burden. The lack of explicit funding to support allied health clinical education is indicative of the problem and leading to an expectation that educational institutions find funds in their already stressed budgets.

Critical problems with clinical placements were discussed at a NSW premier’s roundtable and resulted in a forum being held in November 2004 involving some 100 senior stakeholders, representing all health disciplines, government, educational, professional and service delivery entities. The report from this forum is available from NSW Health, but amongst other things it identified the need to do the following:

- Institutionalise clinical education as part of core business for health practitioners
- Establish infrastructure to support and coordinate clinical education, broadly modelled on the clinical school approach used for nursing, medicine and dentistry. It was considered feasible to unify these structures which would also engender an interdisciplinary approach.

- Identify State and Federal funding mechanisms to explicitly support clinical education in allied health. This has occurred selectively and to very limited extents in various states, typically associated with perceived crises eg radiation therapists in NSW
- Build an expectation that all parts of the health system will contribute to clinical placement needs. The private sector eagerly employs recent graduates, but their participation in clinical education is highly variable. Primarily indemnity issues need to be addressed.
- Establish the capacity of each health service delivery centre to take students across the spectrum of stage and discipline.
- Establish in each state a 'Clearing House' which would document the available places and allocate them on a fair and equitable basis. Allocation would need to take into account the need for a mix of rural, regional and metropolitan experience. Management of the places would most likely be devolved to local areas. It is envisaged that the 'Clearing House' organisation would be sponsored by each state health authority, and draw representation from the key stakeholders.
- Recognise the currently largely lost opportunity for student practitioners to contribute significantly to service delivery. As students competencies are progressively established during their courses, it should be possible to appropriately allow student practitioners to increasingly provide minimally supervised services. Taking the extreme case, final year students are by definition less than one year away from completion and this could be more formally exploited to the benefit of students and the workplace.
- Accept the equivalent needs of other disciplines eg Health Information Management, who have similar student placement needs, but which are not always included in the 'clinical education' category.

Workforce and educational flexibility

It is increasingly recognised that health workforce attrition is caused by many factors other than remuneration and staffing levels. The continued focus on discipline based service delivery limits the diversity of work done by health professionals and generates considerable frustration. Reform and broadening of practitioner roles should be implicit in the development of new models of care. Currently this has rarely been done proactively, but more in response to specific workforce shortages eg nurse practitioners and reporting radiographers.

At Sydney University we are increasingly moving to graduate entry pathways for health practitioners to gain accreditation. This means that for nursing and allied health the discipline specific knowledge and skills will be gained during intensive typically 2 year long graduate entry programs, building on the knowledge and learning skills gained by students in their foundation degrees. We believe that this will lead to more mature and better informed students making the decision to enter health programs, and also provide for the increasing number of people holding degrees in a wide range of disciplines, wishing to enter the health workforce, but put off by the need to complete another 3 or 4 year undergraduate degree. We believe that the graduate practitioners produced in this way will be better equipped with life and learning skills, and better suited to take a place in the now complex and pressured workplace. School leavers may choose to study in a health foundation program and either enter the health workforce in a more generalist health services role, or become a health professional via one of the graduate entry programs.

A further benefit to adding this diversity to the health education spectrum will be the opportunity that it offers to existing practitioners contemplating leaving the workplace. Typically most leave the sector totally or move into a non-service delivery area. A graduate entry program, which appropriately recognises prior learning and experience, means that a practitioner in one discipline area would be able to qualify for practice in another in 2 years or less. This will lead to extensive multi-skilling and allow health professionals to develop professionally and address new challenges.

To facilitate this educational approach, there needs to be considerable flexibility on the part of DEST as to the types of funding they will provide or allow for such graduate entry programs. If they are fixed in the belief that it represents a second degree and therefore should be fee-paying rather than HECS based, there will be many equity issues. Existing workers wishing to re-train via a graduate entry program need to be appropriately treated by the ATO and other funding bodies.

Collaboration & Cooperation

Currently there is very little formal integration of academic positions in the allied health services, which tends to engender an 'us and them' attitude with less than ideal understanding of the issues facing each sector. There are many honorary titles which are primarily given in recognition for research and teaching contributions, but these do little to impact directly on core service delivery. Whilst there are isolated cases where joint University and Health service appointments have been made, we suggest that a deliberate program of joint appointments throughout the health sector would offer the following benefits:

- Foster better understanding of issues facing each sector
- Provide an added attraction for clinical positions in hard to staff locations
- Facilitate the propagation of best practice and new knowledge into the workplace
- Provide an opportunity for work culture and attitude change
- Identification of key problems that are a priority for research in a given region
- Provide a potential for rotation of clinical practitioners into academic positions, providing new challenges and insights.

What is required is a coherent set of joint appointments throughout the health sector. Whilst isolated appointments may have a particular impact, only by having a set of linked appointments will the desired benefits and changed behaviour be achieved. This will require budget allocation, but more particularly needs policy setting in the State Health systems. We contend that the following strategy would be effective:

- Appointment of a Professor of Allied Health in each major state health region, with the responsibility to recommend further appointments in key problem oriented areas not based on discipline eg:
    - Diabetes
    - Healthy aging
    - Indigenous health
    - Obesity

It is further suggested that there is no identifiable forum at State or Federal level which regularly brings academics, health professionals and managers together to discuss issues and strategies. On occasions there are crisis triggered meetings, but what is needed is a formal network which meets and identifies issues to be addressed, and has a capacity to establish working groups or teams in a strategic manner. The benefits are obvious and implicit in much of what has been said above.

The Faculty of Health Sciences is prepared to provide further comment or clarification on request.