The Australian Psychological Society Ltd

Submission to

Productivity Commission Health Workforce Study

From the Australian Psychological Society

APS contacts:

Arthur Crook, Principal Policy Analyst
a.crook@psychology.org.au
David Stokes, Manager, Professional Issues
d.stokes@psychology.org.au
Martine Fazande, Senior Policy Officer
m.fazande@psychology.org.au

The Australian Psychological Society Ltd, Level 11, De Bono Centre, 257 Collins Street, Melbourne VIC 3000
Phone +61 3 8662 3300; Fax +66 3 9663 6177; Email contactus@psychology.org.au; Web www.psychology.org.au

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PART 2 EXECUTIVE SUMMARY

The psychology profession includes many psychologists who constitute a major allied health group in the health workforce. The Australian Psychological Society, as the largest professional society for psychologists, supports many of its members in clinical, professional training, research and management within the health sector. Its members can be found in a range of healthcare settings including acute-care, community care (both mental-health and general health), primary care (both private practitioners and employed professionals), universities, research institutes and Government departments of health and education.

In this paper, considerable emphasis is placed upon the potential contribution that psychologists can provide to relieving workforce shortages (particularly for general practitioners, psychiatrists and hospital based specialists) while increasing community access to cost-effective interventions.

Inability to state definitively the size of one of the largest allied health professional groups in the health sector reflects one of the core concerns of this paper. That is to say, that we identify:

- very poor resource investment, and processes utilised in, workforce data collection
- poor definitions of "psychology" and "health"
- oversimplification of the workforce complexities in such data collection

That the APS is committed to a high level of professional standards is evidenced by its role, and considerable investment in, the accreditation of university courses in psychology. Yet, as is pointed out in this paper, psychology receives the lowest level of funding of any health group under current DEST classifications. As is pointed out, the impact of this too-low classification is highly significant, wide-ranging and likely to harm professional training programs. It is also argued that some current practices in tertiary training further degrade the quality of staffing in universities.

The Australian Psychological Society has long been a strong supporter of “state” regulatory control of professional service delivery and sees appropriate regulation as a strong contributor to professional quality and client safety. However it is also acknowledged that both formal and informal regulatory influences do bring with them burdensome costs, inefficiencies, inequities and, at times, even injustices. The impacts of these factors on the workforce are reviewed and a general discussion provided about the changing

workforce, workforce restructuring and its impact on service quality and workforce retention.

Finally, the paper reviews current practices in overseas recruitment in the health workforce generally and identifies some alternative practices that could relieve the pressure within the health workforce. It also offers some best practice principles for the provision of psychology services to the indigenous population of Australia.

PART 3 RECOMMENDATIONS

Recommendation 1

That the Commission recognises that the growing incidence of mental health disorders and the chronic shortages in the current mental health workforce have created a crisis in public mental health services. It is argued that the predicted rapid increase in general practitioner shortages and specialist services will exacerbate this crisis in both mental and general health in the next ten years. Therefore it is concluded that the Commission commend to the Australian Government that the utilisation of an available and highly qualified psychology workforce could go some way to relieve this crisis by :

- Increasing the mental health workforce by government funded psychology positions and acute health re-structures;
- Resourcing cost-effective psychology services for chronic disease sufferers

Recommendation 2

That in view of the workforce crisis identified above, the current Government initiatives in primary care (eg. Better Outcomes in Mental Health Care and the MedicarePlus initiative) be extended to ensure equitable access by members of the community. This could be achieved by extending the MBS items covering the cost-effective Focused Psychological Strategies (FPS) to accredited private practising psychologists.

Recommendation 3

That a joint project (involving the APS) is conducted, to develop meaningful and widely-acceptable terms and definitions about “health”, “health sector” and “health services”, and to delineate the relevant “health systems”. One project aim would be the achievement of agreement on the scope of Psychology employment and on specialties therein. Another aim would be to provide a basis for Psychologist Registration Boards to maintain regular workforce data collections.

Recommendation 4

That the Commission in its report to Government draws attention to the serious negative consequences, for the professions and for the quality of

service-delivery to the public, of the chronic underfunding of the universities and commends that:

(a) university funding be restored to an adequate level.

(b) the processes by which university profiles are negotiated be made more transparent, more consultative (within the university and where relevant with the professions/occupations), and more long-term.

(c) The number of HECS places be increased to provide more adequately for socially equitable access to higher degree professional programs.

(d) the Australian and State/Territory Governments not use "user pays" expectations and arguments to promote higher degree fee increases, or to move towards full fee payment regimes for higher degree professional programs, or to justify high registration fees for professionals, due to the negative unintended consequences of such expectations and arguments (See Recommendation 7).

Recommendation 5

That the Commission supports and seeks funding for the following research topics (in which research work the APS would wish to be involved):

(a) The "social equity"/access and other workforce impacts of higher fees for post-graduate professional higher degree programs including trainee professionals' attitudes such as to remuneration levels, *pro bono* work, the social and ethical responsibilities of professionals, and related issues.

(b) To what extent and how professional registration fees act as barriers to practice entry.

(c) The nature of overlapping workforces in and implications for quality and maintenance of health service provision.

(d) The implications of the ageing of the Psychology workforce (and in other professions).

(e) Ageing generally as well as in workforce terms.

(f) Attraction of other countries to Australian professionals as sources of employment and professional training and experience.

(g) The effects and implications for professional service delivery of general population growth, and the rapid expansion of the population of major cities.

(h) Details of regulatory arrangements in other countries.

Recommendation 6

That the Commission (through its report) draws to the various governments" attention psychologists' experiences and concerns about the negative effects of removal of public sector professional management and career structures on psychological service delivery, its management and development, and the capacity of governments to carry out adequate workforce planning and development.

Recommendation 7

That the Commission supports our view that:

(a) State and Territory Governments must invest adequately in regulatory mechanisms if their fees to registrants are not to be so expensive as to serve as significant barriers to entry and continued participation by trained professionals;

(b) national consistency must be sought in professional regulation;

(c) strong efforts should be made by governments to prevent and discourage misuse of regulatory mechanisms for pursuit of political agendas or personal issues not related to protection of the public from professional misconduct or unqualified, incompetent and/or unethical service provision;

(d) all qualified psychologists who wish to use the term "psychologist" as a public descriptor be registered, but only those who wish to provide professional psychological services to the public (on a fee-for-service basis or are employed on a salaried basis to provide professional services to the public) be licensed.

(e) advertising and provision of psychological services including those based on psychological tests be restricted to qualified and registered psychologists;

(f) closer attention be given to, and there are clearer legal powers for Registration Boards to act against, unqualified and unregistered persons who offer psychological services.

Recommendation 8

(a) Noting that in the mental health area, a key "threshold" issue for adequate take-up of available services is attitudes towards mental

health problems, stronger efforts be made by the Australian and State/Territory Governments to achieve broad attitude change in the general community and in indigenous communities.

(b) Training and employment of more indigenous professionals be encouraged including in psychological service provision.

PART 4 THE STRUCTURE OF THIS SUBMISSION

This submission is structured largely around the Commission's questions, which we have grouped into sections and question sets, identified by grey highlighting. For example, Section 4 is Workforce Participation and Question Set 8 is "To what extent is participation in the health workforce…"? The question sets are continuously numbered, not re-numbered by section.

Questions that are not grey highlighted are questions that we, the APS have asked, not the Commission.

Some question sets are not addressed in this submission notably those in Section nine, as they do not fall within the APS's areas of expertise.

We have also added some topics of interest and concern to us. These are identified by italicised headings, not grey-highlighted.

PART 5 BACKGROUND

The Australian Psychological Society (APS) is the largest professional association of psychologists in Australia, representing the interests of over 14,600 members. APS membership is voluntary and provides members with access to professional services and workplace support, professional development activities, specialist College membership[1] and study materials, and reduced professional indemnity insurance premiums. A formal membership structure is applied which distinguishes nine classes of membership ranging from Honorary Fellow to Teacher Affiliate. The minimum requirement for full membership of the APS is 6 years of accredited university training.

The APS helps to ensure that high standards of university training in Psychology are maintained through its accreditation of tertiary education courses in Psychology. In this accreditation it now works collaboratively with the Psychology Registration Boards, in a joint body titled the Australian Psychology Accreditation Council, so that the needs of the registration authorities as well as those of the Society are met cost-effectively (accreditation being a complex, demanding and expensive activity).

The APS also provides practice standards, a Code of Ethics and Ethical Guidelines for its members, and runs a strict investigation and disciplinary process when it receives a complaint from the public or other APS members about a member's professional conduct.

While membership of the APS is not compulsory, it is however compulsory for all practising psychologists to be currently registered with the Registration Boards of the States and Territories in which they practice. (These regulatory bodies are part of the apparatus of the "state", not of the APS as is often mistakenly thought.) The minimum educational requirement for psychologists to gain registration is the completion of four years full-time tertiary training plus two years supervised workplace experience as a probationary/conditional psychologist or two years post-graduate training in professional Psychology (i.e. completion of an accredited Masters or Doctoral degree in a professional field of Psychology).

The APS however regards the four-year minimum as no longer adequate for registration purposes, and believes that an accredited Masters degree in Psychology should be the minimum for registration (as it has been for Membership of the Society since 1 January 2000).

[1] There are currently 9 specialist Colleges, outlined in Appendix 1.

PART 6 INTRODUCTION ABOUT THE NATURE AND SCOPE OF PSYCHOLOGY

Psychology is both a scientific discipline and a profession. As a scientific discipline it involves the study of human behaviour in all its diverse manifestations. Psychology as a profession applies this broadranging scientific knowledge widely across various employment spectrums, not just in health systems. Psychologists are social and behavioural scientists whose diverse roles can include:

- academic and applied research at various levels, ranging from the most micro (e.g. physiological and biological bases of behaviour) to the most macro (the social and community levels);
- psychological test design and administration (to assess and predict human behaviour);
- counselling and psychotherapy (either individual or group-work);
- "clinical" work involving assessment, diagnosis and treatment of mental health problems (including in forensic contexts); and other health related;
- organisational design, analysis and development;
- policy development and evaluation research in various government (including health) and business contexts.

Psychologists work in a multidisciplinary way typically with other allied health practitioners in the health sector. These include professions such as social work, speech pathology, physiotherapy, dietetics, occupational therapy, podiatry. In addition, it has close relationships with the specialties of psychiatry, neurology, rehabilitation medicine and a wide range of nursing specialties.

In the Australian health arena, psychologists trained in clinical psychological work play a significant role and are considered experts in the area of mental health, where they help improve or sustain the functioning of mentally healthy people (especially in stressful situations) or specialise in treating people with mental illnesses or dysfunctions.

Psychologists in the health sector can be employed in rehabilitation, forensic, clinical, counselling and neuropsychology specialty areas, as well as in health policy development, evaluation research and helping facilitate the more effective management of health systems and organisations.

In health workforce planning, it is important to appreciate that a considerable proportion of the psychology workforce is employed in non-health occupational settings such as corporate consulting, market research and recruitment; secondary and tertiary education; youth services; defence force selection, training, clinical and field support work; research institutions; and training and development services. But some of them may occasionally provide their own special expertise in health contexts, e.g. organisational psychologists helping health organisations to restructure themselves.

This diverse and much-interwoven character of the profession is often poorly understood and may be ignored by policy makers and national data collections conducted by the Australian Bureau of Statistics (ABS) or commissioned by the Australian Health Ministers Advisory Committee (AHMAC) and the Australian Health Workforce Advisory Committee (AHWAC). Consequently, this bias in perception of the nature of applied psychology – as only a "health profession" - compounds the already inherent difficulties in collecting and analysing reliable workforce information about psychologists.

It may also lead to seriously wrong estimates of the regularly available psychology workforce for health work. For example those who think all psychologists are health workers will vastly overestimate the numbers, while those who do not recognise that some "non-health" psychologists do at times provide specialised services to health systems (e.g. occupational psychologists and organisational psychologists) will underestimate the needs and numbers. A third error (which has already been made) is to confine the definition of psychologist working in the health field to "Clinical Psychologist". All would underestimate the range of specialist types of psychologists and the range of psychological services that they deliver.

Consequently workforce planners must use a "matrix" approach of at least two dimensions (types of psychological services on one dimension of the matrix, and types of applied Psychology on the other dimension) as the basis for beginning to appreciate which services are most frequently provided by which types.

In Psychology, as in many other professions and occupations, employment is not solely demand -(employer-) driven or highly predictable. Thus employer estimates of future needs, or estimates based on existing employment types and patterns, should not be the sole basis for workforce projections. Nor should changes in professional roles be seen as necessarily or simply incremental or predictable in terms of trends.

If patterns in workforce participation of Psychology graduates provide some reflection on the adequacy and relevance of Psychology training in Australia, it would appear that course design and delivery are currently meeting broad workforce requirements, despite the demonstrated chronic inadequacies in tertiary education funding.

The concept of “matching” occupational needs with outputs from educational and training institutions also warrants comment. It is not appropriate to expect to match specific organisational or industry job needs with detailed education and training programs and their outputs. Employers will always have to train new recruits in their particular work roles and should not expect the educational institutions to be able to do it for them. Such specificity, even if it could be attained at a particular time, would be quickly dated as organisations and industries change their ways of working, and the professions also change in significant ways. The most appropriate form of education and training is in the fundamentals of the profession or occupation so that graduates have the basic understandings to be able to absorb, or even themselves generate, new ideas and methods.

This view does not mean that job relevance is an insignificant issue in education and training, but job relevance should not be construed as directly meeting specific employer needs: it is a more fundamental, dynamic and long-term concept.

What is “health”?

This question is very important for workforce planning. The existing definitions and delineations of a health system are not at all clear. For example an important segment of the public is injured workers. Is the workers’ compensation system in part a “health” system? If so, what are its workforce requirements, and how are they changing? (We take this particular matter up in more detail later in this submission.) The Productivity Commission is of course well-placed to appreciate these issues, following its various enquiries into workers compensation and Occupational Health and Safety matters.

Legal efforts to define “health services” (e.g. in regulatory legislation) have been very disappointing. They are typically circular and fail to define the real meaning and scope of “health” and related terms. Developing meaningful and widely-acceptable terms and definitions about “health”, “health sector” and “health services” would be a real step forward. These should comprehend but go beyond the legal terms and definitions.

PART 7 A FUNDAMENTAL CONCEPT IN WORKFORCE PLANNING

Mental health disorders are the leading cause of disability burden in Australia, accounting for an estimated 27% of the total years lost to disability.[1] It is estimated that 18% of adults have experienced a mental health disorder and this is associated with enormous social, individual and economic costs.[2] The high prevalence disorders include affective disorders (depression, dysthymia, mania, hypomania and bipolar disorder), anxiety disorders (panic disorder, agoraphobia, social phobia, obsessive–compulsive disorder, generalised anxiety disorder and post-traumatic stress disorder) and substance-use disorders.[2]

The major professional groups currently government-funded to provide primary service for mental health disorders in Australia are psychiatrists and general practitioners (GPs). As medical practitioners, psychiatrists and GPs are able to manage mental disorders through prescription of medication in addition to providing psychological support and treatment.

Whilst the burden of disease for mental health disorders continues to increase over time, there is a decreasing number of psychiatrists in the workforce to meet the demand. Of the 2500 psychiatrists in Australia[3], most work in private practice, with distribution rates being lower in disadvantaged areas of Australia and much lower in remote areas compared to metropolitan areas[4]. The number of medical graduates entering psychiatry training programs has been declining significantly in recent years.[3]

Although the involvement of GPs in managing mental health disorders has been significantly enhanced by the recent Better Outcomes in Mental Health Care (BOMHC) initiative, funding for this initiative is capped and access to the program is limited to GPs who have undergone training for the program. Of the 32,000 GPs in Australia, only 12 percent are currently involved in BOMHC.[5] This means that the communities served by 88 percent of GPs have no access to this government-funded mental health initiative.

The APS believes that in areas such as mental and physical health, the existing psychology workforce is under-utilised in both the public and the private sectors. Future workforce planning must recognise the availability of our highly qualified and geographically well-dispersed workforce. On the basis of APS membership data, it has been established that 30 per cent of members conduct their professional work in regional and rural areas. This stands in marked contrast to that of psychiatrists for instance. This is also of significance when considered in the light of shortages of general practitioners in regional and rural areas.

This point was argued in our submission to the Senate Select Committee on Mental Health (May 2005). We said: "The demand for mental health services in Australia far outweighs that which is currently being provided by psychiatrists and GPs. In contrast to the number of psychiatrists (2000) and GPs (4000) involved in mental health service provision, there are 22,000 psychologists in Australia, with 17,500 registered to practice[2] and at least 10,000 of these well qualified to treat mental health disorders. This represents the largest mental health workforce in the country. Seventy percent of these psychologists reside in urban areas, while 30 percent (around 3000) are in rural settings. However, psychologists are significantly under-utilised in the provision of mental health services due to limited federal/state funding for allied health in the public sector, and by affordable, government-supported access in the private sector."

To constructively respond, the APS would like to recommend the extension of community access to Government supported health services.

1. MBS Items for Focused Psychological Strategies.

To explain and further expand on this issue, it is necessary to refer to the fact that the MBS item Focused Psychological Strategies (FPS) was introduced as part of the Better Outcomes in Mental Health Care (BOMHC) Initiative and is provided by GPs who have completed Level 2 training under the Initiative. FPS are specific mental health treatment strategies, derived from evidence-based psychological therapies. The Level 2 training requires GPs to receive 20 hours of instruction in FPS, after which they are funded to undertake psychological treatment with patients presenting with mental health problems, using the MBS items.

The techniques that GPs are expected to master in 20 hours are similar to those that psychologists are required to possess to be registered to practise, involving a four-year university degree in psychology, two years post-graduate study (usually a Masters degree) and at least one subsequent year of weekly clinical supervision. We believe that twenty hours of training in psychological therapy techniques is not adequate training and does not meet appropriate professional standards for mastering the skills for effective psychological intervention.

The profession of psychology, which is more highly skilled and qualified to provide psychological interventions for mental health problems, does not have access to Medicare rebates. Many patients have little choice but to use the funded (and hence cheaper), less well-trained practitioner. As a result, a person seeking psychological help from a Level 2 trained GP may not receive

[2] Subsequent estimates put this figure higher – see below.

a highly successful intervention, which could have been delivered by more appropriately skilled hands.

Enabling psychologist access to the Medicare items for Focused Psychological Strategies would use an equivalent amount of funding for treatment, yet would ensure that the highest quality and most effective, affordable care is provided for patients with mental health disorders. This initiative would provide access to best practice psychological interventions in specialised areas of great need, such as youth and aged mental health.

2. Psychology contribution to treatment of chronic disease

As an additional issue, it was noted in the same Senate submission , "..It is now accepted that mood disorders (especially depression) and relationship problems can be causative in conditions like heart disease as well as commonly associated with the onset and development of those disorders[9]. There is also considerable evidence of the beneficial impact of psychological interventions on recovery, treatment adherence and quality of life as well as significant treatment cost reductions for a number of other chronic conditions (cancer, diabetes and respiratory illness).[3] Once again, there is no equitable or universal access for the community to these services as there is for medical services.

Recognition of the multiple roles that the Psychology workforce could play in areas such as mental health services and chronic disease management would facilitate a major re-design of Australia's health system, thereby alleviating the pressures on services which currently exist. However change of such magnitude would require a significant shift in Australian Government policy, as this must involve a review of current fiscal and other gate-keeper arrangements. This change also requires a commitment to rigorous, uniform data collection as a fundamental pre-requisite.

What is vital to conclude from this initiative above is that should the government adequately address the workforce shortage and the medical profession's inability to meet community demand by the utilisation of psychology services, there would then be no spare capacity in that psychology workforce. This would immediately require a revision of training and development programs to meet that demand.

[3] See Appendix 2 for the list of submissions by the APS

PART 8 OUR RESPONSES TO SPECIFIC QUESTIONS

Section 1 Workforce planning

Question Set 1 - What is the underlying rationale for workforce planning in the Australian context?

The APS is fully supportive of attempts by the National Health Workforce Strategic Framework to apply a more rigorous and strategic focus to health workforce planning, given the projected challenges facing Australia's health sector in relation to supply and demand pressures over the next 10 years. In doing so, however, we are conscious of the difficulties of forecasting future developments and associated staffing needs, of the long lead times in producing significant changes in the outputs from professional training programs, and that universities (which generally conduct those programs) should not be viewed or treated as "degree factories" whose "production processes" can or should be devoted principally to occupational training, and can be readily changed to meet altered projections about occupational needs. Indeed the principal roles of the universities – intellectual innovation and stimulation including through theory building and fundamental research – must be actively protected even though their secondary but very important role in occupational training must also be recognised and respected.

The APS is keen to offer solutions to the current and projected crisis in public health including and especially mental health. It regards viable workforce planning and the recognition and removal of structural impediments to ready access to high quality psychological services, as a crucial step forward. However due in part to the problems in data collection outlined above, the potential for the wider health sector to engage in meaningful workforce planning which will effectively incorporate the contribution of the Psychology workforce (and other workforces) is limited.

Substitutability In the health sector

The notion of an highly educated, flexible and substitutable workforce has been reflected in contemporary developments in public health policy. Programs such as the Better Outcomes in Mental Health Care program utilise the intervention of psychologists in conjunction with general practitioners in the delivery of mental health services to the public. While the service is tightly controlled through the Divisions of General Practice, the program is significant in its demonstration (even if limited) of the value of an alternative workforce in the supply of services for which demand is high but where supply by medically trained personnel is inadequate to meet demand.

There is a strong suggestion implicit in these developments that increasing the role of allied health service providers and psychologists in particular, can have significant benefits for the community, for the overstretched medical services and for the effective reduction of repeated visits and unnecessary servicing. This can be achieved by resolving some other behavioural and mental health issues that often prompt such problems (e.g. psycho-social problems for which physical complaints are only the "presenting" symptoms). The role of psychologists, therefore, in providing appropriate services to the community and reducing the workload on general practitioners (and in some contexts, on specialist medical practitioners, e.g. in lifestyle change and pain management, and in neurological assessment and treatment) is a vital one.

One strategy that would considerably assist both general practice and psychiatrists would be the extension of the capacity for prescription rights to specified psychologists. This would be confined to psychotropic medication and for most specialist psychologists this would only require a short course of additional training. They would then be able to fully manage a caseload in either a public health setting or in their own practice.

Substitutability of some types of professions with other types is however a "double-edged sword". Used with proper regard to professional standards and competencies, and to how a multidisciplinary team best functions, it can be of considerable conceptual and practical value. Used as an ideological article of faith, or as an attempted cost-saving device, it can degrade professional standards, weaken professional specialisation and underutilise professional expertise.

Question Set 2 - Are adequate data available to facilitate effective workforce planning?

No. The APS is committed to the acquisition and maintenance of reliable psychology workforce data. However a number of problems exist in relation to the task of developing a national profile of people employed in the psychology profession. As outlined in the interim submission to the Productivity Commission in May 2005, the APS considers that the Psychology Registration Boards are in the best position to capture the most reliable data on the Psychology workforce. This "registrant" data set is, however, restricted largely to practising psychologists (i.e. people who hold Psychology qualifications and who are required to use the title "psychologist" to legally perform their employment role). It may not therefore include all those psychologists who work under other titles, such as some academics in universities in teaching roles or those employed in "non-Psychology" positions within the public service or in many private sector organisations, where registration with the State/Territory registration board is not a legal

requirement (even though Psychology training is highly desirable and sought after, e.g. in "human resource management").

While the APS has a current membership base of over 14,600, the estimated number of fully registered psychologists across Australia is now estimated to be around 17,500 (mid-2005). (There are in addition some 2000 probationary or "conditionally registered" psychologists). The APS considers that the registration board data could provide a reasonable profile of the Psychology workforce, despite not capturing the complete picture. It is of concern that AHMAC in 1997 decided not to include Psychology in the AIHW national data collections. Attempts by the APS to harness this data through a state[4] by state survey of Registration Boards in 2002, which also involved the Australian Institute of Health and Welfare (AIHW) in managing the project, were ultimately unsuccessful due to a stated lack of funds by the AIHW to complete the process.

The APS is currently compiling its own workforce profile by surveying members through the membership renewal process, although this approach provides only a sub-set of the total workforce in Psychology-based occupations (on average probably better qualified than the total workforce due to the APS's higher qualification entry requirement) and therefore perhaps only an approximate picture of the professionally practising workforce.

Current data

In 2004, there were reported to be 17,500 fully registered psychologists across Australia.[5] The APS estimates that this figure is divided roughly evenly between the health and non-health sectors.

The APS is concerned that the ABS defines Psychology in its census data collections for the health sector as "clinical psychology"[6], thereby failing to capture the wide diversity of the profession across the rest of the employment landscape. Its definition does not conform to and is less demanding than the APS's criteria for entry into its specialist Colleges of Clinical Psychologists and Clinical Neuropsychologists, or the Registration Boards' criteria for use of the specialist title "Clinical Psychologist" (where such titles are recognised)[7]. Thus comparisons of ABS data with APS and Registration Board data are difficult to make.

[4] Hereafter the term "State" is used to include the Territories.
[5] Data collected by the APS from State Registration Boards – 2003/2004
[6]" Labour force – other health labour forces" – Health and Community Services Labour Force 2001 - Australian Institute of Health and Welfare
[7] Currently only Western Australia's Registration Board recognises specialist titles. Victoria used to do so, and may perhaps do so again when it revises its current Psychologists Registration Act.

In summary, the APS remains committed to the goal of achieving accurate and reliable demographic (including employment) data to profile the psychology workforce and is keen to work with Government and the registration boards to achieve this goal. Agreement on the scope of the term "psychology" in regard to employment and on specialties therein is an essential first step in doing so.

Section 2 Education and training

Minimum tertiary qualifications in psychology and the locus of professional placements

As earlier indicated, professional training for entry into the practice of Psychology as a profession requires the minimum of a 4-year accredited degree sequence (either a four-year undergraduate degree or a three-year undergraduate degree followed by an Honours degree or a Post-Graduate Diploma as the fourth year), with formal professional training conducted after graduation, either through completion of a postgraduate Masters' or doctoral degree or formal supervised practice of 2 years duration as a probationary psychologist under the supervision of a fully qualified, experienced and registered psychologist.

This structure is in contrast with tertiary courses in medicine, nursing, podiatry, physiotherapy and occupational therapy that incorporate compulsory clinical education placements into the course curriculum at the undergraduate level. Psychology provides formal clinical training only in courses conducted at the post-graduate level although some introductory professional material is usually provided in the earlier years (e.g ethics, psychopathology, assessment and theoretical bases of treatment, etc.)

Unlike medicine, whose specialist Colleges play a significant specialist training role and may be seen as a control mechanism over workforce entry, the APS' Colleges do not do so. Rather, they provide for Professional Development and interchange amongst professional colleagues and set standards for specialty areas.

Tertiary funding issues

Psychology as a university-based science and profession shares similar issues with other allied health professions, but is worse off in that it is in Cluster Five while other allied health professions are in Cluster Six. (Tertiary education courses are placed within a structure of bands or clusters in which disciplines are weighted differentially according to the level of resources

required to deliver the training involved in that particular course. The bands range from levels 1 to 9 on an ascending scale of funding.)

Under this model, Commonwealth funds for operating purposes are provided to universities as a single block operating grant for a specified number of student places, on the basis of an educational profile that covers an higher education institution's teaching and research activities.

We understand that nowadays this profile is negotiated individually by each university's Vice-Chancellor directly with the Australian Government Minister of Education, bringing the universities under much closer and direct political and financial control by Canberra than ever before, and reducing the effective role of State governments and internal Academic Boards in regard to their course profiles and the adequacy of their funding. This process is not transparent, its outcomes may not satisfy the criteria employed by the universities' Academic Boards in their forward planning, and it does not take systematic account of workforce needs except as perceived and valued by the Minister and the particular Vice-Chancellor (e.g. is competitive rather than collaborative amongst the universities). *Ad hoc* decisions are made that may and do have serious workforce supply consequences perhaps not anticipated by the Minister or the Vice-Chancellor.

The Health Professions Council of Australia (of which the APS is a member), which represents the interests of health professions other than medicine and nursing, is lobbying the Australian Government to transfer health courses from Cluster Six to Cluster Nine alongside Medicine, Veterinary Medicine and Dentistry. Psychology has always presented itself as a scientific discipline and promoted the scientist/practitioner model of professional and academic performance. To this end psychology training has always included complex and costly laboratory work and therefore should at least be in the science cluster. The inequity is that it even sits below other allied health (currently in Cluster Six) in Cluster Five.

When the Relative Funding Model was introduced in 1990 Psychology training was deemed (without adequate investigation) to be less resource intensive than courses such as medicine or physiotherapy. However over time the error of this judgment has become clear. Moreover the teaching of Psychology has changed with innovations such as the increasing use of the more demanding and costly bio-technology and bio-mechanics in course design. For example perceptual bio-feedback, EEGs[8] and AABRs[9].

[8] Electro-encephalogram
[9] Automated Auditory Brainstem Response

Professional training problems arising from university underfunding

Over the past 10 years, professional coursework programs in psychology have developed rapidly.[10]This development has been partly in response to the APS requirement for higher qualifications as a pre-requisite for membership but more fundamentally reflects the explosion of knowledge and methods in Psychology world-wide and the consequent need for longer and more specialised training. It also reflects the sustained growth in the Psychology profession, averaging around 10% annually.

The effects of chronic underfunding of universities over the last decade are major. The Australian Psychology Accreditation Council's Standards for tertiary education courses stipulate staff to student ratios that the universities, with their chronic underfunding, now find hard to satisfy. (Some relaxation of requirements has been allowed accordingly). Academic departments have to seek funding for research activity from external sources beyond the ARC (where only around 13% of applications for funding support can be approved due to limited research funds available to the ARC rather than any lack of quality or worthiness of the proposed research projects).

While undergraduate courses continue to subsidise post-graduate professional coursework programs for which little or no Federal Government funding is available via HECS places, pressures are growing within universities for post-graduate programs to become more self-sustaining financially. Some quantum of cross-subsidisation is often necessary to nurture important programs that may attract relatively few students, or that are still in the early stages of development. We are not opposed to cross-subsidisation, merely urge that it be rationally planned as part of the overall framework of University funding. However we do strongly urge the provision by the Federal Government of more HECS places for post-graduate professional programs rather than expecting them to be run on a full-fee basis.

University dependencies on the health sector

Some Psychology Departments operate clinics that are used to train post-graduate students while providing services to the public. While these clinics provide a limited source of income for the Universities (they actually cost more to run than they bring in), university teaching departments of Psychology are still carrying a significant financial burden in ways that do not affect Medicine or other areas of health education. Largely as a result of this funding shortfall, post-graduate Psychology programs for professional training in the health-related fields of Psychology must rely heavily on unpaid supervision and

[10] There are currently 98 coursework programs at the level of Masters and above in Psychology offered by Australian universities (APS 2005)

training by health service Psychology professionals in hospitals, community health centres, outpatient clinics, mental health facilities, GP practices and Division of General Practice Services etc. (Similar problems and dependencies exist in the non-health Psychology fields as well.)

Professional placements at risk

Psychology training at undergraduate level is much more focused on scientific training than professional training, a feature which has helped the profession avoid at the undergraduate level some of the problems experienced by the other allied health professions. The latter arrange fieldwork placements for their undergraduate students which psychology does not do. These allied health courses must depend upon the goodwill of hospitals and health services to provide the supervision and resources necessary to ensure that graduates meet designated competencies for entry to the respective allied health professions. However psychology encounters this problem at post-graduate level, where the university psychology departments experience similar difficulties in securing good Psychology placement opportunities for their students, for a number of reasons explained later in this submission.

Many of the host organisations are themselves under major pressures to cut costs, and find it difficult to provide in-house professional supervisors. Some have pressed the universities to relocate some university staff on their sites to provide that professional supervision of students on placement an approach that in our view defeats at least one of the purposes of placements (to get realistic real-life experience *in situ* under the supervision of a practising senior professional), as well as stretching even further already overstretched university staffing resources.

Parenthetically, similar difficulties are also experienced by graduate students in obtaining supervised practice positions as probationary psychologists in the health areas not only because of strong demand for such positions but also because of "supply" problems, arising from health organisations' lack of such "probationary" positions. Thus the transition from new graduate to probationary psychologist may be thwarted for some time, with "knock-on" effects systemically such as new graduates going into non-health fields where probationary positions are available, or other "blips" in the supply of newly-trained professionals for the health workforce.

Cost-shifting from higher education to health

The situation in universities outlined above generally represents a significant cost-shift from the education sector to Australia's health sector. However, it is also an example of extremely valuable cross-sector cooperation that must be maintained and ought to be expanded if the cost-shifting issue can be

resolved, but that is being placed unnecessarily at risk by university and public service underfunding.

Rising coursework higher degree fees

Due to increasing demand and the existing pressures on university Psychology departments, postgraduate course fees are likely to rise in the future shifting much of the burden directly to full-fee paying students as well as constituting a significant barrier to entry into our profession.

Patrick (2005)[11] describes the increasing pressure on fees requiring fees from post-graduate Masters and doctoral coursework degrees as a consequence of limited funding sources, coupled with increasing demand. Patrick's study estimates that compared with 2001, such coursework degrees in Psychology of the standard necessary to meet Course Accreditation Standards set by the Australian Psychology Accreditation Council and to achieve minimal revenue to cost surplus, would need to increase their total fee for the two-year full time program to at least $30,000.00 per student. Such an amount would predictably reduce the number of students applying for entry into those programs, and have other negative impacts such as biasing the type of student.

Other negative impacts

Anecdotal feedback from academic members has suggested that adverse impacts of full-fee regimes are already being felt on the socio-economic class status of trainee professionals (now more restricted in range), and their career expectations, interests and values. Equity issues are involved here. Also there are thought to be higher expectations about post-graduation remuneration to recover the high costs of their education within a reasonable time span. (Indeed this expectation is shared and has been articulated by governments in their argument as to why a regulatory system should be funded completely by registrants – and indirectly by the users of their services - and not from the public purse.) There may be less willingness by new graduates to perform *pro bono* services, although there is no empirical data yet gathered on this or the other issues. We hope this is not the case, but if it does occur, there are likely to be serious implications in workforce planning terms. Research into these matters is urged.

Regarding his study's prediction of increases in coursework fees, Patrick observes that the benefits of excellent employment prospects for psychologists across the entire spectrum of industry *may* outweigh a rise in

[11] Patrick, J. 2005 – The Economic value of psychology in Australia: 2001, *Australian Psychologist* (in press – can be made available to the Productivity Commission on request).

costs. However decisions by universities to increase fees in post-graduate courses would need to consider (*inter alia*) the impact of competition from international universities. In what is now approaching a competitive global free-market situation in tertiary post-graduate education, a law of diminishing returns could apply if fees continue to increase.

Psychologists' productivity

Using 2001 Census data adjusted for CPI, the Patrick study updates the work of Guldberg and Sivaciyan (1995)[12] who measured the contribution of Psychology to Australia's Gross Domestic Product. Patrick's study estimates an approximate increase by 500% of growth above inflation, in the contribution of Psychology to national productivity between1991 to 2001.[13] Patrick's study also includes a comparative analysis of Psychology with other related professions and has found that "*[Psychology also] contributes ….more than all other related professional groups combined*"[14].

The APS notes the valuable work being done by Patrick. While pleased with the high level of assessed productivity of our profession, we must support the caveats that he makes about the productivity measures typically used to assess professional workforce productivity (notably number of practitioners and their income/salary levels), including his caveat about the figure above of 500% growth in psychologists' productivity reported in his study, and his urging of further research. Certainly more fundamental measures of occupational productivity than workforce size and income/salary levels are needed. The latter in our view are at best very indirect and sloppy indices of occupational productivity, and at worst meaningless if not actively misleading. More will be said later in this submission about better occupational and individual productivity measures.

Question Set 3 - How effective are current education and training arrangements (whether undergraduate, graduate, VET or clinical training)?

Much has already been said above on this issue. However the links between higher education and the Psychology profession need to be made clear.

The following assessment of those links was made in the APS Submission to the Productivity Commission regarding national frameworks for the Workers' Compensation and OHS systems.

[12] Guldberg, H. & Sivaciyan, S (1995). The economic and social value of psychology in Australia,. Melbourne: Australian Psychological Society
[13] Patrick op.cit p. 7
[14] Patrick ibid p.2

"Academic roles have historically involved tenured employment, high job autonomy and task discretion, colleagueship, challenge, and opportunities for nurturance of others. Over the last two decades these positive features have been eroded by periodic "reforms" and other less-publicised changes, especially seriously reduced funding, and the introduction of "user pays" notions. After various institutional amalgamations in the 1980s and 1990s, further funding cuts occurred coupled with efforts to persuade senior academic staff to take early retirement (including financial inducements) that have denuded the universities of much of their professional expertise, directly and by their loss as mentors for professionally-inexperienced junior staff.

Other (often internally contradictory) pressures have included:

- *revitalisation of suggestions about some institutions becoming "teaching only", with consequent damage to the morale of staff in the newer and smaller institutions (those outside the Group of Eight) which in recent years have been valued sources of professional training*
- *stronger pressures for University staff to treat other institutions and their staff as competitors rather than collaborators, reducing inter-institution collaboration and communication*
- *greater use of short-term contracts of employment, and increased casualisation of the workforce with associated staff turnover and largely unpredictable changes in staff mixes in terms of levels and types of professional competencies and experience*
- *greater pressures to be entrepreneurial and be paid for any work done outside the university*
- *heavier non-research workloads including more course administration at a time when the pressures to be an active researcher and to "publish or perish" are stronger than ever*
- *the introduction of industrial processes such as repetitive and time-consuming "enterprise bargaining", adding further to unfunded staff workloads that reduce availability for voluntary work*
- *the emergence of new industrial and professional issues from the "virtual university" (such as time and other workload provisions for learning the competencies required to operate effective electronic teaching-learning processes, and having the capacity to renew equipment and programs to stay up to speed), and*
- *increased "accountability" requirements.*

The impacts of these changes on the working conditions of psychologist (and other) academics has been profound, affecting their capacity to provide the kinds of theoretical, research and other professional training that our profession so greatly needs.

In particular the loss of senior staff with substantial professional experience through early retirement packages has been compounded by their replacement (where indeed they have been replaced) with junior staff with

strong research backgrounds associated with gaining research doctoral qualifications, but lacking in professional experience and expertise. This kind of junior staff member is very important for succeeding in obtaining ARC and NHMRC research grants (still the lifeblood of university research despite strong efforts to attract private sector funds), whereas professionally-experienced staff without a strong research background have much poorer chances of obtaining grants.

Staffing apart, shortage of funds has immediate and direct impacts on professional training as well as delayed and indirect ones. As a minor example, how can students be trained in the highly dynamic area of psychological testing if the department has no money to buy the latest tests and accompanying texts? Also the costs of arranging and supervising professional placements for students is often not funded specifically, and the staff member doing so may be obliged to add this work to other, more formally recognised workload, without any real allowance for it.

Academic staff managing external professional placements in post-graduate professional training programs (Graduate Diploma, Masters and professional doctorate levels) may also feel exposed to legal action for breach of their professional duty of care (independently of the university) if things go wrong with clients being dealt with clinically by their students in the placement "trainee" roles, especially if they themselves have relatively little professional experience. Hence they may feel obliged to acquire expensive professional indemnity and legal insurance cover beyond that provided by the university. The salaries paid to academics (now comparatively poor) make no provision for such expenses.

There is also much greater difficulty these days for staff to find the time and obtain the institutional supports for their own Professional Development (hereafter PD), or to contribute to the PD activities of the APS. Our nine specialist Colleges have PD requirements for continuation of College membership, and historically have relied heavily on University staff to provide (voluntarily) PD sessions covering theory and research in their specialised areas. Nowadays University staff are too overworked and stressed (see Winefield et al. 2001) to have much time or inclination to add this voluntary level of work to their already too-heavy agendas, even if they have enough professional background to qualify for College membership (which many of the new junior staff do not)."[15]

This trend is mirrored in public sector health as we explain later in this document.

[15] See APS Submission to the Productivity Commission re National Frameworks for Workers' Compensation and OHS - Appendix 2

Is there adequate coordination between the various entities involved in this area — governments, hospitals, educational institutions and professional groups — and agreement on common goals?

Some of our earlier comments also apply here.

In addition, we suggest that it would be a mistake to view and treat the "entities" listed as similar in social roles, "mission", goals and objectives. They do not comprise a single system. Certainly communication among them could and should be improved, and consultation enhanced, but agreement on common goals is not realistic, especially if some notion of common priorities is involved. It might be possible to get some level of agreement about a limited and precise set of goals of mutual interest, in relation to professional training and supervision of students, and addressing some defects in current services, or adding new services, but not at some more general, overarching level.

Is the balance in the numbers of training places in particular fields appropriate? If not, what is required to deliver a better balance in the future?

This question is founded on more than one assumption. One prime assumption appears to be that what is the case now is a good indicator of future needs. In the absence of data about trends, or clear indications of important policy changes by governments, this assumption may be justified as pragmatic but must be recognised to be a weak basis for forward planning about health workforce matters. Another assumption is that the notion of "balance" is widely understood and agreed, which is not the case. Does it mean that the graduates from a program will find employment in the particular field for which they are trained, and no other? What about employment in cognate fields? (Psychology graduates go into many jobs other than those titled "psychologist", and many graduates from specialised programs go, sooner or later, into cognate work areas.) "Balance" must be treated as a dynamic concept, not a one-off event.

If mismatches do exist between course outputs and employment opportunities, the gap may well be due in part to the notable lack of consultation between governments on the one hand and the professions and tertiary institutions on the other hand.

But it also reflects the relative absence of workforce planning at all levels, in favour of a "free market" student-choice model that presumes that students are knowledgeable about the available course options, make rational econometric kinds of choices based on employment opportunities and costs of training, and thus serve as the primary mechanism for allocation of

resources and training vacancies. This model is probably not accurate as a description of the complex vocational choice processes in which students engage, or of the various influences on course developments in universities. Nonetheless many participants in the education and government sectors and the professions would perhaps support such a model, not because they are "economic rationalists" but because the alternative prospect of "social engineering" through government-imposed occupational training goals and quotas would be anathema to them. These kinds of views and concerns would need to be addressed in any workforce planning and communication exercises, and should be the subject of research

Another reason for the mismatch is the absence in contemporary public service bureaucracies of a professional-management structure (due to de-professionalisation and contracting out ideologies), as we have explained elsewhere in this submission. This absence means that neither the expertise to carry out sensible professional workforce planning, nor the motivation to do so, now exists in those "administrative" bureaucracies. See the discussion on "genericisation" in the Workforce Participation section of this Submission.

Is education and training occurring in the best institutional settings and is it providing the skills and knowledge base required for effective delivery of health care services? Is the balance between public and private sector training appropriate?

This question has already been largely addressed in our preceding comments about tertiary professional education and the problems flowing from its chronic underfunding.

In Psychology there is little private sector training in terms of courses accredited by registration boards or the APS. There is limited private sector involvement in other professional training such as for Professional Development purposes. The reasons include poor returns on investment, low credibility of the private sector with the profession as a tertiary education provider, lack of support from the States, a perception of private providers as being self-serving (such as often promoting a particular service orientation, and seeking high profits, rather than being genuinely objective professional trainers) and a view that they do not carry out the dispassionate research work that epitomises the public universities. Professional conferences organised by private sector companies are typically much more expensive than those provided by professional associations like the APS – at least double. (A fee of $2000 to $3000 for a two day conference is common.)

Is education and training responsive to changing health care needs?

In Psychology, this question makes sense for only the Masters courses in Clinical Psychology, Clinical Neuropsychology, Counselling and Health Psychology. But our response applies "across the board".

Current funding levels in the universities have led to "lean and mean" staffing levels, as has already been outlined. This trend has produced high staff workloads, forcing individual staff to teach across more than one area of interest and competence. Thus the modern academic finds it very difficult to specialise, yet will lose in promotability if s/he does not develop a reputation in a specialised area (usually through research publications).

How can such a system also be responsive to change? It cements in rigidities.

As a simple example, it takes an experienced academic some 20+ hours of preparation to write a 1-hour lecture in a new field. Yet the modern academic is expected to teach 15 or more hours a week (with an associated preparation workload of around 30 hours), as well as supervise research students, carry out detailed and complex assessments of examination papers, seminar presentations, essays and theses, and undertake her/his own research work independently! Course and other forms of innovation are stifled by such a workload.

Parenthetically but importantly, stress levels are high in academic institutions, and salaries are now comparatively poor, adding to the reasons why academic staff are becoming more and more reluctant to volunteer to run professional development activities for their APS colleagues.

How effective are current arrangements that provide short-term retraining to allow health professionals to return to work, and training to those needing to upgrade their skills?

Current governmental arrangements amount to doing things on a shoe-string, an approach virtually guaranteed to fail. The States provide almost nothing by way of Professional Development (PD), even though Psychology Registration Boards have responsibilities and strong policy interest in PD. PD (including "short-term retraining", a highly specialised activity applicable to small "audiences") is expensive. The APS is able to maintain its PD activities mainly through the voluntary inputs of its members but still incurs considerable costs in policy oversight (carried out by the Board of Directors) and administration (carried out by the National Office). Most of the voluntary inputs have historically come from our academic members, but (as just indicated) they are

now under such strain and workload pressures that many of them are not able to continue with this voluntary contribution.

The Registration Boards have to pay for any PD activities they may run, with no financial support from the governments. Government expectations are that registrants will pass the costs of regulation (including PD) onto clients, rejecting any responsibility for funding despite insisting that the regulatory process allows any member of the public to make a complaint against a registrant, with substantial administrative and legal costs

This government policy results in higher-than-necessary registration fees (particularly to cover the massive legal expenses) that constitute a disincentive against part-time professional practice or graduated return-to-work by psychologists (especially new mothers), and makes access to psychological services even more costly for clients – often to the point where they cannot afford to use the professional services of psychologists in private practice and either go to emergency departments in hospitals, or privately practising psychiatrists (supported by Medicare), or get no help at all.

What role do professional organisations play in the development and content of training courses? Are these arrangements delivering good outcomes?

The APS can speak only for itself here. The APS is a partner (with the Council of Psychologists Registration Boards) in the Australian Psychology Accreditation Council, the accrediting body for tertiary courses in psychology across Australia. It plays a very constructive (if sometimes contentious[16]) role in the accreditation of university undergraduate and post-graduate programs and thereby strongly influences (but does not dictate) the syllabuses and course structures involved.

It plays an even more active role in the provision of post-graduation Professional Development activities, through its structure of regional Branches and specialist Colleges, as well as through its Annual Conference, its specialist Colleges' conferences (e.g. the biennial Industrial/Organisational Psychology Conference), and its research and professional journals and other publications (including electronic). Like other professional associations, the APS has struggled with providing PD for members in rural and remote areas. Innovations in electronic communications provide partial solutions only, and

[16] Occasionally contention may arise because of the (desirable) tension between the occupational mission of the universities and their more fundamental commitment to intellectual innovation (especially but not only through independent and basis research) and the intellectual development of students in their own right, not as adjuncts to occupational training.

the APS has continued to make considerable expenditures in arranging visiting speakers and trainers for country areas.

The general outcomes of the APS course accreditation process have been increased standardisation across Australia, increased utilisation of this process by the State Registration Boards and the consequent ease of transfer by students from university to university.

Section 3 - Regulation of the health workforce

Question Set 4 - Are current regulatory arrangements broadly conducive to appropriate outcomes? To what extent do they increase the cost of and/or reduce access to services?

There is more than one form of regulation of the health workforce. Here we concentrate on only two forms: (a) direct regulation via legislation restricting the use of professional titles and/or restriction of designated professional practices to persons with prescribed qualifications; and (b) indirect regulation through either legislative specification about health workers' employment or government bodies' policies and preferences.

Professional regulatory arrangements

While the APS sees many ways in which the current regulatory arrangements applying to psychological practice could be improved (such as redressing the lack of government funding support as just outlined), it considers them *broadly* appropriate albeit unnecessarily inconsistent across the jurisdictions.. We have been pressing for some years for a nationally consistent approach, unfortunately without success so far.

This aspiration was not assisted by the impact of the National Competition Council's mis-classification of psychology as a 'health profession' in its endeavour to spur State governments into more vigorously reviewing their Acts relating to be regulation of the professions. This pressure not only pushed each State to review its legislation in a sometimes parochial and rushed style but prompted some to adopt an omnibus model of legislation for "health professionals" which included and thereby disadvantaged many of our non-health psychologists and clearly postponed the achievement of nationally-consistent legislation significantly.

The impending Australia-USA Free Trade Agreement, especially its agreed processes for establishing inter-country mobility of professionals, will require

State and Territory governments in Australia to “get their act together” in this regard. Other likely FTAs will no doubt add to this requirement in due course.

The issues of how this form of regulation may increase costs and/or reduce access to services are complex and multi-faceted, as the Commission no doubt already appreciates. Taking the access issue first, regulation of psychologists and associated restriction of access are clearly in the public interest: it is necessary to ensure that the services provided are in fact professionally competent and ethical. Psychologists often work with vulnerable people who can be taken advantage of and abused in various ways by unscrupulous and unqualified persons. Without regulation, such persons cannot be held to account. The recent Palmer Inquiry certainly highlighted the fact that even with regulation, members of the public with mental health disorders are still very vulnerable. The Palmer Report shows up starkly how mental health service provision can be mishandled, the very negative consequences of such mishandling, and the need for accountability mechanisms.

One major matter of concern to the APS is that so much of the regulation of professions is focused on the disciplining of professionals themselves rather than on attempting to control the unqualified pretenders to professional roles. Our concern in this matter does not rest just on the control of charlatans and quacks but even on the provision of services by professional groups who are not controlled by this Act and who may have some level of professional training which leads them to provide services that overlap with psychological practice but without providing the community with the protections of the Act. A classic example of this is the vexed area of “counseling” services provided commonly in the community. These anomalies do not persuade us from supporting regulation but we do urge regulatory bodies to exercise all aspects of their duty of care.

In short, this form of restriction of access is highly desirable in terms of protection of the public, which is not able to make accurate judgments about the qualifications and competencies of service providers. Recent reviews of the legislation for the regulation of Psychology, as part of the National Competition Policy implementation outlined above, have all concluded that such regulation must remain.

It must not be thought that risk to the public from unqualified or incompetent psychological services is low outside the mental health field. Abuses and serious harms can occur even with psychological services provided to clients without serious individual adjustment problems, such as psychological assessment in the workplace (as well as in educational contexts, and in health systems). For example, the Victorian Law Reform Commission’s recent

inquiry into workplace privacy identified a number of concerns about uncontrolled and unethical workplace testing that (in our view) are best addressed through the existing psychology regulatory system rather than fresh legislation (as the Commission had suggested in its Options Paper).

We have some concerns about the development of additional and overlapping regulatory bodies and requirements in the health field in some jurisdictions. To take the ACT as a prime example, the Psychologists Registration Act is being replaced not only by the Health Professionals Legislation Act 2004 (of which the regulation of Psychology is but a sub-set), but also by the Human Rights legislation (Human Rights Act 2004, and those bills amending and adding to that Act, currently before the ACT Legislative Assembly). The consequent maze of interwoven legislation and potential "actors" in professional regulation is daunting, especially in regard to the processing of complaints (already a very long and stressful process for all concerned even in the best-run of regulatory systems). Moreover, added complexity will no doubt lead to greater administrative and legal costs, and thus higher and higher fees for registrants, as well as unacceptably long delays in investigations and even greater stress on those caught up in the complaints process.

Indirect regulation

Indirect regulation occurs where legislation (including regulations) or policies of influential government bodies include limitations on the roles of professionals secondary to the main purposes of the legislation or policy. We are not sure whether there is an emerging trend for parliaments to intrude into professional matters by, for example, specifying the use of certain measures of human behaviour (elaborated on below). If it is, it is a very worrying and unacceptable trend.

For example we have concerns (strongly expressed in the appropriate quarters) about the misassessment in workers' compensation contexts of permanent mental impairment by the use of new and unvalidated instruments especially one (the Psychiatric Impairment Rating Scale) whose scoring system (using the median) deliberately ignores the worst aspects of mental impairment, thereby disqualifying many injured workers from obtaining just compensation. Unfortunately the use of this Scale has been mandated by state parliaments at the urging of workers compensation authorities as well as (in Queensland) in the civil liability arena. Associated with this mandating is restriction of assessors to psychiatrists. This unnecessary restriction has already been brought to the Commission's attention in our submission to its recent enquiry into workers' compensation and OHS frameworks.

Another form of indirect regulation is structural, especially staffing structures in government bodies, and associated policies about workforce usage. For example the Commission no doubt appreciates that the professional workforce involved in workers' compensation matters (assessment and treatment, including rehabilitation and return-to-work) is largely a "contractor" one (managed mainly by the insurers as agents), not an "in house" workforce employed on a salaried basis by the workers' compensation authorities.

Informal regulation occurs through these (government and insurer) agencies' policies about which types of professionals to use for which service-delivery purposes. These policies are not open and transparent. This workforce overlaps not only with the workforce employed in other health systems but also with workforces not typically "health" (such as employment agencies expanding into finding job opportunities for disabled workers).

We know of no research into the complex interactions of workforce influences and requirements in this arena.

Question Set 5 - What influence do registration procedures and professional rules have on workplace or professional mobility, or the ease of re-entry to the workforce after an absence?

Considerable. We have already alluded to registration costs. One of the other problems we have identified with the current regulatory arrangements is lack of portability of registration across the jurisdictions. Psychologists are obliged to register (and pay the associated fees) in every jurisdiction in which they offer services. This requirement is onerous, especially for health psychologists (and some others) who often work at a national or international level.

Another barrier to effective and efficient regulation of psychologists is the failure to distinguish between "registration" and "licensing". Currently all psychologists must register, and registration is also effectively a license to practice even though only a minority of our members offer professional services on a fee-for-service basis. We recommend that all qualified psychologists who wish to use the term "psychologist" as a public descriptor be registered, but only those who wish to provide professional psychological services to the public (on a fee-for-service basis or are employed on a salaried basis to provide professional services to the public) be licensed. This separation would reduce costs of administration as well as have other non-monetary benefits.

Another barrier is out-of-date administrative thinking by governments and regulatory bodies, especially the widespread allegiance to annualisation of

registration processes, Professional Development requirements, and so forth. We commend revising this approach, and substituting for it an approach based more rationally on "natural cycles" of events. For example, if registration is separated from licensing, why should registration not be a one-off, once-and-for-all thing? Psychologists do not come and go from the profession – it is a vocation to which they remain strongly committed even if their formal job title is not or does not remain "psychologist". Many do not provide chargeable services to an identifiable set of service users, e.g. academic psychologists, and salaried psychologists carrying out applied research such as in traffic accident research bodies. They do not need to be licensed. On the other hand both health and mental health psychologists do provide such services and a license to practice and an associated fee would be legitimate. Licensing could well be triennial, not annual, again reducing the costs of operating the registration system. Fee reductions should be achievable, reducing the financial barrier to entry into the profession and especially into partial practice.

We have made some or all of the foregoing points in our various submissions to state and territory governments, notably the ACT (re the Health Professionals Act 2004), Queensland (re the Qld Registration Board's proposed "Recency of Practice" policy), South Australia (re its Psychological Practice Bill 2004), Western Australia (re the WA State Administrative Tribunal legislation circa 2003), the Northern Territory (in commentary about its 2000 review of the existing legislation – the NT Health Practitioners and Allied Health Professionals Registration Act 1985) and Victoria (re its drafting of new legislation to amend the Psychologists Registration Act 2000). These submissions are available on request.[17]

Ease of re-entry must be balanced against requirements for sufficient renewal of professional competencies (if lost while out of the profession, which does not always happen, e.g. with psychologists who go into managerial roles overseeing psychologists and their service delivery). We might not always agree with a particular Registration Board's policies in regard to this balance, but there is no disagreement about the need for the balance.

However we do not see that an attempted "macro" approach to this balance would be workable. In a recent submission to the Queensland Psychology Registration Board regarding the notion of establishing criteria for requiring evidence of recency of practice, the APS commented that *"It rapidly becomes a question of whether "professional practice" can reasonably be defined in such a way as to provide a basis for designating recency of practice. It would seem that unless one defines specialist areas within the profession, it will be*

[17] See Appendix 2

impossible to require a recency of practice concept that can be reasonably tied to a period of time in which these specialist skills have been exercised. - unless, of course, we require all psychologists to be health psychologists."[18]

In psychology agreement among the Registration Boards (and with the APS) would be sufficient (and indeed difficult enough to achieve).

Question Set 6 - Would relaxing current restrictions in some areas improve the effectiveness, accessibility and financial sustainability of service delivery without endangering safety and quality objectives?

No. The restrictions applying to qualifications, training, supervised experience, PD requirements, and professional standards should remain. One of the more valuable benefits that the Registration Boards could provide to the maintenance and monitoring of quality professional services is the requirement of continuing professional development for all registrants. This is not to suggest that they should provide or even necessarily record such a process (this could be more effectively done by professional associations) but the requirement would be of significant benefit.

Are there areas where more regulation would be desirable?

Improved regulation of psychological testing is also required as a quality assurance mechanism. Previous attempts to regulate such testing failed, mainly because they focused on proscribing particular tests. We favour restricting advertising and provision of psychological services including those based on tests to qualified and registered psychologists.

How do Australia's regulatory arrangements compare with those in other countries?

Regulatory arrangements in other countries are dynamic and evolving. In the USA they (like Australia) are state-based, with significant inter-state variations. In the UK, regulation is in its early stages with many problems still to be dealt with. The New Zealand situation is broadly similar to Australia's, partly because mutual recognition arrangements have been made in recent times. In New Zealand the Registration Board has developed the notions of Scopes of Practice which enable them to meet some of the benefits noted in Question Set 5.

[18] ibid.

We do not have details of regulatory arrangements in other countries. Information should be gathered about them. The APS would be prepared to work on a joint project to do so.

Section 4 Workforce participation

Job Prospects and Job Growth in Psychology generally

According to data published by the Department of Employment and Workplace Relations, psychologists rate highly on key indicators measuring job participation and growth in the short to long-term. The Department utilised data supplied by the ABS Labour Force Survey and ranked job prospects for psychologists as "very good" with employment growth for psychologists to 2010 -11 expected to be strong.

"Employment (13,800 in February 2004) rose very strongly in the past five years and in the long-term (10 years). Psychologists have a below average proportion of full-time jobs (64 per cent). For psychologists working full-time, average weekly hours are 39 (compared to 42.1 for all occupations) and earnings are above average…. Unemployment for Psychologists is below average….The vacancy level for psychologists is HIGH"[19].

There is clear evidence from the continued enrolment of students at both undergraduate and postgraduate level that the profession of psychology remains attractive. There is anecdotal evidence that there are no major workforce shortages for psychologists. However it is clear from the information provided (Part 6, Introduction, Crucial Workforce Issue) that were the Australian community to meet its mental health and general health needs through the utilisation of psychologists, there certainly would be a workforce shortage, even for psychology.

However, workforce shortages should not be compensated for by the trend in public health towards "genericisation". This is a dangerous trend leading to the loss of psychology-specific (and other profession-specific) positions and certainly the emasculation of psychology staffing structures in many mental health and community health settings. We elaborate on this trend below.

Employment

According to APS data, females comprise approximately 73% of membership, with a fairly even distribution of males and females across the 30 to 59 year

[19] Australian Job Search web-site – Australian Careers – Psychologists - Department of Employment and Workplace Relations - http://jobsearch.gov.au/

age group[20]. The high proportion of females in the Psychology workforce would account in large part for the below average percentage of psychologists participating in full-time employment reported by the Department of Employment and Workplace Relations.

Strong workforce participation and demand for Psychology services are consistent with Patrick's study on Psychology workforce patterns. According to the Department of Employment and Workplace Relations, psychologists are widely distributed across various industries including (in the health arena) hospitals and nursing homes, other health services, government administration and community care services.

According to APS data, psychologists feature prominently in public sector employment and are significantly represented in independent practice (a growing area), and in salaried private sector employment. As at the 31st May 2005, membership data of the 14,635 APS members provided the following profile:

Government	3344	(23%)
Independent Practice	3537	(24%)
Private Sector	2389	(16%)
Tertiary Education	1615	(11%)
School Sector	1260	(9%)
Student	1596	(11%)
Other	894	(6%)

(Note: These categories total 14,635. Some 894 (6%) were either not employed or could not be allocated unambiguously to one of the above categories.)

Employment Opportunities in the Health Sector

Employment opportunities for psychologists in the public hospital system and in community health services have depended on State Government grants to hospitals and community health services which then determine the mix of services to be funded. Similarly until 1st July 2004, Psychology services were not supported by Medicare. Until this time, access to psychological services had been either provided by psychologists in private practice and restricted to people with sufficient personal funds, or adequate levels of private health

[20] Australian Psychological Society Annual Report 2004 pp 14 - 15

cover, or by public health services such as hospitals which operate outpatient mental health clinics or community health centres where extensive waiting lists are prevalent.

On the 1st July 2004, the Federal Government introduced the MedicarePlus program which provided a very limited rebate to clients. While this rebate of $44.90 was satisfactory for some health practitioners working in short sessions (less than 30 minutes), it failed to adequately cover the costs of professions like psychology working generally between 50 and 60 minutes. In addition the client was referred by a general practitioner to private allied health practitioners for a maximum of 5 sessions of allied health services per calendar year. This severely limited any capacity for an adequate package of treatment (considered to be a minimum of 12 sessions for cost-effective interventions).

While the update of referrals to psychologists has been steady[21], a recent policy change to the scheme through the introduction of the Chronic Disease Management Item (which took effect on 1st July 2005), is likely to cause a reduction in referrals by general practitioners, thereby once more restricting access by the public to private psychological services. This has been engineered in response to the GP complaint of increased paperwork. Essentially the GPs have been offered the opportunity to write a case plan for the client without involving a multi-disciplinary input and hence cannot refer to allied health for rebateable services. Clearly faced with the option of reduced paperwork, and not having to consult with other health professionals, the GP will choose the easy path thereby denying patients/clients access to the very allied health service that best practice suggests.

Psychologists working in the public health sector have been employed predominantly by hospitals and outpatient health clinics. Psychologists have also been employed in Government administration and clinical management positions such as Clinical Advisor or Chief Psychologist roles. However over the past 10 to 15 years, there has been a trend by State/Territory government bodies to either abolish Psychology positions and replace them with generic positions termed "Mental Health Worker" or "Community Health Worker", or abolish the position entirely once it becomes vacant. Referred to as the "genericisation of the professions", and as "de-professionalisation", these trends mean that psychologists can no longer look forward to the continued availability of a clearly defined, Psychology-specific career path within public sector administration.

[21] There were a total of 7115 services provided by Psychologists from July 2004 to December 2004 – Health Insurance Commission – Medicare Benefits Schedule (MBS) Item Statistics

In practice, genericisation has expressed itself as the advertising of positions that were previously psychology positions as open to supposedly-equivalent social workers, occupational therapists and nurses. Although a range of explanations have been proffered for this development, the main one has been cost reduction. By and large, many psychologists have been better paid than social workers, nurses or other allied health categories of staff.

Unfortunately, the consequence has been that a loss of expertise provided by clinically trained psychologists with a thorough grounding in mental health and a wide range of clinical skills and the creation of positions that could only provide the lowest common denominator of professional expertise. This is not to downgrade the expertise offered by non-psychologist professionals, but it is clear that no one professional can provide the highest level of expertise of three or four other professionals individually and must only be able to provide second-best (if not seriously deficient) skills in areas outside their training.

The ethics of undertaking this kind of too-broad professional work are also a real issue, as are the associated legal risks of successful prosecution of a complaint of professional incompetence and/or negligence, or of disciplinary action by the relevant Registration Board (e.g. of a nurse undertaking psychological work when not qualified and registered to do so). “Generication” cannot and must not be allowed to be used as or accidentally become a means of defeating the professional regulatory legislation, even when it is sponsored by governments.

The other problem often associated with the "generic" health positions is that of adopting the common case management approach to the support of clients. This denies the opportunity for any specialist to provide the high level of expertise for which they are trained. For a clinical psychologist, this has been a serious cause of professional frustration and a damaging undermining of the clinical resources with which that organisation had previously been provided. Hardly surprising was the reaction of the UK mental health expert, Professor Sir David Goldberg, while visiting Australia: “Why do you have clinical psychologists locked up in case management?”

A second aspect of the rationalisation of professional positions, particularly in the public sector, has been the loss of senior and experienced staff who were able to provide supervision and quality management capacity. The introduction of flatter structures and the removal of senior positions apparently has been seen as a means of reducing costs and removing "fat" from the system. This has been shortsighted from the professional point of view and not cost saving from an organisational management point of view. What management had overlooked on many occasions was that the complexity and

demanding nature of psychological work, particularly in the mental health domain, is such that the provision of senior experienced staff provides:

- professional support to more junior staff
- quality control for the whole professional service
- experienced opinion and input to policy and service development
- a crucial ingredient of risk management for complex clients
- reduced stress and burnout (and costs) for professional staff.

Genericisation can represent a serious problem for the Psychology profession as well as for employing bodies. Historically, highly trained clinicians with expertise in a range of therapeutic interventions had access to a career path formalised by an applicable industrial award. The award stipulated progressive financial increments based on experience and ascending levels of seniority (with duties also defined), to senior professional-managerial levels. Over the past 10 years, due partly to restructuring of awards at the State Government level and a push for greater administrative efficiencies, a vacant program management or project officer position could now be filled by either a nurse, social worker, occupational therapist or psychologist, or not filled at all, as earlier outlined.

The public interest also suffers from these trends. As we noted in a recent letter to the Minister of Education and Educational Services in Victoria regarding some negative impacts of the Victorian Public Service Agreement 2004, the defects directly or indirectly impairing professional services to the public include:

- “Lack of coordination of psychological services.

- Lack of accountability for psychological services collectively. No psychologist is in charge of them across the Department or even regionally. No psychologists can be held accountable for them beyond the level of the individual psychologist. No one with professional qualifications is present in the management structure to represent, plan for, speak on behalf of, or defend them.

- Lack of planning of the future directions for the development of professional services, which is either not achieved (indeed some valuable psychological services are no longer provided), or progresses in an ad hoc way that is not linked with the department’s service delivery goals and associated staffing plans.

- Loss of professional leadership to tackle systemic and individual problems and to drive innovation and “best practice” in psychological services such as through organised in-house Professional

Development activities. There are now no identifiable senior or even middle-level officers in the Department charged with and qualified to provide such professional leadership. Issues such as protection of the privacy of psychological records seem not to be considered at a policy level with professional input.

- Reduced morale of professional staff.
- Diminution of collective expertise (as psychologists frustrated by lack of career progression go elsewhere). "

These problems apply generally, not just in the education sector of the public service. The APS is pushing for the restoration of the structures and career pathways necessary for effective professional service planning, development and delivery.

A further trend away from the traditional clinical practitioner role has been evident in the increase in non-clinical work activity such as administration and program management responsibilities. This feature of public sector employment was noted in Patrick's study which referred to Lancaster, Milgrom and Prior's (2001)[22] argument that psychologists in the Victorian public health system are underutilised in relation to their qualifications and skills, with 48% of their time allocated to generic activities. This underutilisation must be considered a serious defect in the current system of service delivery, as the need and demand for such specialised services is undeniable. Generic workers cannot fill this gap.

At the same time, members of allied health professions other than medicine and nursing have been lobbying nationally for greater influence over Government decision making. Collectively referred to as "Allied Health", the move towards the use of the title "Director of Allied Health" has been progressively implemented across a number of public sector domains.

While this structure can provide a career path for the management "generalist" and with it, improved levels of remuneration and conditions of employment, the move away from the profession into management involves a departure from the application of profession specific skills, competencies, ethical codes etc which contribute to the notion of "belonging" to a profession. Such a departure would also have implications for members of registered professions where the introduction of "Recency of Practice" policies in states such as Queensland could impact on any career move by a practitioner away from the practice of Psychology.

[22] Lancaster, S., Milgrom, J. & Prior, M. (2001). Facing the hard facts: The employment of psychologists in Victorian Public Health. *InPsych,* 23 (6), 39-45.(InPsych is the APS's bulletin for members.)

Job Changing

Vacancies arising from job changing (psychologists changing employers but remaining in the same occupation) are expected to provide 80 per cent of vacancies, compared with 11 per cent from job openings (Psychologists leaving the occupation) and 9 per cent from new jobs (employment growth for Psychologists)[23]. (The latter figure roughly parallels the growth in APS membership over many years.)

Research is needed here. Job changing probably reflects at least two influences: women psychologists following their spouses in geographical re-location due to the spouses' job changes; and dissatisfaction with poor career prospects, especially in organisations that have undertaken "de-professionalisation" of their staffing structures, and contracted out the professional work to private practitioners (often the same staff who provided the services on a salaried basis and who were forced out of salaried employment by the organisation's changes).

Question Set 7 - What are the key influences on workplace participation and job satisfaction? For example, how important are remuneration, conditions (including hours of work, job design and access to training), and workplace pressures?

These are matters inadequately researched in Australia at the level of particular professions. However our professional services staff in the National Office (who deal frequently with APS members and the public) can attest to the importance of:

- a clear professional role that respects the specialised competencies of psychologists ("generic" positions are seriously problematic for them);
- being supported professionally, both structurally (e.g. there are senior psychologists with sufficient organisational standing and "clout" to address problems and to provide professional supervision) and socio-emotionally (i.e. that there are professional peers and other persons in a team context who provide emotional and other supports in times of stress and crisis);
- managers who understand and support the nature and demands of the professional work done by psychologists, and do not demand professionally inappropriate or unethical behaviour (such as access to client records); and

[23] Australian Job Search web-site – Australian Careers – Psychologists - Department of Employment and Workplace Relations - http://jobsearch.gov.au/

- the presence of a career structure that allows them to continue to work and grow professionally and not have to transfer into a general management role in order to be promoted.

For most psychologists the balance of work with family obligations is very important. The provision of access to child-care is an obvious consideration. Flexibility of working conditions is also important to them but can be used maliciously against their interests (where for example some employers use "flexibility" arguments to demand working hours that are difficult for a working mother).

Professional working conditions are also important:

- Lack of access to a quiet, properly appointed office for conducting interviews or carrying out testing is a real problem, as is lack of access to the latest psychological tests (often unavailable because the employer body is not prepared to pay for them).

- The latest psychological tests may be very expensive to purchase and be trained to use, having taken the test constructors years to develop, validate and norm properly. It is difficult to demonstrate direct and immediate economic gains from their use, compared against older tests, even though the professional benefits and the efficacy of treatment gains for clients from more accurate assessment are much more evident. Moreover not using the latest measures is arguably poor professional practice and may land the psychologist in court on grounds of professional misconduct or negligence, or before a Registration Board.

- Access to PD activities is also important. These activities go well beyond attending professional training sessions: they include access to research journals, the capacity to discuss developments with professional peers, secondments to other Psychology units carrying out innovative professional work, and so on.

Remuneration is also important. Psychologists' salaries have marginally reduced in real terms (Patrick 2005)[24] despite the massive increase in the costs of professional training. Such costs cannot be readily recovered from employers (if the psychologist is salaried) or the client (if in private practice). Please note that psychologists in private practice often work with socially and economically disadvantaged clients who cannot afford the full hourly fee, and some of them are dealt with on a partial or full *pro bono* basis.

[24] Patrick 2005 p. 2

Patrick's study points to a growth in numbers of people with Psychology qualifications at 53.8% between 1991 and 2001 and the fact that "there are more individuals with Psychology qualifications in virtually every industry than all other related professional groups combined"[25]. The study does however also point to a decrease in real income levels in most sectors over the period, with Psychology incomes lagging 9.2% behind related professionals. Patrick attributes this finding to "the combined effect of industry deregulation, industrial reforms, and increases in permanent part-time and casual employment"[26]. There is however a positive correlation between average annual income and level of qualification attained. Individuals holding a Bachelor degree only, experience a higher rate of unemployment than their peers with higher qualifications or compared to the national average of people with the same level of qualification.

One reason for this differential appears to be that holders of only the basic degree do not qualify for registration as a psychologist, and do not get the full benefit, salary-wise, of their three years of training unless they go into a cognate field.

Question Set 8 - To what extent is participation in the health workforce influenced by short term cyclical conditions in the economy rather than longer term structural factors?

In the health-related areas of Psychology, short-term economic downturns tend to be reflected in lower capacity for clients to pay private practice fees. Government policies will have indirect impacts on the availability of employment opportunities for psychologists and other professions employed by the community services and health sectors. Decisions by Governments to reduce direct expenditure on public programs will directly affect the supply of services and associated employment positions to implement these programs. During times of financial restraint, positions available for psychologists in the public sector are directly affected. Employment options are limited with more short-term contracts and temporary positions replacing full-time permanent positions.

Human service organisation restructuring can also emanate in flatter organisational structures or merged structures with an associated loss of positions and services provided. All of these factors will significantly curtail participation by psychologists in the Australian public health sector.

Participation by psychologists in the private sector is particularly affected by the ability of health service consumers to pay for services. Given the

[25] ibid p.15
[26] ibid p. 9

relationship between maintenance of private health insurance and fluctuations in income, economic downturns will invariably affect the willingness of consumers to keep insurance cover when faced with competing financial pressures. Consumer behaviour in this respect will adversely affect demand for psychological services provided by independent practitioners.

Question Set 9 - Apart from their impact on work satisfaction, do features of job design in the health care area detract in other ways from effective workplace outcomes — through, for example, inhibiting efficient work allocation and affecting the scope for mobility and re-entry?

In most areas of the health workforce, psychologists find themselves in a secondary role to medical and specialist practitioners. In the mental health sector, they are often viewed as "assistants" to psychiatrists and in the private sector regularly viewed as in that role with general practitioners. This is clearly found to be convenient for the medical practitioner but is not necessarily appropriate in terms of effectiveness and best practice. This is particularly so because of the extensive level of training in which most psychologists engage. APS full membership currently requires six years tertiary training and most graduates into the health workforce are currently six or seven year trained. The fact is that with many of the cases to whom psychological services are being provided, the psychologist is in a better position to manage the professional responsibility and to take the senior role in the decision making. This will require some major re-structuring and re-education in the health workforce.

Question Set 10 - To what extent could initiatives to improve job design and working conditions increase the recruitment and retention of health professionals, and encourage the development of the required skills mix, over the next ten years? What new institutional arrangements would be required to support such initiatives?

Some improvements are obvious (particularly under Question Set 9 above), and commented on in other parts of this submission:

- More mental health positions
- Restoration of public sector professional management structures
- Primary care changes to make greater use of multidisciplinary teamwork
- Medicare Items to support greater access to allied health services

- Provision of adequate office accommodation
- Professional tools (e.g. the latest psychological tests, and good computer facilities including full Internet access[27])
- Better capacity to refer difficult cases to, or discuss them with, a more expert practitioner (who may be outside the particular health care system).

The latter is inhibited in “contractor”-based systems by their “competition” perspectives where such experts are treated as competitors, rather than colleagues with whom one ought to cooperate. In these systems of service delivery the danger for workforce planning is that the contractors will sell their available expertise and services rather than anticipate and make provision for different future needs. This is especially likely where the “buyer” has no in-house professional expertise to judge trends and future professional service needs.

Question Set 11 - What other practical, financially-responsible, measures might reduce the rate of attrition in particular health professions and facilitate re-entry into the workforce?

In short, in the public sector generally, better salaries and a proper career structure, associated with a “professional-management” hierarchy and “best practice” managerial philosophies and resourcing, are the fundamentals of a solution to the premature loss of Psychology staff.

While the current and anticipated rate of attrition is not seen as a major problem for Psychology as a whole, it could be in some specialised segments of the Psychology workforce. Ageing of the Psychology workforce may well become a problem in the future but Psychology is not a physically demanding occupation and psychologists appear to have considerable occupational longevity. Again, research is needed into such matters.

[27] Often denied psychologists in public sector organizations on a “level” (and status) basis rather than a “needs” basis.

Section 5 Migration issues

Question Set 12 - Should recruitment of overseas trained health care workers continue to supplement local health care resources?

No. There are adequate training processes and facilities in Australia. As emphasised above, there is a great need for adequate resourcing of this training program. That is not to deny that many overseas trained psychologists bring with them valuable differences in perspectives, training and experience, but there seems no need to pursue this strategy.

Should such recruitment mainly be used to address short term gaps, including in rural and remote areas, or is there scope to meet some ongoing needs in this way?

No. The difficulties of providing high-class psychological services in rural and remote areas call for very experienced, widely-competent practitioners including in cultural and "way of life" issues in Australia. Overseas trained workers are generally unable to deal effectively with these issues, especially if they lack the necessary language competencies and understanding of rural and remote communities and their social structures and ways of functioning. What is necessary, however, are funded rural student placements (rural scholarships) as it is now well understood that many practitioners will settle where they receive their training or are on internships.

Should ethical considerations limit the future role of overseas trained workers in the Australian health care system?

Of course – they go hand-in-glove with the professional competency issues already outlined.

Question Set 13 - Do current regulatory and training arrangements facilitate the effective use of overseas trained health workers?

No, nor should or need they do so. Indeed, put more strongly, the use of overseas trained professionals who are sub-standard by Australian standards is strongly opposed. The Australian Psychological Society maintains serious reservations about the appropriateness of utilising overseas trained health workers particularly in the area of mental health where such practitioners are often too culturally different.

In its submission to the Senate Select Committee on Mental Health the APS said: "*Another aspect that has added to the problem [in public mental health] has been the tendency of government to resolve the medical staff shortages*

by employing overseas trained specialists. The psychiatric milieu, more than any other aspect of medicine, relies very much on the awareness and sensitivity of staff and their capacity to provide socially familiar and culturally appropriate interactions." In other words, non English-speaking (and probably even non Australian-born) health practitioners take a number of years of acculturation before they can develop appropriate rapport and effective therapeutic relationships with Australian clients.

There may be "niche" opportunities for some practitioners with "Language other than English" and associated capacities (such as specialised cultural knowledge), in regard to some segments of our multicultural population. From the point of view of psychologists, there is not a general need to be seeking overseas trained professionals. Where there are shortfalls of specialty trained psychologists, this can be more effectively and easily remedied by the support of extended training and/or professional development opportunities.

Question Set 14 - What are the implications for the Australian workforce of competing demand from other countries also facing health workforce shortages?

In the absence of appropriate research we are hesitant to comment. The main competitor countries at this time appear (anecdotally) to be the UK, the USA and some Asian countries (the latter mainly through multinational companies operating there). The UK and the USA seem attractive educationally, especially in being the *loci* for some kinds of advanced psychological research not available elsewhere. The USA appears attractive occupationally, for many psychologists, as it is the home country for many multinational companies offering exciting professional employment opportunities (with excellent remuneration, job scope and job experience). For health psychologists, the UK appears the more attractive options but opportunities for clinical training and experience in the USA are also sought after. This is yet another area where research is needed.

Section 6 Productivity

Question Set 15 - How should the productivity of the health workforce be measured? On currently available indicators, how does productivity in Australia compare to health workforces in other countries? Is there significant variation within Australia across jurisdictions and health fields, or between the public and private sectors?

We made the following observations about productivity measures in our recent submission to the Productivity Commission regarding its Discussion Draft reporting its review of the NCP implementation process.

"At a more micro level, and especially with regard to the ageing of the Australian population, there is great difficulty in reaching agreement about how to measure "shop floor" productivity. Since the Discussion Draft uses US productivity levels as a benchmark for estimating the impact on productivity of workforce ageing in Australia, we have tried to establish how those US levels are measured.

To quote the Minnesota Department of Human Services website (Monday, November 22, 2004):

"Productivity of Older Workers: The Facts

There is a general lack of data to provide direct evidence on the productivity of older workers versus younger workers. Many employers do not track measures of productivity. Those employers that do track this data do not report it (Committee for Economic Development, 1999). This may be largely due to the disagreement that exists over the reliability of productivity measures.

There is a tremendous diversity in jobs, the tasks needed to fulfill those jobs, and the skills of individual workers – whatever their age. These factors make it difficult to uniformly measure productivity across workers and industries. Additionally, there are huge variations in the skills, work experience and productivity levels within the older workers group."

This commentary, we consider, applies equally in Australia."

We also said:

"Performance benchmarking" is of value if chosen and used wisely. Unfortunately too often the indicators used for benchmarking are accounting ones rather than criteria of professional service delivery, which as often as not

distort rather than improve service delivery. They may dominate management thinking and become administrative control devices such that key goals and characteristics of good service delivery become secondary to meeting the accounting benchmark standards. For example, measures of costs may lead decision-makers to decide not to allow the use of particular methods (such as the latest psychological tests) because of their expense rather than their professional value, leading to inferior assessment of psychological conditions"

We have detailed views about particular professional performance indicators. However this level of detail may not be appropriate for this Inquiry by the Commission. We would be happy to supply further material on this matter if requested.

Question Set 16 - Beyond the various avenues canvassed above, what options are available to improve the productivity of the health workforce? For example: What contribution can e–health make?

There has been much interest generated among psychologists regarding the possibility of the utilisation of electronic systems for the presentation of therapeutic interventions. Although this has been enthusiastically pursued by some, there is a general understanding that such processes limit the interpersonal aspect which is crucial to therapeutic relationships. However there is a role for the utilisation of web-sites, CD-ROMS and even email for the transfer of vital supportive and background information so necessary for therapeutic change and personal growth.

Electronic Health Records

The Australian Psychological Society has been involved in the developments with regard to the electronic health record both by being represented at consultations with Health Connect and more recently with direct dealings with the National Electronic Health Transition Authority. It believed it needed to represent its members' concerns regarding confidentiality of the health record particularly with regard to mental health clients. However, it also sees the positive benefits of the electronic record. Many of its members already utilise computers extensively in their practices and many of these practitioners have abandoned paper files completely.

Is there scope to reduce the total costs of service delivery by greater investment in labour saving technologies (such as robotics)? Are there any particular impediments to such investment and how might they be addressed?

The scope for such improvements in direct psychological service delivery is relatively limited. Internet access to psychological tests could be very advantageous but there are some serious problems to solve, including

improper access, intellectual property and copyright issues, and how to discourage the premature publication of tests which have not been validated or normed in Australia (or in some instances at all). Of course, the interpretation of test results is no way guaranteed or protected in this process. Ready access to professionally relevant research findings – new ideas and the latest theory development - is an obvious boon.

Would less restrictive delineation of work responsibilities within and between professional groups allow better use to be made of the health workforce? Are there particular regulations, education and training or workplace constraints that prevent or hinder this from happening now?

No. As earlier indicated in our comments about genericisation, it would generally be counter-productive. However there are a number of areas where traditional and historical divisions of work responsibility have inhibited the opportunity for community access to psychological services. Apart from the inequitable distribution of public moneys, the areas of traditional responsibility in mental health service provision in the public sector and in the community have centered around practising psychiatrists. There are clear shortages in that workforce and significant opportunities for reducing that pressure and demand by the utilisation of appropriately trained psychologists. Adaptation and changes within those domains would increase access and significantly reduce demand and distress of clients/patients.

The same psychiatric exclusivity has been noted in the area of accident compensation and disability assessment, as we outlined earlier in this submission. Here again, traditional use of psychiatrists for the assessment of impairment and psychiatric disability has limited client access and significantly increased costs of assessment. There are many equally qualified psychologists able to provide these services.

Another example is the failure in the public sector mental health services to utilise highly trained and expert psychologists in the provision of mental health services. Restructuring in public sector mental health units to utilise postgraduate trained clinically expert psychologists who are as competent as psychiatrists to diagnose and treat mental health disorders would increase their capacity to meet demand. In workforce terms, the number of psychiatrists is very low and is reducing, and they are almost all located in the capital cities. This has been elaborated elsewhere (Part 7 and Question Set 1) where the issue of restructuring in acute mental health and the extension of psychotropic prescription rights were discussed. This shortage in the psychiatry workforce can be very counterproductive for successful therapeutic work or rehabilitation, where early intervention (assessment and therapy) is crucial. Even the extension of limited prescription rights to such expert

psychologists would significantly reduce workforce pressure. This is already happening in very circumscribed areas of clinical practice for podiatrists and practice nurses.

Section 7 Demand

Question Set 17 - Are recent assessments of future demand for health care services and workers, and the specific impacts of factors such as ageing and advances in medical technology, broadly appropriate?

Recent assessments differ on significant points. We said in our earlier submission to the Productivity Commission:

"…the Discussion Draft … presents the ageing population primarily as a burden, particularly economically, and as a looming crisis (despite its assertion that it is not, at this time). It seems to ignore or make little use of submissions such as that by Richardson 2004 (Professor of Health Economics at Monash University) who argued cogently that the effects of ageing per se on health costs are likely to be small. Moreover, generally it does not present positively enough the many valuable economic and non-economic contributions made by older people…….The stronger "burden" and "crisis" emphasis in the Discussion Draft appears already (judging by recent newspaper, radio and TV commentaries) to have reinforced the worrying divisive tendency with some media commentators to portray and implicitly to blame the ageing population as an imminent, major and unfair drain on the younger-generations taxpayers, and also may reinforce ageist discrimination in employment and elsewhere. It is likely to do so by over-emphasising the projected health costs of the older cohorts.

This over-estimate is contraindicated by the analytic conclusions reached by Richardson. Further, the Discussion Draft should have warned that cohort projections must not be confused with individuals' health status and health future. Also it should but does not reject negative stereotypes about ageing and older workers' competencies that unfortunately still abound, including among employers. Worse (as already said) it is likely only to reinforce those prejudices.

Certainly there are good grounds for the Commission's concern about increased demands on health and aged care systems, which the Discussion Draft presents in a clear and compelling way ."

This does not take away from the individual case of chronic disease in the aged population and the need for best practice intervention for both physical disorders (respiratory, diabetes, cancer and cardiac) as well as the mental disorders particularly dementia.

We should add that those projections outlined above have also been non-specific. Specific issues such as age-related disorders have not been adequately canvassed, leaving government policy open to speculation and myths about the ageing process and the alleged inevitability of brain damage and associated memory loss and other impairments. Much more use should be made of the available research findings in this area, and more research work must be undertaken.

Question Set 18 - Will future growth in demand have different implications for workforce needs and policies in particular health care fields and/or geographical areas?

An important source of change in health service needs is that of general population growth, and the rapid expansion of the population of major cities without adequate infrastructure and health services. This problem aspect includes inadequate provisions for workplace safety and health (including rehabilitation services) as businesses expand into provincial cities or outer capital city suburbs that lack strong health services and OHS expertise. Predictably they will have difficulty in using “contractor” arrangements or local council or community health centre services. They will probably have to employ their own OHS people and perhaps at least a basic medical department. Unfortunately mental health services will predictably continue to be neglected despite the enormous rise in “stress” claims in recent years.

One of the priority areas in terms of meeting community demand and the continuity of care will be the proposed establishment of Divisions of Primary Care. Such divisions will encompass the current Divisions of General Practice but will also incorporate other primary care providers (such as psychologists) both in the clinical service provision and in the management of such structures. This will become even more vital given the significant shortage of general practitioners (predicted by such bodies of the Australian Divisions of General Practice and the Australian Medical Association) in the next five years.

Question Set 19 - Are the benchmarks that are currently used in workforce planning to translate expected demand growth into specific training and deployment strategies appropriate?

Please note our earlier comments about the National Health Workforce Strategic Framework, and the “free market” allocation of education and training resources.

We are not aware that any benchmarks are otherwise currently used in systematic workforce planning, and reserve comments until we are able to examine any that are in use..

Section 8 Regional, remote and Indigenous issues

Question Set 20 - What particular workforce issues arise in relation to the delivery of services to people living in regional and remote areas and to Indigenous Australians? Are there issues specific to Indigenous Australians living in urban areas?

Services to indigenous people and others living in rural and remote communities must be tailored to their circumstances and needs. Any “parachute service provider” model, wherein the provider drops into the community and treats a large number of people during a short visit, may be an adequate if far from optimal approach for providing (say) some forms of urgent dental treatment, but it will very probably not work with mental health issues.

At the same time, it must be recognised that where providers live in a community, clients are often reluctant to go to the local provider for fear of inadequate confidentiality or of role boundary-blurring. Thus they tend to prefer to go to a provider (or service) in a nearby town, who is familiar with the regional culture but is not part of local social networks. This kind of issue and preference pattern should be built into whatever model(s) of service provision is chosen for rural and remote service delivery. Empowerment and good resourcing of professionally-trained indigenous service providers is also important.

With regard to indigenous people living in urban areas, there are multiple forms and sources of social and economic disadvantage (including exclusions) that need to be recognised in any effort to modify behaviours.

The Commission is no doubt aware of the efforts made by governments and the professions to improve professional services to indigenous people everywhere. For example the Federal Government-supported website *Healthinsite* contains material and links regarding various aspects of health care delivery to indigenous people.

Another example is the APS's Ethical Guidelines for service provision and research work with indigenous people, individually and collectively. The first version was produced in 1995. The latest version was updated in 2004. The APS also has an active Interest Group that concerns itself with indigenous issues. Further details of their work may be provided to the Commission on request.

Question Set 21 - Are these issues mainly related to the attraction and retention of staff? Or are the appropriate mix of service providers and the skills that specific providers must have, different from those required by other groups?

These issues concern awareness by the service providers of the situation of indigenous people and their perceptions of that situation, of the realistic job and other "quality of life" opportunities available, of the genuine kinds of social and economic prejudice and disadvantage they suffer, and of the limitations that must be expected in terms of individual behaviour change in a milieu that may reinforce the old patterns. It is also about their beliefs around health, mental health, the role of family and social context.

There must be awareness of cultural differences, and respect for them: the service deliverer must not attempt to impose non-indigenous expectations and behaviour norms. Such awareness must be coupled with the appropriate exercise of professional skills, but it is lack of awareness and inappropriate expectations and attitudes rather than specific skills that create most of the defects in service delivery. Of course working in a remote location, whether professionally or otherwise, may be dangerous, lonely, ill-paid, and poorly resourced and supported, thereby contributing to poor staff retention.

Question Set 22 - To what extent could system-wide initiatives to promote better workforce outcomes assist Indigenous Australians and those living in regional and remote areas? What more focused initiatives are required? What is the potential for telemedicine to improve services for these groups?

In the mental health area, a key "threshold" issue for adequate take-up of available services is attitudes towards mental health problems. Stigma occurs as much in indigenous contexts as in others. Attitude change should be a system-wide initiative (not only for indigenous communities but more broadly). Employment of indigenous professionals would predictably go some way towards tackling this problem. Training and upskilling of Aboriginal Health Workers is considered the most appropriate intervention with the indigenous population.

The potential for “telemedicine” in the mental health area is limited. It carries the danger of over-reliance on use of prescription drugs as a ready electronic means of providing some help to a mentally disturbed client. More appropriate services (eg. psychological treatment) may not be attempted. Electronic forms of service delivery also suffer from (*inter alia*) standardisation. Typically only minor options and variations can be built into them (unless very substantial research and developmental funds have been made available for their construction, usually not the case).

They should not be seen as a means of replacing the human service deliverer but may be a very useful supportive aid. However they do not save money: they require development and tailoring to specific uses and circumstances that has significant start-up and ongoing expense.

APPENDIX 1

List of APS Colleges

There are nine Colleges of the APS, representing a range of specialist areas in psychology. Each College promotes its area, maintains practice standards and quality assurance, and encourages and supports the education and professional development of specialist practitioners.

- Clinical Psychologists
- Clinical Neuropsychologists
- Community Psychologists
- Counselling Psychologists
- Educational and Developmental Psychologists
- Forensic Psychologists
- Health Psychologists
- Organisational Psychologists
- Sport Psychologists

APPENDIX 2

LIST OF RELEVANT APS SUBMISSIONS

1 Submissions to the Australian Government and national organisations

(a) The Senate Select Committee on Mental Health – 2005
(b) Workers Compensation and Occupational Health and Safety (two submissions and oral presentation).
(c) National Competition Policy Reforms.

2 Submissions to state and territory governments regarding recent NCP-driven registration legislation reviews and consequent legislative amendments:

(a) the ACT re the Health Professionals Act 2004) (various submissions and representations),
(b) Queensland re the Qld Registration Board's proposed "Recency of Practice" policy),
(c) South Australia (re its Psychological Practice Bill 2004) (formal submission and subsequent discussions),
(d) Western Australia (re the WA State Administrative Tribunal legislation circa 2003),
(e) the Northern Territory (in commentary about its 2000 review of the existing legislation – the NT Health Practitioners and Allied Health Professionals Registration Act 1985) and
(f) Victoria (re its drafting of new legislation to amend the Psychologists Registration Act 2000) (two submissions).

3 Other submissions or representations:

(a) Victorian Ministers of Health and Health Services re the Victorian Public Service Agreement 2004.
(b) The Victorian Law Reform Commission re its Workplace Privacy Inquiry and Options Paper (two submissions).
(c) The NSW Government re Mental Health planning.
(d) Better Outcomes in Mental Health Care – Evaluation Report 2004

APPENDIX 3

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