RESPONSE TO THE PRODUCTIVITY COMMISSION REPORT

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The Report provides an excellent review of current health workforce issues in Australia and is sensibly provocative in some of its recommendations. In general terms, I think there should be somewhat more of a focus on efficiency gains within the health system rather than on just saving money. With an ageing population and an increasing focus in the community on maintenance of good health, it is unlikely that we are really going to see a decrease in healthcare costs – what we must hope to do is to increase the total cost of health more slowly and make sure that we are getting more for our dollar.

I think that there could be much more of a focus on revisiting the relative values study – there is no doubt in my mind that the inequities of health service financing with a major emphasis on procedures is significantly directing young doctors to move into those areas where there is the highest remuneration. This seems to be one of the issues that has driven the US health system in the direction of subspecialisation. This also acts as a disincentive for specialists to refer patients back to their primary carers and encourages a number of perverse behaviours that act against reducing health costs and a primarily primary care driven (controlled) health system.

This may also now be influenced by the increasing debts that students have accumulated on leaving medical school with the increased fees they are required to outlay during their medical courses and the very significant differential in reimbursement between procedural and non-procedural specialties.

Reviewing Table 2 – the Summary of the Commissioners Draft Proposal

I am strongly in favour of establishing an Advisory Health Workforce Improvement Agency. The benefits for this would be significant but this group does need to be given some "teeth". I strongly believe that the Council of Australian Governments needs to endorse the NHWSF and make sure that there really is a linkage between the various areas and levels of government involved in health workforce policy. This Advisory Improvement Agency would not only be able to identify areas of health workforce innovation, but then ensure that pilot studies were carried out and evaluated in an appropriate fashion. If these evaluations were shown to be positive then the Agency should also have an implementation strategy and a budget as well.

In terms of more responsive education and training arrangements, there may well be other ways of improving co-ordination between these two sectors. I am not really sure that moving the quantum of funding from DEST to DOHA will make all that much difference and it would certainly impact on intra-University relationships – between the Health Science Faculties and the Vice-Chancellors. The same outcomes might be achieved by setting up some sort of Co-ordinating Committee between the two organisations and making sure that there is linkage between workforce training and the jobs that are available or need to be provided for. The State Health Departments could be encouraged

(required) to take a responsibility for training and research (something they do not do at the moment) through the Medicare Agreement. If it was clearly stated in the Medicare Agreement that there was a responsibility for the States to provide for clinical training aspects of all health professions (and there was appropriate funding) then this would go a long way to providing universities with fiscal relief for this training and also engage the State health systems in training and research as well (encouraging the partnership that should exist between the State Health Agencies and the Health Science Faculties).

I would be very much in favour of the establishment of an Advisory Health Workforce Education and Training Council as has been suggested by the Committee of Deans of Australian Medical Schools. I would, however, go further and make sure that this is " health" education rather than just medical workforce education. This group needs to look at both vertical and horizontal integration of curricula and I believe, very importantly, needs to involve the VET sector as well. There will be significant opportunities for the VET sector in health workforce education particularly in the area of carer training and possibly even physician or allied health assistant training. As we move to a more multi-skilled health workforce and one that works in 'teams', it is important that the concept of Health Education is encouraged in order to develop an inter-professional learning agenda.

In terms of clinical training, this whole area needs to be broadened. Other groups, such as universities or university/college consortia, should be allowed to establish training programs. The issue of the pro bono teaching given within the College Training Programs needs to be looked at carefully. Much of this pro bono training is done by College Fellows who have full time positions in universities or hospitals or are engaged in training while receiving payment from the State health system as VMO's. The enormous amount of work that many health professionals do in training the health professionals of the future needs to be acknowledged, but does need to be put in the context of the total remuneration packages that the teachers receive. One of the problems at the moment is that there is very little transparency in the system and this allows certain groups to control postgraduate training both in terms of numbers and in terms of content. I have no problem with Colleges continuing to set the standards, it really is an issue of allowing candidates to meet those standards through different pathways. A model has already been created by GPET and this has been reasonably successful in terms of providing "regionalised" training and opening up the system to new innovation and flexibility.

Recently a Consortium of Universities for Professional Health Education (CUPHE) has been established. Participating Universities are, The University of Queensland, The University of Melbourne, The University of Sydney, Australian National University and The University of Newcastle. This group has developed a brief to initially provide

- Online basic science program available to all vocational trainees
- Continuing professional development provision for career medical officers;
- Training radiographers to read x-rays;
- Training pathology technicians to prepare and report histopathology.

This group plans to work collaboratively with Colleges and other providers to develop and deliver these and other programs.

I would be strongly in favour of a Consolidated National Accreditation Regime. I believe that accreditation should continue to be done on a discipline-specific basis but registration could be controlled by a National Health Professions Board. There needs to be the opportunity of health

professionals to cross state jurisdictional boundaries and still be covered in terms of indemnity etc. I disagree with the Commission that the move to a National Registration System should take place over a period of time. There is no reason why this should not occur rapidly with the amendation of the various Registration Acts.

I am very much in favour of the proposal to provide incentives for workforce change – the establishment of an independent review body to advise on services to be covered by the MBS is an excellent suggestion. Not only should this body review new items that might be subject to MBS reimbursement but over a period of time the MBS system itself should be reviewed and those treatments deemed not cost effective, be identified to the Minister. The Minister would still have the option of making a political decision as to whether to remove funding or not, but at least the evidence would be there for him/her to make that decision, as is the case with the PBAC.

In terms of creating new types of health workers, the issue of delegation of responsibility should be carefully considered. There should be both incentives and disincentives for this delegation. These should produce a flexibility of service as well as differential drivers for change.

The Relative Values Study should certainly be revisited in this context. There is little doubt that the gross disparities in remuneration between procedural and non-procedural work in Australia is driving people to take up those higher remuneration specialties, particularly in medicine. This has certainly happened in the United States, although of course the system is significantly biased there by a distinct lack of "gatekeeper" (General Practitioners in Australia). Whatever else happens, it is very important that this gatekeeper role is maintained - it may well be in the future that the General Practitioners are not the only gatekeeper to specialist referral,- for example – physiotherapists referring to Rheumatologists or orthopaedic surgeons or nurse practitioners referring to specialists. It is important to maintain the role of primary carer in the Australian context- this person is currently the GP – and is likely to remain so in the foreseeable future but this would need to be reviewed carefully – possibly by the same body reviewing those services covered by the MBS.

I would probably put less effort into the issue of projecting future workforce requirements than is found in the report. Having watched the health workforce for some years now, I think it is incredibly difficult to predict things. Who, for example 20 years ago, would have predicted HIV/AIDS or the gross shortages that we now have in the medical and nursing workforce. Of greater importance is the creation of a dynamic and <u>flexible</u> workforce that can respond rapidly to change – possibly with some significant retraining over short periods of time.

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I am surprised that the report did not make more of the opportunities that new technologies such as telemonitoring, telehealth and teleeducation might make to health workforce productivity over the next few decades. Although these technologies are still in their infancy, there seems significant potential, particularly in a distributed country like Australia, to have telemedicine, for example, providing consultation and services to rural general practitioners or other primary health care workers. This has already been shown to be cost effective by a number of studies including those in Australia conducted by the Centre for Online Health at The University of Queensland. I enclose for your information two recent review articles looking at the evidence of benefits of telemedicine. These studies cover a wide range of services including teleconsultation, teleradiology, telepathology, patient monitoring, dermatology, cardiology and a number of others. A significant constraint in Australia up until recently has been the lack of any reimbursement for telemedicine.

Telepsychiatry consultations are now able to be billed and a broadening of these arrangements would encourage other groups to be involved in this form of healthcare delivery. Obviously, these systems should be tested in a properly controlled fashion but are likely in some areas to be cost effective and provide a much broader coverage to the population as a whole.

Tele-education also has the ability to maintain competencies for healthcare workers' particularly those in isolated areas and encouragement of the rolling out of broadband technology to provide access for rural and remote Australia would be a significant advantage.

The options canvassed in the report are bold and will need significant 'buy in' from government to implement them. The report comes at an opportunity time when the community is faced with a failure of the health system to deliver a consumer focused, and patient friendly system. These changes will require a paradigm shift but one that must occur if we are going to deliver health for all. It may also stimulate the debate long overdue in this country and one that generations of politicians have failed to address – 'what does the community want from its health system and what is it prepared to pay'?