SUBMISSION TO THE PRODUCTIVITY COMMISSION INQUIRY INTO THE AUSTRALIAN HEALTH WORKFORCE

by

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Task Substitution

In previous published papers I have argued for expansion of task substitution in Australia, and specifically that there be legislative support for delegation of tasks by health professionals. In this submission I expand on the legislative and policy requirements to facilitate task substitution. These facilitators will vary across different States and across different settings. The facilitators will differ according to the regulatory environment of the State, the delivery environment within which the delegation or task substitution occurs, and the method of payment for the task (referred to as the payment environment).

In terms of the regulatory environment, States have adopted different approaches to the regulation of health professions. In some States the scope of practice of a profession is regulated, whilst in other States there is reservation of the title of the profession. These different legislative environments create different requirements in terms of task allocation. In States where there is scope of practice regulation, there may need to be specific legislative authorisation to validate delegation of tasks that fall within the scope of practice. There is no such requirement in States which reserve a title, indeed legislative prescription in these states may undesirably constrain flexibility in task substitution.

Delegation can occur in different delivery environments. Although probably more appropriately cast as a continuum, delivery environments could be dichotomised into *tightly structured*, for example public or private hospitals where there are extensive organisational systems surrounding care delivery, and more *loosely structured* environments such as independent private practice. (Community health centres typically fall closer to this latter category.)

In more tightly structured delivery environments, oversight of task assignment could be undertaken as part of the normal administrative processes of the organisation through formal position descriptions etc. Here patient safety would be protected through the extension of the organisation's own internal quality management processes and its credentialing processes. Typically current credentialing processes only apply to medical (and dental) practitioners. The same principles and processes could be used for credentialing other professionals undertaking tasks outside "normal" roles. In contrast, in loosely structured organisations, formal credentialing processes are less well established. Patient safety would therefore require that there be some form of exogenous oversight of task assignment. Health professional registration boards should have scope to review the appropriateness of any delegation decisions made by registered practitioners supported by published guidance. In order to ensure that such oversight has patient safety as its clear

object (rather than protection of the interests of the profession), any guidelines issued by registration boards should be subject to approval by the Minister for Health to ensure that they are in the public interest. An alternative (or supplement) to registration board oversight would be to strengthen existing organisational accreditation processes. Practices/organisations with acceptable credentialing processes could endorse task substitution in the same way as 'tightly structured' organisations.

In both environments there may also need to be explicit recognition in indemnity policies that appropriate task substitution is covered by the policy.

The payment environment also affects task substitution. In a fee-for-service environment, the payer would need to validate that it was legitimate for a professional to bill for the work of a substitute provider. This validation is not required in a bundled payment environment.

The table shows the interaction of these different environments.

Table: Policy requirements for task substitution in different environments

Delivery environment	Regulatory environment	
	Scope of practice	Reservation of title
Tightly structured		
• Fee for service	• Endogenous credentialing; legislative and payer validation	• Endogenous credentialing; payer validation
• Bundled	• Endogenous credentialing; legislative validation	• Endogenous credentialing
Loosely structured		
• Fee for service	• Registration board/accreditation oversight; legislative and payer validation	• Registration board/accreditation oversight; payer validation
• Bundled	• Registration board/accreditation oversight; legislative validation	• Registration board/accreditation oversight

The table shows, for example, that in a tightly structured organisation in a State/profession subject to scope of practice regulation, task substitution of a professional service funded under fee-for-service would need to be supported by an endogenous credentialing process

and legislative and payer validation. In contrast, in a loosely structured organisation and bundled payment environment (such as a community health centre) where there is regulation of title, task substitution may not require any legislative policy change, although the task substitution decision may be subject to guidance issued by the relevant registration board.

In the case of the Medical Benefits Scheme, the Commonwealth would need to make an assessment about the extent to which task substitution would be introduced across the schedule or be limited to particular procedures. Here it would be appropriate for the Commonwealth to make a distinction based on location as well as the nature of the task. Task substitution in many of the procedural items may be appropriate wherever they are performed, but given the possibility of supply-induced demand, it may be appropriate to limit substitution for those items which are especially sensitive to supply-induced demand to particular geographic areas. Thus, for example, substitution for the consultation items might be restricted to areas where there is a designated short supply of practitioners, such as rural and remote practice.

Responsibility for allocation of educational places

I have argued previously that responsibility for allocation of health professional places in universities should be transferred from the Department of Education, Science and Training to the Department of Health and Ageing with the objective being to provide a closer link between the funders of education and the service delivery sector. Unlike most other areas of university education, given the dynamic nature of the health sector and the changing roles of health professions, there ought to be a very strong link between the health sector and the universities providing health professional education.

Of course the Commonwealth Department of Health and Ageing itself has not in the past been close to service providers and not developed policy capacity across the range of health professions. This new responsibility for allocation of health professional education within the Department of Health and Ageing would require the development of processes to ensure a closer match between service provider requirements and educational providerws. If the Department of Health and Ageing had responsibility for allocation of places, then it would be appropriate to consider incorporation of funding of health professional education within the 2008-2013 Australian Health Care Agreement. Specifically, in addition to providing for appropriate levels of Commonwealth support for health delivery, States could be given a notional allocation of Commonwealth Supported Places (eg. a State could be advised that in

the first year of the agreement there would be $200 million worth of Commonwealth Supported Places for health professional education in the State, rising to $240 million in the final year of the agreement). The State would then have the ability to negotiate with universities about the allocation of those Commonwealth Supported Places. The Commonwealth's financial risk would be defined in the Australian Health Care Agreement. States would have an increased ability to shape the nature of health professional education in terms of:

- the curriculum, to ensure it is more responsive to contemporary needs;
- the distribution of places across the various professions
- the distribution of places across universities;
- development of new programs (and new pathways into existing programs) to meet new needs.

In return, universities would expect that, where they had negotiated a particular profile of health professional education, the State would assume responsibility for ensuring adequacy of clinical placements. This would address a key rate limiting factor in expanding health professional education in Australia. The State-university negotiation should also encompass full-fee places and courses (both domestic full-fee and international student intakes) to ensure that the full workforce and clinical placement impacts are planned.

Decoupling health professional education from other university courses would also provide the opportunity to adjust payment relatives better to reflect the increasing cost of health professional education.

Following the negotiation process between the States and the universities, each State would advise the Department of Health and Ageing of its proposed allocation. The Department of Health and Ageing would be able to validate this in terms of national requirements and then advise the Department of Education, Science and Training about the negotiated allocations. The payment to universities could still be made through the Department of Education, Science and Training or could be made via the Department of Health and Ageing. The total payment to universities would be the funding for Commonwealth Supported Places and the student contribution.

A change of this kind would facilitate greater experimentation with models of health professional education as universities would bear a lower risk of introducing courses for which there was no workplace demand. This approach would also help to align better the universities' supply of health professionals and the workforce demand.