DIETITIANS ASSOCIATION OF AUSTRALIA:

RESPONSE TO:

PRODUCTIVITY COMMISSION'S POSITION PAPER
'AUSTRALIA'S HEALTH WORKFORCE'

November 2005

Introductory Comments

As a member of the Health Professions Council of Australia (HPCA), the Dietitians Association of Australia strongly endorses the position and comments of the HPCA and this response seeks only to strengthen that position by reinforcing issues of particular concern or interest to the profession of Nutrition and Dietetics.

In general, DAA is concerned at the apparent lack of attention to the crucial area of **recruitment and retention**. No amount of restructuring, regulation or redesign is going to be of significant value if joining or remaining in the health workforce remains unattractive to the individual practitioner.

Response to Draft Proposals (Specific)

Draft Proposal 5.1

The Australian Government should consider transferring primary responsibility for allocating the quantum of funding available for university-based education and training of health workers from the Department of Education, Science and Training to the Department of Health and Ageing. That allocation function would encompass the mix of places across individual health care courses, and the distribution of those places across universities. In undertaking the allocation function, the Department of Health and Ageing would be formally required to:

- consider the needs of all university-based health workforce areas; and
- consult with vice chancellors, the Department of Education, Science and Training, other relevant Australian Government agencies, the States and Territories and key non-government stakeholders.

<u>DAA Response</u> – Not supported. DAA believes strongly that this responsibility remain with DEST. Handing the responsibility to DoHA overlooks the fact that many 'health professionals' do not work in the health services at all. Dietitians are employed in education, research, food service, food industry, non-government organisations, media and public relations, corrective services, sporting bodies and government departments. Despite not delivering one to one clinical services, these Dietitians need the same knowledge base and understanding of nutrition in health and disease as their clinical colleagues. This proposal poses the very real risk that the education of Dietitians would be narrowed purely to meet the needs of health services. This would undermine the rich diversity of the profession and its proven ability to adapt to new roles and situations.

DRAFT PROPOSAL 6.1
The Australian Health Ministers' Conference should establish a single national accreditation agency for university-based and postgraduate health workforce education and training.

- It would develop uniform national standards upon which professional registration would be based.
- Its implementation should be in a considered and staged manner.

A possible extension to VET should be assessed at a later time in the light of experience with the national agency.
AND
DRAFT PROPOSAL 6.2
The new national accreditation agency should develop a national approach to the assessment of overseas trained health professionals. This should cover assessment processes, recognition of overseas training courses, and the criteria for practise in different work settings.
AND
DRAFT PROPOSAL 7.1
Registration boards should focus their activities on registration in accordance with the uniform national standards developed by the national accreditation agency and on enforcing professional standards and related matters.

<u>DAA Response</u> – DAA supports the concept of national frameworks for accreditation and national regulation of individual professions and a standardised approach to overseas recognition. However, DAA sees no value in attempting to create a large and potential expensive 'super agency' in an attempt to develop generic standards. Apart from the risks posed to quality and safety there are other ways in which this can be achieved with much lower cost to the taxpayer.
DAA is already doing all these things uniformly, on a national level and not in any way restricting access to the profession and not costing the taxpayer anything. The process could be even more timely and efficient with a small injection of funds to the professional body which could report against National Guidelines. There is no reason why this model could not be adapted to other professions.

DRAFT PROPOSAL 8.2
For a service covered by the MBS, there should also be a rebate payable where provision of the service is delegated by the practitioner to another suitably qualified health professional. In such cases:

- the service would be billed in the name of the delegating practitioner; and
- rebates for delegated services would be set at a lower rate, but still sufficiently high to provide an incentive for delegation in appropriate circumstances.

This change should be introduced progressively and its impacts reviewed after three years.

<u>DAA Response</u> – DAA believes there must be a very clear definition and understanding what delegate means. The following is offered as a potential working definition.

'Delegation' means that the primary practitioner is well qualified and able to provide a service or perform a procedure but chooses to ask another suitably qualified support practitioner to do it for them.
'Referral' means that the primary practitioner does not have the necessary expertise or experience to provide the service and sends the patient to a specialised practitioner who does.
Delegation may reasonably attract lower rebates for the support practitioner but a referred service should not as it is provided by a 'specialist' in their own right.

DRAFT PROPOSAL 10.2
The brief for the health workforce improvement agency (see draft proposal 4.1) should include a requirement for that agency to:

- assess the implications for health outcomes in rural and remote areas of generally applicable changes to job design; and
- as appropriate, consider major job redesign opportunities specific to rural and remote areas.

DAA Response – It is disappointing to note that proposals related to improvements in the rural health workforce (and indeed indigenous health) are at the end of the document and imply that when decisions are made about workforce an attempt should be made to fit rural health needs into the framework. DAA contends that much can be learned from approaches which already work in the rural health arena to inform future initiatives. DAA also contends that people in rural areas are entitled to the same quality of care as their urban compatriots. The overtone that a 'generic worker' would somehow solve the problem of rural health is a concept which is unlikely sit comfortably with the rural population. There is also no guarantee that this 'new breed' of health worker would be any more inclined to move to or stay in rural areas than the current ones.
Up-skilling of existing qualified allied health practitioners to take on wider roles is a reasonable approach.

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