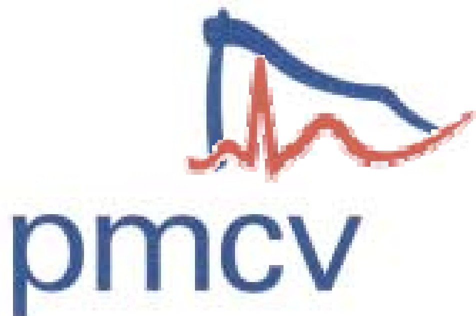

Postgraduate Medical Council of Victoria

Further Submission to the Productivity Commission Health Workforce Review

November 10th, 2005

Dear Commissioners,

The Postgraduate Medical Council of Victoria (PMCV) welcomes the opportunity to make a further submission to the Productivity Commission Health Workforce Study in response to the recently released position paper: *Australia's Health Workforce.*

In order to focus our response, we have reproduced each of the key recommendations and provided a short commentary where applicable:

3. OBJECTIVES & STRATEGIES

3.1 CoAG to consider endorsing National Health Workforce Strategic Framework (NHWSF) subject to broadening of self sufficiency principle

PMCV agrees with this recommendation provided that it does not entrench a long term reliance on an overseas trained health workforce to the detriment of local undergraduate and vocational medical training.

3.2 CoAG to commission regular reviews of progress in implementing NHWSF

PMCV supports this recommendation.

4. WORKFORCE INNOVATION

4.1 AHMC to establish an advisory health workforce improvement agency to evaluate and facilitate major health workforce innovations

In general terms PMCV supports this recommendation.

It is critically important that innovative approaches to health service delivery are explored across regional and rural as well as metropolitan settings. Fostering innovation and managing change in regional and rural areas will be challenging and expensive but is critical to the equitable development of healthcare services and the improvement of the health workforce across all settings.

Innovation should not be reduced to job simplification or substitution. There is a risk that the clinical experience of medical practitioners in training will be diluted by such changes. It is essential that any changes are guided by an evidence-based approach to workforce planning and job design.

Clinical information technology, appropriately designed and effectively implemented, offers great opportunities to support and facilitate health workforce innovation, particularly in regional and rural settings.

5. EDUCATION & TRAINING

5.1 Government to transfer primary responsibility for allocating funding for university based education and training of health workers from DEST to DoHA

PMCV can see advantages and disadvantages in this approach.

The provision of funding through the Department of Health and Ageing may lead to better identification of workforce pressures and more appropriate matching of training to service needs.

Disadvantages include the potential to lose the critical nexus between health professional training and research activities. There is also a danger that funding identified for training purposes will be subsumed into direct service provision in hospitals.

Further consultation and discussion is required with vice-chancellors, hospital based educators and health service providers.

5.2 AHMC to establish an advisory health workforce council to provide independent and transparent assessments of opportunities to improve health workforce and training

PMCV broadly supports this concept. However, it is important that the organisational and functional relationships between the new agencies (Health Workforce Improvement Agency and Advisory Health Workforce Council) and with AHMAC avoid duplication and allow any recommendations to be acted upon in a timely and appropriate manner.

5.3 AHMC to focus policy effort on enhancing the transparency and contestability of institutional and funding frameworks

PMCV strongly supports the promotion of increased transparency in institutional and funding frameworks. In particular, there should be more specific information available on the funding mechanisms and costs of providing training for health professionals.

Explicit payments for trainers and supervisors will provide financial incentives to achieve appropriate training outcomes and recognition of the fundamental importance of training to a sustainable health workforce.

Increased contestability does not necessarily produce better outcomes. The benefits of tendering out general practice training, for example, are yet to be demonstrated. Open tender processes may not be readily applicable to the health professional workplace. Continuity and a long term outlook are important as substantive workforce development and improvement are unlikely to be achieved within the three to five year terms of existing contracts.

6. ACCREDITATION

6.1 AHMC to establish a single national accreditation agency for university-based and postgraduate health workforce education and training

PMCV is unsure of the scope and implications of this recommendation.

The Council supports streamlining of accreditation programs and the potential development of consistent, high level national accreditation standards that will be underpinned by existing professional and discipline-specific standards. However, common accreditation processes across the various healthcare disciplines may be a threat to the integrity and independence of each profession.

Medicine and other health professions already have sophisticated accreditation models (e.g. Australian Medical Council, Postgraduate Medical Councils and Colleges) and considerable expertise neither of which are necessarily applicable across other disciplines. While there are opportunities to rationalise the accreditation processes within each profession, valuable expertise may be lost with the creation of an entirely new agency.

Accreditation processes, particularly with regard to prevocational training, must remain relevant to conditions in particular states and territories. Close working relations must be maintained with professions, practitioners, registration bodies and training providers at the local level.

6.2 New national accreditation agency to develop a national approach to the assessment of overseas trained health professionals covering assessment, credentialing and scope of practice

A consistent national approach and consistent standards are strongly supported by PMCV. A new national accreditation agency is not necessarily the only or best way to achieve this end.

7. REGISTRATION

7.1 Registration boards to focus their activities on registration in accordance with the uniform national standards developed by the national accreditation agency and enforcing professional standards

Subject to the comments under 6.1 above, PMCV supports this recommendation.

7.2 States and territories to collectively take steps to improve the operation of mutual recognition in relation to the health workforce

This recommendation is strongly supported by PMCV.

7.3 Jurisdictions to enact changes to registration acts to provide a formal regulatory framework for task delegation where delegating practitioner retains responsibility for clinical outcomes

It is not appropriate for PMCV to comment on this recommendation.

8. FUNDING MECHANISMS

8.1 Australian Government to establish an independent standing review body to advise Minister on the coverage of the MBS

It is not appropriate for PMCV to comment on this recommendation.

8.2 For services covered by the MBS, to be a rebate payable to the delegating practitioner where the service is delegated to another suitably qualified health professional

It is not appropriate for PMCV to comment on this recommendation.

9. WORKFORCE PLANNING

9.1 Rationalise institutional structures by abolishing AMWAC and AHWAC and forming a single secretariat

PMCV supports any structural changes that can be shown to improve workforce planning.

9.2 Projections to be directed to advising governments of the implications for education and training of meeting different levels of health services demand

PMCV considers this to be self-evident.

10. RURAL & REMOTE ISSUES

10.1 AHMC to ensure that all broad institutional health workforce frameworks make explicit provision for rural and remote workforces

PMCV strongly supports equity of health service provision between metropolitan and rural healthcare settings, supported by accurate data collection.

10.2 The health workforce improvement agency to assess the implications for health outcomes of changes to job design including those specific to rural and remote areas

See 4.1 above.

10.3 AHMC to initiate a cross program evaluation exercise to ascertain which approaches are likely to be most cost-effective in improving the sustainability, quality and accessibility of workforce services in rural and remote Australia

PMCV strongly supports evidence based evaluation of the efficacy of programs. Policy and action should be based on evidence rather than political considerations.

The further development and enhancement of clinical placements in rural areas are compromised by high travel costs, grossly inadequate accommodation and minimal support for accompanying spouses and families.

11. SPECIAL NEEDS

11.1 AHMC to ensure that all health workforce frameworks provide for the requirements of groups with special needs including: indigenous; mental health; disabilities; and aged care

PMCV supports this recommendation.

Thank you again for the opportunity to comment on the recently released position paper: *Australia's Health Workforce.*

Yours sincerely,

Dr Ian Graham,
Medical Director, Postgraduate Medical Council of Victoria
on behalf of
Associate Professor Brendan Crotty, Chairman, PMCV
& **Ms Carol Jordon**, Executive Officer, PMCV

November 10th, 2005