HPCA

Health Professions Council of Australia Ltd

Submission to

Productivity Commission
Health Workforce Study

From the Health Professions Council of Australia Ltd

Response to Productivity Commission's Position Paper 'Australia's Health Workforce'

Contact:
Rina Harber, Health Professions Council of Australia

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The Peak Body Representing Allied Health in Australia

PO Box 38, Flinders Lane PO, Melbourne VIC 8009
Ph: +61 3 8662 3300 Fax: +61 3 9663 6177
Email: hpca@psychology.org.au Website: www.hpca.com.au

ABN 60 083 141 664

Introductory comments

The Health Professions Council of Australia (HPCA), the peak body representing national allied health professional organisations, welcomes this opportunity to further contribute to the current debate on health workforce issues.

The HPCA's current membership covers audiologists, dietitians, occupational therapists, orthoptists, orthotists and prosthetists, pharmacists, physiotherapists, podiatrists, psychologists, radiographers, radiation therapists, social workers and speech pathologists.

Collectively, these professionals are at least as numerous as doctors and medical specialists. Their contribution to Australian health care is substantial and growing, particularly in relation to aged care, the management of chronic disease and obesity, and the increasingly important field of preventative health care. Solutions to Australia's current health workforce issues necessarily require the active support and input of allied health professionals and their representative organisations.

This submission provides general comments and specific responses to the draft proposals set out in the Productivity Commission's Position Paper, '***Australia's Health Workforce'***.

It builds on matters raised in the HPCA's earlier submission to the Commission, entitled, ***'The Allied Health Workforce in Australia: Challenges and Opportunities'***. This can be found on the HPCA's website, www.hpca.com.au, as well as on the Productivity Commission's own website.

Overview of HPCA response to proposals

The Health Professions Council of Australia recognises the significant effort made by the Productivity Commission in drawing together such a comprehensive body of information on health workforce issues, and strongly supports some of the proposals set out in the position paper. There are many areas, however, where we have deep concerns – not just with the proposals, but with the thinking and attitudes they reflect.

In essence the Position Paper proposes introducing national health workforce planning, education and training, and accreditation bodies that would cut across existing higher education funding and course approval arrangements, and across State professional regulatory mechanisms and processes.

The HPCA recognises and supports the need for national approaches to health care, together with the evolution of professional roles, so long as any new measures enhance rather than diminish health services and working conditions. The Council of Australian Governments (CoAG) should not contemplate measures which might in any way reduce the safety and quality of our health services.

HPCA believes that, rather than creating three new bodies envisaged in the position paper, just two new bodies are needed: one for health workforce planning incorporating education and training, and another for workforce accreditation.

The primary driver for this alternative proposal is the HPCA's concern for the quality and safety of health services delivered to consumers. To ensure this, there needs to be close interaction between the health professions and the relevant government

departments. National Government bureaucracies that seek to by-pass or override allied health professional associations are likely to result in lower-quality health services for Australian consumers.

The HPCA strongly supports the proposal to establish an independent standing review body to advise the Minister on the coverage of the Medical Benefits Scheme (MBS). There are huge benefits and cost savings to be made by basing MBS decisions on clinical effectiveness and efficiency, rather than the current situation where MBS rebates are almost entirely focussed on treatments provided by doctors.

The HPCA also strongly supports the creation of national standards and benchmarks designed to ensure universal high-quality health services for Australian consumers.

There is an urgent need, as recognised in the Productivity Commission position paper, to tackle health education issues and to improve health workforce data collection, future needs projection and strategic planning. The HPCA does not, however, support the Productivity Commission's proposals for the creation of a number of separate bodies to manage these issues.

As noted above, the HPCA believes that CoAG combine the proposed advisory health workforce improvement agency and the advisory health workforce education and training council to create a single new health workforce advisory body, replacing the functions of AMWAC and AHWAC. Separate bodies encourage internal competition and 'silo' building, and complicate communications with stakeholders.

The HPCA suggests that the single new body might be called the **Health Workforce and Education Improvement Agency (HWEIA).** Such a body would be responsible for mapping supply and demand, monitoring progress towards implementing the National Health Workforce Strategic Framework, and facilitating workforce and educational innovation.

Although advisory, the HWEIA must have the authority to direct the Department of Education, Science and Training (DEST) with respect to allocation of health professional places (mix and distribution), and to monitor the adequacy of funding for health professional education. Its governing body should include high level Departmental officials plus representatives of the health professions, consumers and the universities – a true partnership of government, providers and consumers. Possible responsibilities and relationships of HWEIA and the proposed National Health Workforce Accreditation Agency are set out in Fig 1, below.

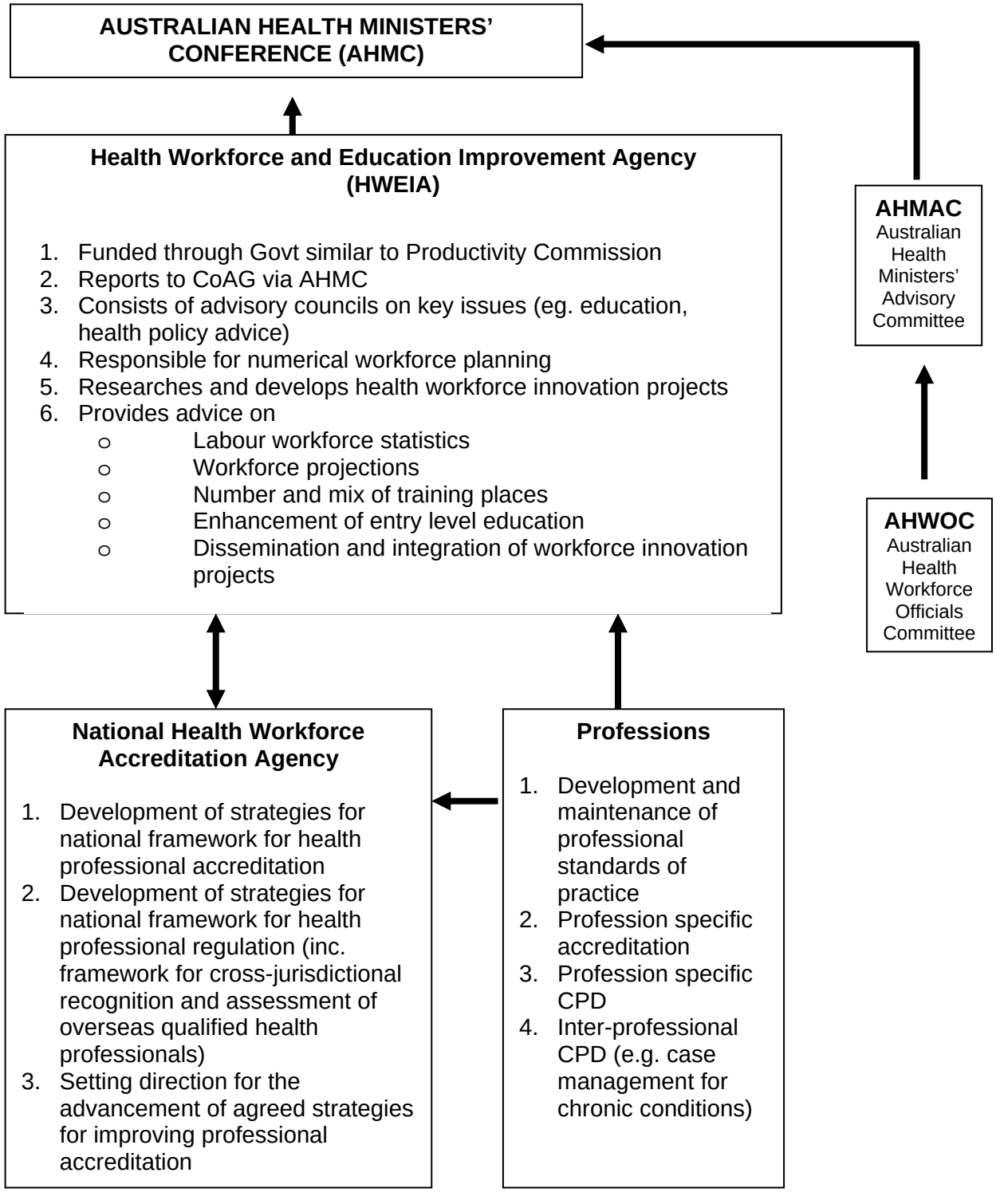

Fig.1. Flowchart indicating relationships and functions of proposed new workforce agencies. (Adapted from OT AUSTRALIA)

Clearly these two new organisations – HWIEA and the National Health Workforce Accreditation Agency - will need to be properly resourced, with capacity to engage experts as required, if they are to be effective.

The HPCA does not support transferring responsibility for allocating funding for tertiary health education from DEST to the Department of Health and Ageing. We believe these decisions should be made after consultation with stakeholders through HWEIA.

The HPCA strongly urges the Productivity Commission to stress to the Council of Australian Governments the significant impact of under funding, particularly in relation to allied health education and training. There is a chronic failure to adequately fund allied health clinical placements. Apart from the impact on health consumers, these shortfalls have a deleterious effect upon the workplace environment and on staff retention.

The HPCA supports the creation of a national accreditation agency and recognises the value of developing a national framework for course accreditation so long as it applies to all tertiary courses – medical, nursing and allied health. Such a national framework needs to be developed in close consultation with universities, health professional organisations, consumers and other stakeholders.

The proposed national accreditation agency should not be responsible for developing profession-specific accreditation standards, as clinical standards must be set by clinical experts. In order to maintain the highest possible standards of care for health service consumers, and ensure international recognition of courses, the professions themselves need to own and set the practice standards relevant to their profession.

The allied health professions, in fact, undertake the work of course accreditation at minimal cost. It is largely done on a volunteer basis, or for a modest honorarium. This represents a major contribution by the allied health professions to the safety and quality of Australian health services; and it will be important not to jeopardise this goodwill in any redevelopment of accreditation arrangements.

It should also be noted that allied health professional associations do not restrict the supply of allied health professionals by limiting the number entering the market; nor do they create artificial boundaries to limit work practices. There are many difficulties associated with health services funding, structures and inter-connections. Allied health professions believe that true collaborative partnerships between industry and government are more likely to result in mutually agreeable outcomes for the benefits of consumers than policy directives from the government alone.

The HPCA rejects the Productivity Commission's statement that 'Profession-based accreditation impedes workplace innovation and job redesign.'[1] This proposition lacks any sound foundation in fact. Accreditation is not standing in the way of job redesign. Professional accreditation represents professional specialisation, which in turn underpins the development of expertise, innovation and the evolution of new roles within the health setting.

Allied health professionals, along with doctors and nurses, are constantly working to improve and expand their skills. One result, in allied health as in medicine, is the emergence of 'specialists'. Specialisation is not a problem but a benefit for consumers of Australian health services. Indeed, the only legal barriers to expanding

[1] See page LXVII of the position paper.

professional roles in most jurisdictions are State laws. The other major obstacle is insufficient funding of health services.

Health professional role redesign, or more accurately role evolution, is important, but must be built on a professional foundation. Safety and quality are paramount, and training in a profession is a necessary precursor to safe professional practice. Professionals should take on new roles once they have developed expertise in their own profession. They can then undertake further education to broaden their scope of practice. Para-professionals must be adequately trained and must work under appropriate professional supervision.

A particular concern in relation to accreditation is the concept of a graduate-level 'generic' allied health professional**.** [2]. The 'generic' concept – if it envisages someone who in an undergraduate course has acquired sufficient knowledge of psychology, physiotherapy, dietetics, speech pathology etc to deliver a range of allied health therapies rather than just one – would be essentially dangerous and damaging for consumers of health services. It is simplistic, unrealistic and not the way to tackle workforce shortages.

All health professionals – including doctors, nurses and allied health professionals – should complete a core group of undergraduate subjects, as a foundation for future multi-disciplinary teamwork. There is also merit in qualified allied health professionals expanding their knowledge-base to include other therapies and disciplines. Thus, 'generic' as an 'up-skilling' concept has some value, but is harmful if it implies producing undergraduates who have received inadequate training and are therefore a risk to consumers.

It is important to recognise that 'allied health' is not one discipline but many. Although they work closely together in multi-disciplinary teams, each profession has its own areas of specialisation. In addition, many qualified allied health professionals do not work in the health sector at all, but are involved in such diverse areas as industry, education, commerce and management. To assume that allied health is a homogenous group is akin to saying that all doctors and medical specialists are alike – that a cardiologist, for instance, has similar skills to a psychiatrist.

Also of concern in relation to accreditation is the need to ensure that education does not become so vocationally focused as to discourage or deskill potential researchers. There is some concern that this may be happening in the United Kingdom; and it must not be allowed to happen here. Currently Australian health professional research is very much more prolific than in the UK.

The HPCA is disappointed that the position paper does not include any draft proposals to address the major problem of health workforce retention. It is clear that for many professions, high attrition rates are related to poor career paths and inadequate pay. In order to achieve better remuneration and career prospects, many experienced allied health professionals are choosing to move out of clinical areas into such fields as management and education, resulting in shortages of clinical practitioners.

As a useful short term measure to increase the supply of allied health professionals, the HPCA urges CoAG to investigate the efficacy of 'attract back to practice' schemes in Australia and overseas.

[2] See page XVLIV of the position paper.

CoAG should also develop a project to examine the career choices of allied health practitioners, including retention and attrition factors and gender issues, along the lines of the medical careers project undertaken by the Australian Medical Workforce Advisory Committee (AMWAC).

Given the high proportion of females in some allied health professions, it is also important to provide family friendly employment conditions, such as the provision of child care at all public hospitals, to increase "attractiveness to participate" at all stages of life.

In summary, the Health Professions Council of Australia urges a greater appreciation of the contribution to Australian health care – now and in the future – of individual allied health professionals and their representative organisations.

HPCA believes that CoAG needs to work in true partnership with the health professions, identifying health workforce problems and formulating new initiatives in a transparent and straightforward way. Policy initiatives informed by evidence-based input from the health professions are more likely to gain support from professionals and consumers, and are therefore much more likely to succeed, than those developed without effective consultation.

In a voluntary manner, and often at the expense of its members, allied health professional associations have made a major contribution to professional standards, codes of ethics, professional development, tertiary training course accreditation and to developing good relationships between professions through agencies such as the Health Professions Council of Australia and The National Allied Health Classification Committee. They are leaders in the area of role evolution and skill enhancement, and their focus is on providing quality services for consumers rather than on protecting professional boundaries.

'Inflexibility', one of the problems much discussed in the Commission's position paper, is the hallmark of bureaucratic top-down processes and 'one size fits all' strategies. It is not a feature of the grass-roots professional organisations represented by the Health Professions Council of Australia.

The HPCA's responses to specific draft proposals in the position paper are set out in the following pages of this submission.

HPCA response to draft proposals in the Position Paper
(To be read in conjunction with 'Overview' comments)

DRAFT PROPOSAL 3.1
In its upcoming assessment of ways to improve the level of integration within the health care system, the Council of Australian Governments (CoAG) should consider endorsing the National Health Workforce Strategic Framework (NHWSF), subject to broadening of the self sufficiency principle, in order to enhance cohesion between the various areas and levels of government involved in health workforce policy.

HPCA response:
HPCA supports the National Health Workforce Strategic Framework. There is opportunity to demonstrate increased political will and leadership in its implementation. CoAG should recommend that the NHWSF be integrated into State and Federal Government planning processes, and that any proposed new health measures should be assessed against the Framework to identify their possible impact on the health workforce.

DRAFT PROPOSAL 3.2
CoAG, through its Senior Officials, should commission regular reviews of progress in implementing the NHWSF. Such reviews should be independent, transparent and their results made publicly available.

HPCA response:
Supported.

DRAFT PROPOSAL 4.1
The Australian Health Ministers' Conference should establish an advisory health workforce improvement agency to evaluate and facilitate major health workforce innovation possibilities on a national, systematic and timetabled basis.

- Membership of the board should consist of an appropriate balance of people with the necessary health, education and finance knowledge and experience.

HPCA response:
The HPCA believes that this proposed agency should be amalgamated with the proposed Workforce Education and Training Council, suggested in proposal 5.2, and should also take over the numerical workforce planning discussed in proposals 9.1 and 9.2. This single national body might be called the Health Workforce and Education Improvement Agency (HWEIA). See 'overview' for more discussion of this issue.

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.

HPCA response:
Not supported – but acknowledge need for better connection between identified skill needs and place allocation. The HPCA believes DEST should take advice from the proposed advisory body HWEIA. See 'overview' for more discussion of this issue.

DRAFT PROPOSAL 5.2
The Australian Health Ministers' Conference should establish an advisory health workforce education and training council to provide independent and transparent assessments of:

- opportunities to improve health workforce education and training approaches (including for vocational and clinical training); and
- their implications for courses and curricula, accreditation requirements and the like.

HPCA response:
HPCA believes this should be amalgamated with the proposed advisory agency in 4.1. See 'overview' for more discussion of this issue.

DRAFT PROPOSAL 5.3
To help ensure that clinical training for the future health workforce is sustainable over the longer term, the Australian Health Ministers' Conference should focus policy effort on enhancing the transparency and contestability of institutional and funding frameworks, including through:

- improving information in relation to the demand for clinical training, where it is being provided, how much it costs to provide, and how it is being funded;
- examining the role of greater use of explicit payments to those providing infrastructure support or training services, within the context of a system that will continue to rely on considerable pro bono provision of those services;
- better linking training subsidies to the wider public benefits of having a well trained health workforce; and
- addressing any regulatory impediments to competition in the delivery of clinical training services.

HPCA response:
Concept is supported: but the Productivity Commission needs to make it clear that these measures will not solve the current problems relating to allied health clinical training. Additional funding is urgently needed for allied health professional education; until there is funding equality with other clinical areas, notably medicine, improved transparency and contestability will not assist in the provision of allied health clinical training.

The HPCA believes that allied health professions with workforce shortages identified by both DIMIA and DEWR should be immediately classified as

national priorities for education funding by DEST[3], as has been done with nursing and teaching.

In the longer term, DEST needs to address the education funding inequities between allied health professions (in Clusters 5 and 6) and the much more generously funded medical courses in Cluster 9, to ensure that all health professions receive adequate funding for clinical education.

Schemes such as support for medical students on rural placement also need to be expanded to include allied health students.

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.

HPCA response:
Supported, subject to agreement with the allied health professions on the constitution, membership and functions of the new agency. The HPCA supports development of a national framework, and recognises that the education sector is struggling with current differences in accreditation processes for health professional courses. However, within any new national framework, the professions must continue to own and set the practice standards for their own profession. See 'overview' for further discussion of this issue. The HPCA only supports a possible extension to VET for para-professional training.

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.

HPCA response:
The HPCA supports development of a national approach, but to protect consumers the allied health professions need to continue to assess overseas applicants.

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.

HPCA response:
Supported.

[3] DIMIA = Department of Immigration and Multicultural and Indigenous Affairs; DEWR = Department of Employment and Workplace Relations; DEST = Department of Education, Science and Training.

DRAFT PROPOSAL 7.2
States and Territories should collectively take steps to improve the operation of mutual recognition in relation to the health workforce. In particular, they should implement fee waivers for mobile practitioners and streamline processes for short term provision of services across jurisdictional borders.

HPCA response:
Strongly supported. Mutual recognition is part of the broader need to implement nationally consistent approaches toward health professional regulation. Individual professions must have uniform regulation across Australia to ensure that clients and consumers are not exposed to possible harm. This can be either statutory registration or recognised self-regulation, but not a mix of the two within one profession, as is the case at present with some allied health professions.

DRAFT PROPOSAL 7.3
Under the auspices of the Australian Health Ministers' Conference, jurisdictions should enact changes to registration acts in order to provide a formal regulatory framework for task delegation, under which the delegating practitioner retains responsibility for clinical outcomes and the health and safety of the patient.

HPCA response:
The HPCA supports regulatory changes to allow allied health professionals to delegate to suitably qualified para-professionals. See also the HPCA's response to proposal 8.2.

DRAFT PROPOSAL 8.1
The Australian Government should establish an independent standing review body to advise the Minister for Health and Ageing on the coverage of the Medicare Benefits Schedule (MBS) and some related matters. It should subsume the functions of the Medical Services Advisory Committee, the Medicare Benefits Consultative Committee and related committees. Specifically, the review body should evaluate the benefits and costs, including the budgetary implications for government, of proposals for changes to:

- the range of services (type and by provider) covered under the MBS;
- referral arrangements for diagnostic and specialist services already subsidized under the MBS; and
- prescribing rights under the Pharmaceutical Benefits Scheme.

It should report publicly on its recommendations to the Minister and the reasoning behind them.

HPCA response:
Strongly supported. There are huge benefits and cost savings to be made by basing MBS decisions on clinical effectiveness and efficiency, rather than the current situation where only treatments provided by doctors attract an MBS rebate.
In the light of workforce shortages particularly in rural areas, MBS rebates should be paid directly via the health professionals providing the service, not indirectly through possibly quite distant doctors' practices.

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.

HPCA response:
Proposal needs further clarification. Allied health professionals delegating to para-professionals should be able to claim MBS rebates for delegated procedures that they supervise. However, because allied health professionals are autonomous and are responsible for their own clinical decisions, doctors can 'refer' but not 'delegate' to them.

DRAFT PROPOSAL 9.1
Current institutional structures for numerical workforce planning should be rationalised, in particular through the abolition of the Australian Medical Workforce Advisory Committee and the Australian Health Workforce Advisory Committee. A single secretariat should undertake this function and report to the Australian Health Ministers' Advisory Council.

HPCA response:
HPCA supports the abolition of these bodies, but not creation of a secretariat. This work should be done by the proposed national workforce body HWEIA. See 'overview' for further discussion of HWEIA.

DRAFT PROPOSAL 9.2
Numerical workforce projections undertaken by the secretariat should be directed at advising governments of the implications for education and training of meeting differing levels of health services demand. To that end, those projections should:

- be based on a range of relevant demand and supply scenarios;
- concentrate on undergraduate entry for the major health workforce groups,

namely medicine, nursing, dentistry and the larger allied professions, while recognising that projections for smaller groups may be required from time to time; and

- be updated regularly, consistent with education and training planning cycles.

HPCA response:
Supported, but projections must be based on need for service, not demand for service – eg marginalised communities may not demand services but they may need them. Also, there is a limited demand for preventative services but there is a great need for them. These projections should be undertaken by the proposed national workforce body HWEIA.

DRAFT PROPOSAL 10.1
The Australian Health Ministers' Conference should ensure that all broad institutional health workforce frameworks make explicit provision to consider the particular workforce requirements of rural and remote areas.

HPCA response:
Supported. See below.

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.

HPCA response:
Supported. See below.

DRAFT PROPOSAL 10.3
The Australian Health Ministers' Conference should initiate a cross program evaluation exercise designed to ascertain which approaches, or mix of approaches, are likely to be most cost-effective in improving the sustainability, quality and accessibility of health workforce services in rural and remote Australia, including:

- the provision of financial incentives through the MBS rebate structure versus practice grants; and
- 'incentive-driven' approaches involving financial support for education and training or service delivery versus 'coercive' mechanisms such as requirements for particular health workers to practise in rural and remote areas.

There should also be an assessment of the effectiveness, over the longer term, of regionally-based education and training, relative to other policy initiatives.

HPCA response:
10.1, 10.2, 10.3 – The HPCA supports measures to improve access to rural health services. However, principles of equity require that, if something is not acceptable for the city, it should not be implemented in the country. Innovative arrangements developed to provide improved country services should be equally useful and applicable in city/suburban areas. There should be a central repository for evaluation, and a moratorium on new initiatives until evaluation indicates what works. There should also be an assessment of the effectiveness, over the longer term, of regionally-based education and training, relative to other policy initiatives.

DRAFT PROPOSAL 11.1
The Australian Health Ministers' Conference should ensure that all broad institutional health workforce frameworks make explicit provision to consider the particular workforce requirements of groups with special needs, including: Indigenous Australians; people with mental health illnesses; people with disabilities; and those requiring aged care.

HPCA response:

The HPCA believes that the best mechanism to achieve this is the creation of Divisions of Primary Care, in place of Divisions of General Practice. Since primary care services are delivered by a range of health professionals, broadening the Divisions to include all appropriate local health professionals would help ensure integrated services for people with special needs. To maximise the value of government funding to the Divisions, governance arrangements must also involve consumers and health professionals other than doctors.

HPCA contact information:

Rina Harber
Health Professions Council of Australia

PO Box 38, Flinders Lane
Melbourne Vic 8009

Phone 03 8662 3300

Email: hpca@psychology.org.au

Website: www.hpca.com.au