RESPONSE TO THE POSITION PAPER ON AUSTRALIA'S HEALTH WORKFORCE

Presented to the Productivity Commission

Prepared by the

Australian Physiotherapy Association

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Authorised by

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INTRODUCTION

The APA commends the Productivity Commission on its Position Paper on Australia's Health Workforce. In general we believe the Commission's analysis of the problems facing the sector is sound, particularly given the limitations imposed by the terms of reference of the enquiry. Many of the resulting proposals would, if implemented, lead to more efficient utilisation of the existing workforce. Indeed we are delighted to note that some of the proposals have been informed by previous APA submissions.

The purpose of the health workforce is to provide high quality, safe services to health consumers. The needs of the consumer are therefore paramount and supersede the interests of the professions. However, the co-operation of the professions is essential to effect reform and the APA argues that health care providers must be involved in the development of reforms, even if this slows the reform process. The APA also strongly supports community engagement in reform.

The aim of innovation in workforce planning and provision must be to ensure that consumers have affordable, timely access to the appropriately skilled health professional to meet their health care needs. Delivering this aim requires change to funding, structures, attitudes and education. The Commission has demonstrated an understanding of the extent of change required and the APA is confident that the Commission's final proposals will be directed toward meeting this aim. The APA is committed to working with CoAG to implement the reforms required to deliver the right care at the right time.

In this paper the APA comments on the overall report, highlights perceived deficiencies, and suggests alternative solutions to some of the identified problems. Following the overview, the APA responds to each proposal. Despite these APA constructive criticisms, the Commission is to be congratulated on the position paper and the APA looks forward to the final report.

RECOMMENDATIONS

Valuing professional education:
That the Commission acknowledge the value of entry-level education leading to qualification within a professional discipline and tailor its recommendations toward qualified professionals obtaining skills outside their usual scope of practice via interprofessional education. Recommendations regarding paraprofessional roles should also be within a disciplinary scheme.

Retention:
That research into attrition and retention factors in physiotherapy be conducted as a matter of urgency.

That 're-entry' courses meeting the requirements for re-registration be developed and made available to physiotherapists seeking to return to clinical practice.

Servicing populations with special needs:
The APA urges the Commission to reconsider the importance of transforming the governance and operation of Divisions of General Practice into Divisions of Primary Care.

That benchmarks be developed on the range and depth of health services required to meet the needs of communities with special needs.

That CoAG endorse the NFATSIH and ensure that it informs Indigenous health policy and service delivery.

That the Commonwealth renew its commitment to the PHCAP and that the States continue to contribute appropriate funds.

That governments and employers create payment structures to reward clinical expertise in working with populations with special needs. As a starting point, clinicians with postgraduate qualifications in the provision of clinical services to populations with special needs should be entitled to a loading to acknowledge their expertise. In large public hospitals, consultant and research posts should be created for clinicians other than doctors who work with populations with special needs to provide career paths and promote retention.

That professions develop structures to support clinicians working with groups with special needs.

A new agency:
The APA recommends the establishment of an advisory agency, operating in consultation with health professionals, consumers, and education and health bureaucracies, to conduct numerical workforce planning, investigate

workforce improvement, and make recommendations on health workforce education.

The APA recommends that the new health workforce agency make recommendations to DEST on the mix and distribution of places and that DEST be required to incorporate such recommendations into its allocation of places.

Education:
That, as a matter of urgency, physiotherapy be designated as a national priority under the Commonwealth grant scheme for tertiary education.

That physiotherapy be placed in the same cluster as medicine under the Commonwealth grant scheme for tertiary education.

That physiotherapy students be provided with the same level of support while on clinical placement as is currently available to medical students.

Cross-professional reform:
To facilitate cross-professional reform State and Territory governments need to:

- identify beneficial extensions in the scope of practice of disciplines such as physiotherapy;
- ensure that appropriate educational programs are in place to up-skill professionals;
- identify the legislative barriers to reform;
- remove the legislative barriers; and
- create posts in public hospitals to be filled by physiotherapists with an extended scope of practice.

At the same time, hospitals should be recruiting suitably trained assistants to work under the supervision of clinicians.

Registration:
That a national registration agency be established to replace State and Territory registration and that agency have profession-specific panels to respond to complaints relating to the standard of clinical practice within that discipline.

MBS reform:
That patients referred for X-ray by physiotherapists be eligible to claim the same MBS rebate that applies upon GP referral.

That patients referred by physiotherapists to medical specialists be eligible to claim the same MBS rebate that applies upon GP referral.

OVERVIEW

The Commission has correctly identified the fact that policy makers have traditionally neglected the contribution to the health workforce made by health professionals other than doctors and nurses. This acknowledgement is reflected in many of the recommendations and is welcomed by the APA. However, the paper tends to apply a uniform analysis to the entire workforce where in some instances it may be more appropriate to apply a different approach to doctors and other health professionals. Precisely because of the bias toward health services provided by doctors, there are major differences in some measures needed to address the shortage of doctors and the shortages of other health professionals. For example, there is an underlying assumption in the paper that all health professionals are resistant to change, and are particularly resistant to role redesign. The APA accepts that doctor groups have historically opposed the evolution of new roles such as nurse practitioners and physician assistants. In contrast to this position, the APA supports the development of physiotherapy assistant roles and the evolution of complementary professions such as exercise physiology. The physiotherapy profession is responsive to the needs of the community.

The Commission has also correctly concluded that there are barriers both to the appropriate use of existing health professional skills and to professionals acquiring and applying skills outside the professional scope of practice. The APA contends that it would be helpful to couch recommendations within this framework. Such a framework allows for consideration of what can be achieved without further education and reforms that will require educational support. The former should be prioritised while structures are developed to deliver educational interventions necessary to underpin extended scope practice.

Accreditation

The position paper overestimates the role of accreditation as a barrier to reform of professional roles and thus focuses too heavily on the capacity of accreditation reform to drive further reform. Course accreditation does not prevent interdisciplinary education or constitute a barrier to extended scope practice. Administrative efficiencies can be gained from accreditation reform, but other measures are needed to drive cross professional reform.

At the outset, the Commission needs to acknowledge the importance of professional education as a foundation on which new skills can be built. Professional education equips health professionals with a grounding in the principles that underlie the practical skills they acquire. It also develops the professional characteristics that are essential to quality care and imbues professionals with the sense of loyalty to the profession which drives them to contribute their expertise to the profession on a pro bono basis. It takes more than a skill set to make a health professional: a grounding in a professional discipline is essential to producing health professionals who can develop

expertise in their own field and then acquire additional knowledge and skill to adapt to the changing demands for health care services.

Professional education equips professionals to adapt to the demands of new technologies and changing community needs in relation to the type of service required and how it is delivered. Once students have established their professional identity, participation in interprofessional education promotes understanding of other disciplines and professional cooperation.

Acquisition of skill outside the scope of practice of a discipline – breaking down so-called silos – can only occur safely at a postgraduate level. Each profession needs to accept that once practitioners have acquired expertise in their own profession, they are able to acquire skills to take on tasks traditionally within the scope of practice of another profession. The APA accepts and embraces this proposition and calls on other health professions to do likewise. The APA also urges the Commission to accept that this is the appropriate approach to role expansion.

***Recommendation**:*
That the Commission acknowledge the value of entry-level education leading to qualification within a professional discipline and tailor its recommendations toward qualified professionals obtaining skills outside their usual scope of practice via interprofessional education. Recommendations regarding paraprofessional roles should also be within a disciplinary scheme.

This issue is addressed further in the response to draft proposal 6.1 below.

Retention

Health workforce reform cannot be considered without discussing retention and re-attraction strategies. There is a lack of research on attrition and retention in physiotherapy but based on anecdotal evidence the APA is deeply concerned that young physiotherapists are ceasing practice after as little as five years.

***Recommendation**:*
That research into attrition and retention factors in physiotherapy be conducted as a matter of urgency.

There are reports that it is becoming increasingly difficult for physiotherapists who have taken a break from practice to return. It appears that recency of practice provisions (which the APA support as a mechanism to ensure quality) in registration acts combined with a lack of ‘re-entry’ courses are major factors. Courses need to be established and funded appropriately before attract back to practice schemes are implemented.

***Recommendation**:*
That 're-entry' courses meeting the requirements for re-registration be developed and made available to physiotherapists seeking to return to clinical practice.

Decisive action is needed to stem the flow of qualified practitioners from the profession. The APA believes that lack of recognition, limited career paths and lack of remuneration are major contributors to attrition. There are virtually no clinical research posts for physiotherapists in public hospitals and there are few opportunities for appropriate remuneration for clinical expertise. The creation of senior clinical research posts for physiotherapists and the capacity for physiotherapists to undertake additional education, acquire new skills and work in areas currently prohibited by state law would go a long way to addressing these problems. Role redesign to enhance career opportunities for physiotherapists is a critical plank of the required retention strategy.

See the response to proposal 6.1 below for further details.

Communities with special needs

In its second submission to the Commission the APA called for the transformation of Divisions of General Practice into Divisions of Primary Care. The submission argued that divisions supporting health professionals other than GPs would increase the capacity of the private sector, particularly with respect to management of chronic disease. Divisions of Primary Care would also assist in the facilitation of multidisciplinary care and are likely to have a positive impact on rural workforce.

At present, there are no structures to support health professionals other than doctors in rural and remote locations. Figure 3 of the Commission's Position Paper shows that the physiotherapist to population ratio drops more than the GP to population ratio the further the population is from major cities. The APA contends that the support provided for GPs by Divisions is a factor in this difference and that Divisions of Primary Care would be a positive factor in attracting and retaining health professionals to rural and remote communities.

Divisions of Primary Care, with governance structures incorporating local health professionals and representatives of communities with special needs, would be well placed to develop local solutions to local problems. Such Divisions could play a central role in identifying health service needs and developing models to meet those needs effectively. This would include mechanisms to recruit and retain the spectrum of health professional skills required.

While several Divisions have developed a comprehensive primary care focus, and some have been renamed, there has been little change in their culture or governance arrangements. Most Divisions are governed almost exclusively by GPs and, as a consequence, have a medico-centric culture generally not conducive to effective multidisciplinary care or consultation with

disadvantaged communities. Considering the substantial level of public investment in Divisions, the APA contends that Government funding arrangements for the Division network should place an increased onus on Divisions to adopt reforms that promote interprofessional cooperation and multidisciplinary primary care.

***Recommendation**:*
The APA urges the Commission to reconsider the importance of transforming the governance and operation of Divisions of General Practice into Divisions of Primary Care.

The APA disputes the Commission's claim that the range of health services that can viably be offered in smaller communities is necessarily limited. While it is true that it cannot be expected that practitioners of all disciplines would reside in a small town, other service delivery models can be developed to provide access to the requisite level of care. For example, if the government funded basic infrastructure in a small town and made it available to visiting professionals, local residents would have access to a range of services, if only on an occasional basis. Other models such as outreach teams could also be investigated.

What is needed in the interim is the establishment of benchmarks of the range and depth of services required to meet the needs of various communities. Once these benchmarks are established then service delivery models can be developed to meet communities' needs.

***Recommendation**:*
That benchmarks be developed on the range and depth of health services required to meet the needs of communities with special needs.

Like the National Health Workforce Strategic Framework, the National Framework for Aboriginal and Torres Strait Islander Health (NFATSIH) was developed using wide consultation and is supported by a broad range of stakeholders. The Framework should inform the development of Indigenous health programs and policies.

***Recommendation**:*
That CoAG endorse the NFATSIH and ensure that it informs Indigenous health policy and service delivery.

One specific program that has been effective in developing workforce capacity to provide Indigenous primary health care services is the Primary Health Care Access Program (PHCAP). The program, which pools State and Commonwealth funding, has been in operation for five years and has had a positive impact on the Indigenous health workforce in the Mt Isa and Katherine regions. Unfortunately Federal funding is dwindling and the program is under threat.

***Recommendation**:*
That the Commonwealth renew its commitment to the PHCAP and that the States continue to contribute appropriate funds.

Throughout the position paper the Commission refers to the demand for health services. The APA understands that the language of supply and demand is entrenched in the lexicon of economics, but submits that it is not strictly applicable in health. The distinction comes to the fore in the case of communities with special needs. That is, many communities with special needs are disenfranchised and do not have the power to demand health services. They may have a demonstrable need for health services but are unable to demand them in the economic sense of the word. It is also noteworthy that demand does not apply in relation to preventive services. One of the problems with preventive care is convincing well people to act to prevent future problems: they are certainly not demanding preventive services, but they do need them.

RESPONSE TO DRAFT PROPOSALS

In this section the APA responds to the Commission's draft proposals. Proposals are grouped where the APA response relates to multiple proposals. Proposals have been reproduced for ease of reading.

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.
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.

The APA supports these proposals and argues that the Commission should go further and recommend that CoAG require that the NHWSF be addressed in all proposals for health policy reform at all levels of government.

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.

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.

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.

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.

The APA agrees that there is a need for a body focusing on workforce improvement and innovation and that the agency should be advisory in nature. However, the APA considers that it should not be a stand-alone agency, rather it should be part of a larger agency with responsibility for numerical workforce planning and providing advice in relation to health workforce education. That is, the agency would assume responsibility for the functions described under proposals 5.2, 9.1 and 9.2.

The rationale here is twofold. First, there is a link between the subject matter to be considered. For example, innovation is likely to include an educational component and numerical planning requires research that would be relevant to innovation. Once the number and types of health professionals required have been identified, collaboration with the education sector will be necessary to ensure that the right professionals are located in the right places. Second, it is essential that the functions are integrated both to improve efficiency and to ensure that they move in the same direction.

The agency:

- should have a specific brief to address rural and remote workforce shortages, and the workforce servicing Indigenous communities. It should start by evaluating programs and making recommendations on what has been tried and found successful. There should be no possibility that these areas are addressed as after-thoughts, or as add ons to other programs. They need to be dealt with specifically and directly, within the co-ordinated framework of the broader agency.
- should be tasked with collaborating with health consumers and health professionals to engender engagement of those groups with the processes and proposals of the agency.
- needs high-level linkages with health departments and the Department of Education, Science and Training.
- must be adequately resourced to conduct its investigations, trial innovations, and make recommendations for reform and in relation to the allocation of placements for tertiary health professional education.
- ideally would consider workforce requirements for the provision of community, aged care and disability services. Many of these services require the same technical skills as employed in the health setting.

Recommendation:
The APA recommends the establishment of an advisory agency, operating in consultation with health professionals, consumers, and education and health bureaucracies, to conduct numerical workforce planning, investigate workforce improvement, and make recommendations on health workforce education.

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.

The APA is pleased that the Commission has acknowledged the need for co-ordination between workforce requirements and the mix and distribution of tertiary places. While transferring primary responsibility for the allocation of funding from DEST to DoHA has merit, on balance the APA is unable to support the proposal.

The main concern for the APA is that physiotherapy education supplies graduates to other work settings. For example, physiotherapists work in industry, sports, education, disability and aged care as well as the health sector. The APA would be concerned that DoHA would plan only for graduates required directly in the health workforce and it is difficult to conceive of a model where some physiotherapy places are funded by DEST while the majority are funded by DoHA.

The APA would also be concerned that DoHA may have an excessively vocational focus at the expense of research. Australian physiotherapy research is internationally renowned and vocationally focused programs may threaten that research productivity, jeopardising both the evidence base of the profession and clinical innovation.

Recommendation*:*
The APA recommends that the new health workforce agency make recommendations to DEST on the mix and distribution of places and that DEST be required to incorporate such recommendations into its allocation of places.

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.

The APA supports this recommendation but contends that the Commission must also make a further recommendation to increase funding for physiotherapy education. DEST has shown no willingness to revisit its relative funding model and without pressure from health is unlikely to do so. What is more, strong support is required to overcome the influence of vested medical influences. The APA asserts that the Commission is a well-respected agency and that its recommendations carry considerable weight.

The disparity between physiotherapy and medical education funding is anachronistic and must be addressed. The resources required to teach anatomy, physiology and other sciences to physiotherapy students are the same as those for medical students. Both groups have lectures and tutorials and laboratory and dissection classes. The resources to teach communication and ethics are also the same. As physiotherapists graduate as independent practitioners who do not require an internship year, the APA argues that more resources are required to provide clinical education to physiotherapy students than to medical students. Yet, physiotherapy schools receive half the funding allocation per student per year from the Commonwealth that medical schools receive.

With the number of physiotherapy schools doubling in the past five years, there is increasing demand for clinical education places in public hospitals, without a concomitant increase in the size or capacity of physiotherapy departments. Inadequate and inequitable funding is severely hampering the capacity of schools to pursue private sector placements or innovations such as clinical simulation or standardised (actor) patients, to complement education provided in the public sector.

The strain has already precipitated a crisis in Queensland, with a cohort of students facing the prospect of being unable to graduate this year for lack of clinical experience. If the students are able to graduate, it will be due to a gargantuan effort by the heads of schools, which will not be repeatable in the future. The shortfall in funding of physiotherapy education is also progressively taking its toll on schools of physiotherapy, with many schools perennially operating on deficit budgets. Without urgent action physiotherapy education in Australia is poised to collapse.

In the short term, additional funding could be used to ensure the sustainability of existing programs, and provide support for placements in the private sector. With a substantial long-term injection of funds, schools of physiotherapy could investigate new models of delivery in new settings (such as Indigenous health services, aged care facilities and the community sector), trial the use of simulated patients, and research clinical simulations. Additional funding would also allow the pursuit of interdisciplinary clinical placements.

The APA understands that DEST is unlikely to revisit the relative funding model in 2006 but asserts that, in the medium term, physiotherapy must be brought into the same cluster as medicine. Urgent action is required in the interim, so the APA calls for the designation of physiotherapy as a national priority area (along with nursing and teaching) until the relativities are adjusted. There is also an urgent need to provide support for physiotherapy students on clinical placement.

***Recommendations**:*
That, as a matter of urgency, physiotherapy be designated as a national priority under the Commonwealth grant scheme for tertiary education.

That physiotherapy be placed in the same cluster as medicine under the Commonwealth grant scheme for tertiary education.

That physiotherapy students be provided with the same level of support while on clinical placement as is currently available to medical 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.

The APA acknowledges that differences in accreditation procedures are difficult for universities to manage. The APA agrees that a consistent approach would be advantageous. Similarly, the APA agrees that there are some aspects of accreditation standards that could be standardised across the professions and that there may be administrative efficiencies created by a single accreditation agency. However, the APA rejects outright the notion that professional standards are best established by anybody other than clinical experts in that discipline.

Standard setting must be done in consultation with the community and industry, but it is ultimately clinical experts who must determine what is required of a new graduate of that profession. There is a place for health professionals from other disciplines in standard setting, but final responsibility must rest with the profession.

The APA disputes the assertion that course accreditation is a barrier to role redesign or interprofessional education and co-operation. The barriers to role extension for physiotherapists are:

- State and Territory drugs and poisons acts;
- State and Territory radiation safety acts;
- State and Territory medical practitioner registration acts;
- Funding structures;
- Lack of recognition of the professional capacity of physiotherapists; and
- Turf-protection by some doctor groups.

These barriers do not relate to course accreditation nor would a national accreditation authority remove these barriers.

The APA would support an interprofessional accreditation agency only if professions maintained custodianship of the clinical standards of their discipline. As acknowledged above the APA can see potential benefits for universities and administrative savings, but the APA does not believe the agency would have the capacity to drive cross-professional reform.

***Recommendation**:*
To facilitate cross-professional reform State and Territory governments need to:

- *identify beneficial extensions in the scope of practice of disciplines such as physiotherapy;*
- *ensure that appropriate educational programs are in place to up-skill professionals;*
- *identify the legislative barriers to reform;*
- *remove the legislative barriers; and*
- *create posts in public hospitals to be filled by physiotherapists with an extended scope of practice.*

At the same time, hospitals should be recruiting suitably trained assistants to work under the supervision of clinicians.

At the same time, hospitals should be recruiting suitably trained assistants to work under the supervision of clinicians.

To some extent different approaches to cross-professional reform will be required to enable change in the public and private sectors. The above recommendation relates to reforms by State and Territory governments and will thus operate only in the public hospital sector. While a national approach to role reform would be desirable, the reality in the public sector is that it will occur on a jurisdictional basis.

The approach taken to extended scope of practice in the UK is necessarily public sector focused due to the dominance of the NHS as a health care provider. The solution that evolved develops posts to fit the needs of the specific health service, and to some extent, the skills of the individual practitioner involved. The Consultant role relates to that particular post and

does not credential the individual to work in another setting, nor does it ensure that there will be another individual able to fill the role should the Consultant move on.

While it is desirable that health professionals are appropriately skilled to meet the needs of a particular service, there are dangers in developing skill complements that are not portable and not readily replicable. It is noteworthy that NHS officials now recognise the individualised nature of the roles as a limitation and are taking steps to develop a national framework for recognition. Some mechanism is needed to develop frameworks for role evolution in Australia.

National professional associations are well placed to develop specialisation frameworks (such as that which is evolving at the APA) to provide some consistency to the reforms, and provide a mechanism for them to operate within the private sector.

Extended scope roles will logically be filled by practitioners with specialist expertise that is relevant to the extension in the scope of practice. For instance, a physiotherapist with expertise in musculoskeletal physiotherapy is the most logical person to take on extended scope practice such as joint injection and arthroscopy. The APA has a specialisation framework to recognise specialist expertise in musculoskeletal physiotherapy. Working in consultation with state governments to ensure appropriate legislative change, and with universities to provide appropriate educational intervention, it would not be difficult to extend the APA specialisation framework to certify competence in extended scope areas.

Such a framework to recognise competence outside of the current scope of practice would underpin role development in the public sector and enable extended scope practice in the private sector. The flexibility to service very specific skill needs within hospitals can be facilitated by in-hospital credentialing programs, but this process should be limited to avoid the creation of roles that cannot readily be filled by other individuals.

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.

The APA supports the development of a national approach to the assessment of overseas-trained health professionals.

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.

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.

The APA strongly supports the development of uniform national registration standards. In fact, the APA would go further and argue in favour of national registration. In previous submissions to the commission the APA has outlined the difficulties experienced by physiotherapists, particularly sports physiotherapists, who practise in multiple jurisdictions. National registration is also supported to ensure that consumers receive a consistent standard of protection across disciplines and across the nation.

***Recommendation**:*
That a national registration agency be established to replace State and Territory registration and that agency have profession-specific panels to respond to complaints relating to the standard of clinical practice within that discipline.

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.

The APA considers that there is some need to regulate the practice of paraprofessionals and that the delegating professional should retain responsibility for the clinical outcome. In respect of physiotherapy assistants, the APA considers that a decision regarding the mechanism to regulate their practice is probably premature.

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.

The APA strongly supports this proposal.

The APA understands that the Commission is reluctant to make specific recommendations regarding the MBS. However, change under this proposal will not be realised in the short term and the APA contends that there are profound workforce and cost savings to be made now with only minor adjustments to the MBS. The APA calls on the Commission to urge CoAG to implement the recommendations below as soon as is practicable. The changes are minor and substantial workforce savings would be realised upon implementation.

Arguments supporting these recommendations appear in previous submissions to the Commission.

Recommendations:
That patients referred for X-ray by physiotherapists be eligible to claim the same MBS rebate that applies upon GP referral.

That patients referred by physiotherapists to medical specialists be eligible to claim the same MBS rebate that applies upon GP referral.

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.

The APA supports the development of MBS items for services provided by paraprofessionals, in the employ of the professional, on delegation from the professional. The APA currently lacks the expertise to advise the commission on the appropriate discount to encourage use of the items.

It is unclear in the proposal how the Commission defines delegation. It is worth noting that, as independent practitioners, physiotherapists do not receive work on delegation from other health professionals. Physiotherapists accept referrals, and provide professional services in their own right. Where a doctor identifies that the services of a physiotherapist are required, the doctor refers to the physiotherapist who is remunerated at the appropriate market rate, be it under the MBS or private payment arrangements.

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.

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.

All role redesign and workforce innovation proposals should be assessed in view of their impact in rural and remote settings so in principle the APA would support these recommendations.

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.

The APA agrees that there is insufficient evaluation of rural workforce initiatives and argues that there is a culture of developing new programs rather than pursuing approaches that are demonstrably effective. The vast majority of rural workforce programs have focused on doctors, to the detriment of other professions. GPs play a critical role in rural health care, but without the support of other health professionals their position is not sustainable. When programs are evaluated they should be measured against their impact on the entire rural health workforce and not just on doctors. Only those programs with a demonstrably positive impact on the entire workforce should be continued.

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.

Health professionals working with groups with special needs are often not well rewarded financially and their roles lack status among the profession. Workers attracted to these fields often have personal experience leading to a commitment to the group with special needs. Clearly, reliance on altruistic motives does not deliver the requisite level of workforce support to meet the needs of the populations in question.

To meet these needs, governments must invest in remuneration to make the roles financially attractive, and professions must invest in raising awareness among professionals of the benefits of working with groups with special needs. For example, the APA has recently created an Indigenous Health standing committee of its Board. One of the roles of the committee is to raise awareness within the profession of Indigenous health issues and the clinical challenges available to physiotherapists who work with Indigenous people. The APA also has gerontology and neurology groups to support the clinical education needs of physiotherapists working with older people and people with disabilities. These groups are also working to formalise a specialist qualification in their fields to provide recognition of clinical expertise.

***Recommendations**:*
That governments and employers create payment structures to reward clinical expertise in working with populations with special needs. As a starting point, clinicians with postgraduate qualifications in the provision of clinical services to populations with special needs should be entitled to a loading to acknowledge their expertise. In large public hospitals, consultant and research posts should be created for clinicians other than doctors who work with populations with special needs to provide career paths and promote retention.

That professions develop structures to support clinicians working with groups with special needs.

In summary, the APA supports this proposal but calls on the Commission to make specific recommendations to improve payment and career structures to promote workforce recruitment and retention to meet the needs of groups with special needs.