Health Reform South Australia (HRSA)

Submission to Australian Government Productivity Commission

Position Paper: Australia's Health Workforce

November 2005

Introduction

HRSA is a coalition of organisations (Appendix 1) outside of government that, as stakeholders in health care, is committed to promoting and implementing health reform as proposed in the South Australian Government endorsed recommendations of the Generational Health Review http://www.dh.sa.gov.au/generational-health-review/ and as outlined in HRSA's Position Statement (Appendix 2).

This response was developed by the HRSA working party on Health Workforce which welcomes the focus on this important issue by the Productivity Commission and contributors across Australia.

We wish to provide our responses on the draft proposals arising from the position paper.

Overview

It is not clear from the wording in the recommendations that these proposals are farsighted in regard of building a workforce that is a good match for a reformed future health system such as that envisioned by HRSA and outlined in processes such as the Generational Health Review in South Australia.

As we have indicated in some of our responses, we believe the workforce requirements of groups with special needs should be legitimised and integrated into all of the proposals. The proposals have not adequately addressed areas of high priority to the Australian community, namely, the workforce for care of the aged, people with mental illness, people with chronic illness and Indigenous health. These special needs groups are mentioned in the final point which gives the appearance of them being an afterthought, rather than being integrated within the whole approach to workforce.

Of additional note, there is no health workforce response to the health reform imperative to improve the overall health of the population through health promotion and prevention strategies which, in due course, are expected to reduce demand on acute services. Health promotion needs to be an integral component of all health training and education as well as ensuring that workforce planning includes Health Promotion specialist positions.

Overall the proposals give the appearance of an overwhelming focus on university undergraduate training of importance to the acute hospital sector (vis-à-vis the aged and community care sectors), to the detriment of the VET trained workforce and clinical specialist training.

The proposals have not addressed issues relating to the gradually diminishing volunteer workforce and the implications that this social change will have on health workforce requirements.

An implementation plan and timetable should follow the finalisation of these proposals, with a regular review process (open and accountable) to ensure progress is made towards improved health outcomes for the Australian community.

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.

<u>HRSA response</u>: We support this proposal.

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.

<u>HRSA response</u>: We support this proposal, whilst stressing the need to include Vocational Education Training within these reviews.

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.*

<u>HRSA response</u>: We support this proposal.

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>HRSA response</u>: Whilst we support the intent of this proposal, we are concerned that this is a very complex issue that would require significant discussion with key stakeholders to identify the approach most likely to achieve the desired results. Whatever process is agreed on would require, at a minimum, strong policy input from the Department of Health and Ageing. It would also need to accommodate any of the initiatives to redefine health worker roles.

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.

<u>HRSA response</u>: Whilst we believe this proposal has merit it is essential that it work in collaboration with the advisory health workforce improvement agency. There is an imperative for these new advisory bodies to be integrated in order to maximise the achievement of desirable outcomes, not just expand bureaucratic structures.

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.

<u>HRSA response</u>: We support this proposal.

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.

<u>HRSA response</u>: We believe this proposal has merit, but argue that VET should be considered in tandem with university based training, not at a later time. VET provides a substantial proportion of the workforce for aged care and community care. Since the vocational health workforce sectors will experience a growth in demand as a result of the ageing population it is imperative that accreditation and where applicable, registration standards, be nationally consistent. VET also provides some good examples of how it has developed training in response to community need and this experience may be valuable when considering redefinition of roles and the competencies required within these roles.

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 practice in different work settings.

<u>HRSA response</u>: We support this proposal and in addition, recommend that the assessment processes include competency assessment.

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.

HRSA response: We support this proposal.

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.

HRSA response: We support this proposal.

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.

HRSA response: We support this proposal, but would urge that the regulatory framework and processes of supervision occur in such a way that the task delegation leads to improvements in efficiency and effectiveness for clients.

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.

HRSA response: We support this proposal, but would want this to be occurring within the overall framework of health system reform.

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.

HRSA response: We support this proposal as a way of funding delegated tasks, but would see it as a very complex process that would need rigorous review. The review would need to identify if delegation of tasks is being helped or hindered by the level of rebate that is set, and whether there are any unintended consequences to this initiative.

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.

HRSA response: Whilst we support this proposal in principle, we would want to ensure that there is sufficient infrastructure for the consultation and implementation role of the new committee. The health sector needs access to relevant and appropriate data across Australia and the whole workforce. We would want to ensure a balanced picture is painted, without undue influence from individual professional groups.
Ongoing review would be necessary to ensure that the replacement secretariat met rationalisation objectives.

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.

HRSA response: We support this proposal, but would add that it is essential to include specialist clinical service providers where known and pending shortages exist and VET trained health workers.

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.

HRSA response: We would argue that the health workforce frameworks should consider and address the requirements of all geographic areas and socially disadvantaged groups. Urban fringe areas and specific population groups, such as the indigenous people, disabled or those with a mental illness, also warrant consideration of their workforce needs.

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.

HRSA response: We support this proposal, but would argue that rural and remote areas are only the starting point for considerations of job redesign, and that these need to be reviewed with regard to their applicability to other areas of the health system.

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 practice 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.

HRSA response: We support this proposal, but believe there is a need to consider the implications of these approaches in all geographic areas and with socioeconomic groups that are under workforce pressures.

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.

HRSA response: As we have indicated in some of our previous responses, we believe the workforce requirements of groups with special needs should be legitimised and integrated into all of the previous proposals. To be inserted in this final point gives the appearance of them being an afterthought. Rather, this diversity should be integrated within the whole approach to workforce.

Summary

Overall the proposals give the appearance of an overwhelming focus on university undergraduate training of importance to the acute hospital sector (vis-à-vis the aged and community care sectors), to the detriment of the VET trained workforce and clinical specialist training.

The proposals have not addressed issues relating to the gradually diminishing volunteer workforce and the implications that this social change will have on health workforce requirements.

The proposals have not adequately addressed areas of high priority to the Australian community, namely, the workforce for care of the aged, people with mental illness, people with chronic illness and Indigenous health. We believe it is important to establish a review process to ensure these changes move us towards improved health outcomes for the Australian community.

Appendix 1

Health Reform South Australia

C/o Royal Australian College of General Practitioners
15 Gover Street, North Adelaide, SA 5000
Phone: (08) 8267 8343 Fax: 8267 8319 Email: hrsa@racgp.org.au

Chair: Mark Waters
Deputy Chair: Tori Wade
Coordinator: Amanda Haller
Coordinating Group: Mark Waters, Tori Wade, Gwyn Jolley, Ian Yates, Lee Thomas, Michael Forwood, Chris Morris

HRSA Member Organisations

Aboriginal Health Council of SA
Advanced Community Care Association Inc.
Aged and Community Services SA & NT Inc
Association of Major Community Organisations
Australian College of Midwives Inc.
Australian Health Promotion Association – SA Branch
Australian Nursing Federation
Cancer Council of SA
Carers Association of South Australia
City of Salisbury
Council on the Ageing
Diabetes SA
Flinders University
Health Consumers Alliance
Health Consumers of Rural and Remote Australia
Liquor, Hospitality & Miscellaneous Workers Union
Mental Health Coalition
Multicultural Communities Council of SA
Public Health Association
Royal Australian College of General Practitioners
Royal College of Nursing Australia, SA Chapter
SA Divisions of General Practice Inc
South Australian Community Health Association
South Australian Council of Social Service
University of South Australia

Appendix 2

Health Reform South Australia (HRSA)

Position Statement

Implementation of SA Generational Health Review

HRSA is a coalition of organisations outside of government that, as stakeholders in health care, is committed to promoting and implementing health reform as proposed in the South Australian Government endorsed recommendations of the Generational Health Review (GHR). In order to implement these health reforms, it will be necessary to develop a common purpose between SA Government controlled and funded health agencies (hospitals, community services) and those stakeholders who are outside the direct control of SA Government but are integral to achieving improved community health outcomes. These stakeholders include private enterprises (e.g. general practices, health insurers, private hospitals), community sector peak bodies (e.g. South Australian Council of Social Service [SACOSS], Council On The Ageing [COTA], South Australian Community Health Association [SACHA], SA Divisions of General Practice Inc [SADI] etc) and agencies that take responsibility for a range of community services, training and research institutions (e.g., universities), professional bodies (e.g. Royal Australian College of General Practitioners [RACGP], Royal College of Nursing Australian [RCNA]) and trades unions (e.g. Australian Nursing Federation [ANF])and consumer and carer groups. Many of these organizations receive funding from either the Australian Government, through membership fees and/or direct community contributions.

Collectively, these organisations have come together in HRSA to promote health reform and among other things, provide a platform for negotiation with the SA Government (Department of Health) to achieve a truly integrated population health system that delivers community benefit. [Appendix 1. HRSA Member organisations]

HRSA has participated and will continue to participate in the range of SA Government working parties to implement health reform. In addition, members of HRSA will negotiate with the Australian Government and private providers to achieve the health reform objectives that can only be delivered by way of agreement between all the stakeholders.

The following statement is the position of HRSA members on the key factors for the development of a reformed health system. These position statements will be the basis for HRSA negotiation with and participation in health reform working parties and interactions with the Australian Government, private organisations and Regional Boards that are associated with population health care.

Key Elements of Health Reform

The main objective of HRSA is to achieve a system of health care that delivers the best health outcomes for the community using available resources. The following statements guide the work of HRSA:

<u>Population Based Funding</u>

The determination of health priorities comes from looking first at the health needs of the population and prioritising these needs as the basis for resource allocation and systems of governance and management. Fair and equitable funding to regions through a risk-adjusted population allocation is required. This model should take account of Australian Government and private contributions to health funding. We also encourage the development of innovative forms of funding such as Australian and State Government fund pooling, that reduce the problem of cost shifting and produce greater efficiencies and better outcomes for the community.

Groups requiring special consideration in population funding models include Aboriginal people, victims of violence and people with mental illness.

<u>Governance</u>

New governance arrangements have the potential to deliver much improved health outcomes for individuals and populations as well as better-targeted and more efficient services. Accountability and measurement of performance has to relate to improved population health outcomes. This will require:

- Engagement of all sectors of health (public, private, not-for-profit and the community)
- Full empowerment of regions to coordinate resources from the Australian and State Governments and the private sector.
- A system of health outcome benchmarking.
- Transparency of health service agreements such that health care providers and the community can see what outcomes are being delivered at what cost.

<u>Health Service Agreements</u>

Health Service Agreements must reflect the role and responsibility of Health Regions to achieve health reform through a health system based on:

- A population health approach
- Increased investment in primary health care
- Active and meaningful community participation
- Collaboration and coordination between providers
- A proactive approach to addressing the needs of disadvantaged groups
- Research and evidence-based practice.

Community Participation

Community participation can assist in ensuring that health services are relevant and accountable to the people they intend to serve. The use of community and consumer strategies must underpin better health outcome initiatives across health planning, service delivery, health service evaluation and personal treatment and care.

One model or formula does not fit all situations therefore participation strategies need to be tailored to meet local contextual requirements through cooperation between service providers, planners and community members. HRSA has played and will continue to play a major role in ensuring that community participation is an integral part of Health Reform.

Primary Health Care

Primary health care is the cornerstone of health reform. Implementation will require a redistribution of resources and 'control' from hospital and tertiary disease management systems into organisations that are in a position to provide for comprehensive primary health care.

HRSA supports the scope and context of Primary Health Care defined by the SA Government as follows:

> "*Primary Health Care is both an approach to dealing with health issues as well as a level of health service.*
>
> - *As an approach, there is a strong emphasis on working with communities and individuals to improve their health and well being. It can include a range of strategies from health promotion, health protection, disease prevention, advocacy, social action and assessment, diagnosis, early intervention, treatment and rehabilitation, systematic chronic disease management and support for community living.*
>
> - *As a level of health service, Primary Health Care is often used to describe the first point of contact that a person has with the health system, such as general practice, community nurses, pharmacists, social workers and other health providers"* (Primary Health Care Policy Statement 2003-2007, Department of Human Services).

HRSA also acknowledges that family carers comprise an important part of the primary health care workforce as providers of informal care.

The resources and commitment required to improve primary health care certainly include the SA Health budget and the Department of Health but much more than that – notably GPs, community aged care, many community service agencies, volunteers and ultimately everyone who can contribute to maintenance of their own health and prevention of disease progression.

Hospital Avoidance

A key for reversing the skew towards hospital care is finding the least restrictive, safe and local alternatives to unnecessary hospitalisation. Chronic disease management and hospital substitution delivered by local health professionals and well-supported carers strengthens primary health care resources while at the same time giving hospitals additional capacity to deliver quality tertiary health care to those in need.

Mental Health

Primary mental health care should be developed in tandem with primary health care, and mental health reforms aligned with the overall health reform agenda. Co-morbidity between physical health, mental health and substance misuse is common and the public should be able to receive a service that can meet these needs in an integrated fashion. HRSA believes that mental health services have been chronically under-funded for many years in this state, and that addressing mental health needs of the community will be one of the major challenges to health reform.

Workforce

Workforce planning and development are central to health reform. Current skill shortages and recruitment and retention issues for the health workforce are key barriers to health reform. Solutions must go beyond existing constraints to include:

- Establishing new models of care and new roles for the workforce which broaden the scope of existing practice
- Debating the assumptions about who can deliver safe care
- Maximising self management
- Addressing rural and remote workforce needs without stripping developing countries of their professional workforce
- Effective communication between health care workers across disciplines to provide coordinated care
- Recognising carers as part of the primary health care workforce and providing adequate and support and training.

Research and Training

The implementation of the above initiatives will require research and training investments that are aligned with the objectives of health reforms. Existing research and training organisations (Universities, Commonwealth Scientific & Industrial Research Organisation [CSIRO], and Registered Training Organisations [RTOs]) should be fully engaged and working in collaboration with the Department of Health and the Health Regions in fostering research and training.

Training needs to be provided within the health system on *primary health care* and *community and consumer participation* to ensure that the reform is supported by a cultural change within health organizations and among health providers.

The development of a population based health outcome system provides the opportunity for creating a research and training system that could take on international leadership roles and external funding – and this opportunity should be facilitated.

Evaluation and Monitoring

Monitoring and evaluation need to be an integral part of health reform implementation. Evaluation should take account of multiple perspectives including public, private and non-profit providers; researchers and academics; Departmental bureaucracies; users of health and welfare services and the whole SA community. The evaluation should focus on the process of reform, i.e. what has supported or blocked the implementation of desired changes, and the achievement of the anticipated outcome, i.e. improved health for all people in South Australia, using the available resources. The impact of reform on informal care provided by family carers is an important area for monitoring and evaluation i.e. in meeting the reform what have been the resource and health costs to family carers?

The evaluation will need to be resourced and conducted in parallel with the implementation of reform and it would create an opportunity for South Australia to become a leader in health system research.