Productivity Commission Study into the Health Workforce

Victorian Government Response to the Commission's Position Paper

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Victoria
The Place To Be

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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.

Victoria supports the Council of Australian Governments (CoAG) endorsing the National Health Workforce Strategic Framework (NHWSF).

Victoria, however, believes that the Commission has not adequately reflected the underlying shortage of locally trained health professionals and the significant impact this has on the composition, supply, distribution and cost of the health workforce and ultimately, its capacity to meet future health service needs by restricting who can provide services and the cost of these to consumers.

In relation to the broadening of the self sufficiency principle, Victoria believes this warrants further clarification. Victoria understands and considers it needs to operate in a world labour market for health professionals and it is appropriate to draw on suitably qualified, overseas trained, professionals to supplement the locally trained workforce, and to recognise that its own health workers will migrate to other countries.

However, it is concerned that the Commission's statement that there is a "... need for Australia to produce sufficient numbers of health workers such that there is not an unsustainable reliance on health workers trained in other countries" leaves open to interpretation the extent to which local supply should meet local demand and what an unsustainable reliance on overseas trained health workers is. Victoria contends that all States and Territories within Australia should aim to produce sufficient number of health workers net of migration inflow and outflows.

It was reported to the International Medical Conference in 2004 that the four major western countries actively recruiting international medical graduates are already the highest users of these in their workforce, with the United States having 26.8% of its total medical workforce trained overseas, the United Kingdom 28.3 %, Canada 23.1% and Australia 20.6% [1]

This report also identified that the largest exporter of medical graduates to Canada and Australia was the United Kingdom at 17.4% and 32.5% of the international medical graduate workforce respectively. Migration rates, however, for Australians going to these countries were substantially lower, with Australians only making up 1.6% of the international medical graduate workforce in Canada and 2.2% in the United Kingdom.

Active measures being undertaken in the United Kingdom to attract and retain its domestically trained workforce would indicate that the continual supply of practitioners from this country will diminish. It is also worthwhile to note that India figures in the top three exporters of medical practitioners to United States, the United Kingdom, Canada and Australia. It is questionable the extent to which this market can be relied on as competition for such graduates is increasing and is also affected by compliance with ethical recruitment protocols set by the Commonwealth nations.

Victoria also believes that any approach to net self sufficiency needs to be considered on a State and Territory basis. Whilst some level of interstate migration of health professionals is to be expected and encouraged, Section 4.3.1 of the July Victorian submission to the Productivity Commission provided evidence of the generally low rates of health professionals working outside the state in which they gained their qualification. A recent analysis of this trend in nursing identified that only 7.9% of Victorian nurses had gained their qualification interstate. The AMWAC study into career decision making by junior doctors further demonstrated that only just over 5% of doctors envisaged that they would be working within the next 5 to 10 years, in a state different to where they had gained their qualification.[2]

Given the shortages being experienced across Australia, Victoria believes that each State and Territory should attempt, wherever possible, to achieve a net level of self sufficiency in the supply of health graduates, taking account of imports and exports. Any State or Territory that does not do so, and seeks to recruit from other jurisdictions, will impact on the policy responses being developed and implemented by that jurisdiction to address workforce shortages.

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[1] Mullan *Filling the Gaps: International Medical Graduates in the United States, the United Kingdom, Canada and Australia* Washington 2004

[2] *Career Decision Making by Doctors in Vocational Training, AMWAC Medical Careers Survey,* AMWAC (2002), p118

Victoria contends that, notwithstanding the use of overseas trained practitioners or other mechanisms developed to improve retention and the flexibility and efficiency of the workforce, substantial increases are required in the number of undergraduate university places in health disciplines. These increases need to take into account the supply and demand planning frameworks that the Commission has proposed and implemented through the revised governance and funding mechanisms. Determining the numbers of places needs to be dynamic so that existing health workforce shortages are addressed and new shortages do not emerge.

Whilst this appears implicit in the Commission's Position Paper, given the importance of the issue, Victoria seeks an explicit recommendation that addresses the current shortfall in the provision of funded undergraduate health places available within a State or Territory based on planned and identified need for that State or Territory.

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.

Victoria supports this Draft Proposal.

The regular reviews of progress should include consideration of the relative priority of health workforce education and training funding, including the size of the funding pool available, informed by the evidence about health care service need, and the effectiveness of new agencies established as a result of the Commission's proposals.

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.

Victoria supports the proposed establishment of a national health workforce improvement agency, but believes that the functions proposed for an advisory health workforce education and training council (as per Draft Proposal 5.2) should be combined with those currently proposed for this agency.

Such an approach is seen to have a number of benefits, including:

- A more integrated approach to progressing workforce innovation, in which educational reform and workforce and service needs both drive change.
- Education and training required (across all levels of the Australian Qualifications Framework) to support development of new or amended roles across services streams is fully understood and taken into consideration in examining options for workforce redesign.
- A reduction in the number of new bodies established to progress the workforce agenda, which would in turn assist in ongoing co-ordination and maximise best use of available resources.
- Retention of the separation between advisory functions and regulatory/standard setting functions that the Position Paper identified as important.

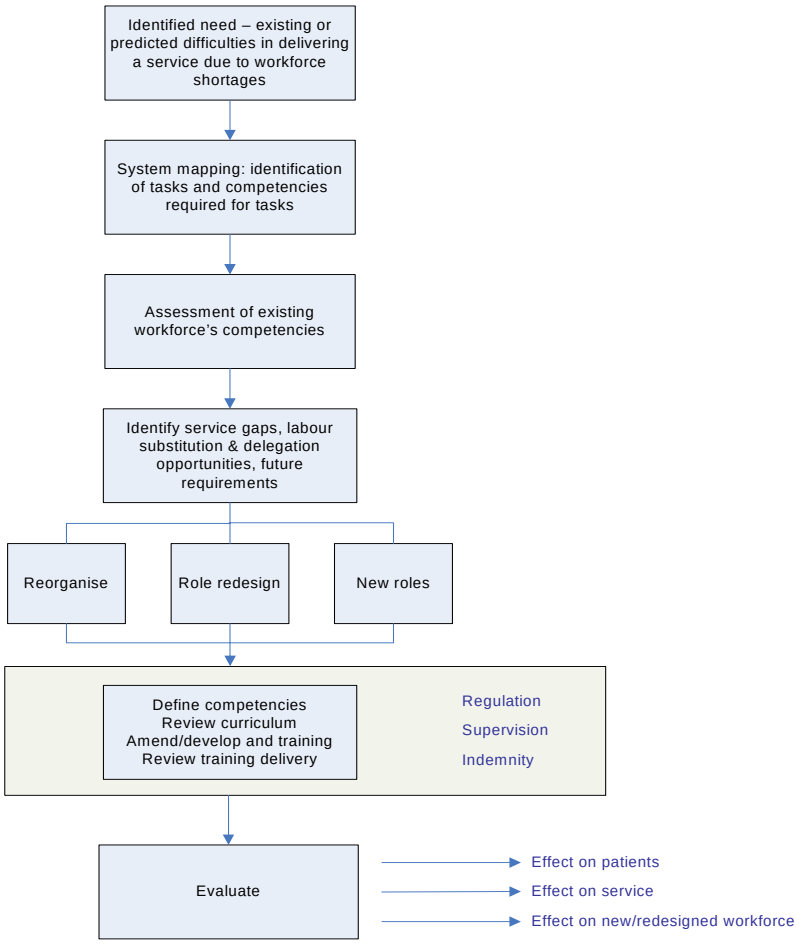
Education and training are essential to ensuring that staff assuming new roles are safe and competent to practice. Identification of appropriate training requires access to the necessary educational and professional expertise: consolidating the workforce improvement and education and training functions into a single entity would be an efficient, effective means of ensuring an cohesive, well informed approach to work design.

The Victorian approach to role review and redesign:

- Commences with consultation with a service or work area and interested parties.
- Maps a service stream or work area.
- Analyses the tasks required in delivering care.
- Analyses the skills and competencies required to perform those tasks.
- Clusters skills and abilities most effectively into work roles.
- Develops and delivers the curriculum and/or training required to support those roles.
- Embeds the role into the service.

Changed and new roles can then be trialled and evaluated, and if successful, implemented more broadly across the sector. The intrinsic link between job design, competency identification, curriculum development and training is outlined in Diagram 1.

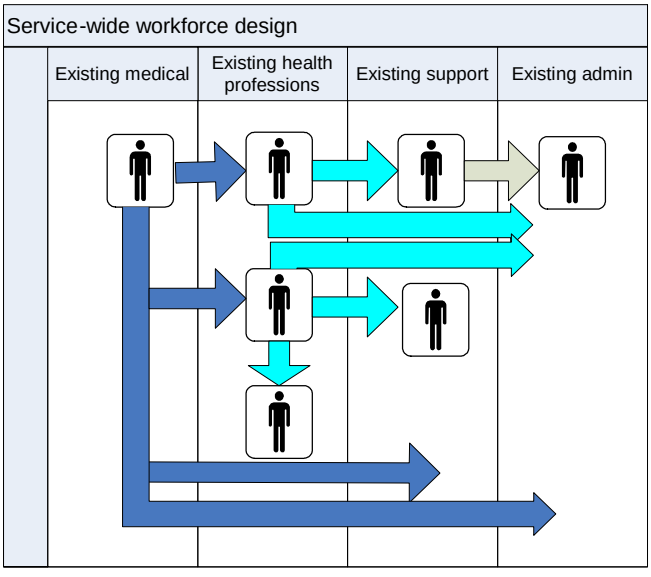
Figure 1: Job design workflow



The question of whether VET should be part such an education and training advisory function has also been raised. It is considered important that VET be included in this function, to promote a more articulated approach to training across the VET and higher education sector and facilitate a more systems based approach to workforce design rather than one focused on targeted changes to specific roles.

As depicted in Figure 2, such an approach would, for example, allow identification of the training required for an allied health assistant or even administrative support staff, to undertake additional tasks at the same time as an allied health practitioner's role might be extended to include tasks traditionally the sole domain of medical practitioners. The training of allied health assistants and administrative support staff falls into VET curriculum areas and it will be critical that such is developed in an integrated manner with higher education.

Figure 2: Service wide workforce design



There is broad recognition that changes in role delineation can be very contentious, and experiences such as the establishment of optometry prescribing rights in Victoria highlight that different professional groups will often have divergent views regarding the level of training required to safely undertake additional tasks. A consolidated, cross-disciplinary advisory body could be a mechanism through which these issues (which ultimately relate to scope of professional practice) could be debated.

The innovation and education and training agency would play a key role in providing advice on workforce reform, which could be adopted by the accreditation agency and translated into the development of new workforce roles and new curricula for education and training.

The independence of the agency, and an effective governance structure, supported with adequate resources will be essential to the success of the agency. For such a body to be fully effective there would be a need for it to have some capacity to act upon its findings. The proposal that it report to the Australian Health Ministers Conference via AHMAC is supported and sufficient funding will need to be made available to support piloting of identified innovation. Such an approach would enable the Agency to identify what is possible, demonstrate such reforms in action and where possible, contribute to the development of nationally consistent training elements.

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.***

Whilst Victoria's supports the Commission's intent to better link health policy and planning with health workforce education planning and allocation, it is concerned that the fundamental question of State and Territory (as the primary provider of health services) involvement in the distribution and allocation of health education places is not addressed.

Decisions to change the number and composition of health training places have significant impacts on State and Territory health services. In the short term, this involves provision of clinical training opportunities and the resources required to support these: over the medium to long term, decisions regarding training numbers and their distribution influence the capacity of such services to access sufficient numbers of suitably qualified staff.

Given these interrelationships, a collaborative planning approach between the Commonwealth and the States and Territories would be expected to deliver the most effective training and workforce outcomes. To date, however, Victoria's attempts to engage the Commonwealth in such an exercise in relation to medical numbers have been unsuccessful. This leads it to believe that a formal structure to facilitate joint approaches is required.

In addition:

- The approach proposed by the Commission through transferring what are currently inadequate funds both in terms of numbers and of course funding rates to the control of the Department of Health and Ageing has the potential to cement a structural deficit in undergraduate places across Australia and may hinder an integrated approach to the allocation of education places across the broader tertiary sector based on prioritised need.
- The exclusion of the VET funding from any model fails to acknowledge the critical role VET training will play in delivering an appropriately structured and trained workforce. As Victoria outlined in Section 4.3.4 of its July submission to the Commission, use of VET trained staff has the potential to make a substantial impact on meeting many of the workforce supply and distribution problems. A system that more effectively encompasses higher education and VET planning and allocation at a state level will provide the capacity to allocate across both sectors in an integrated and complementary manner and support substitution between VET and higher education providers where required.
- Successful implementation of the Commission's Draft Proposal 5.3 will be highly dependant on the capacity of all parties to effect change across the various aspects of curriculum, clinical training and funding. An integrated planning and allocation model will be critical to this.

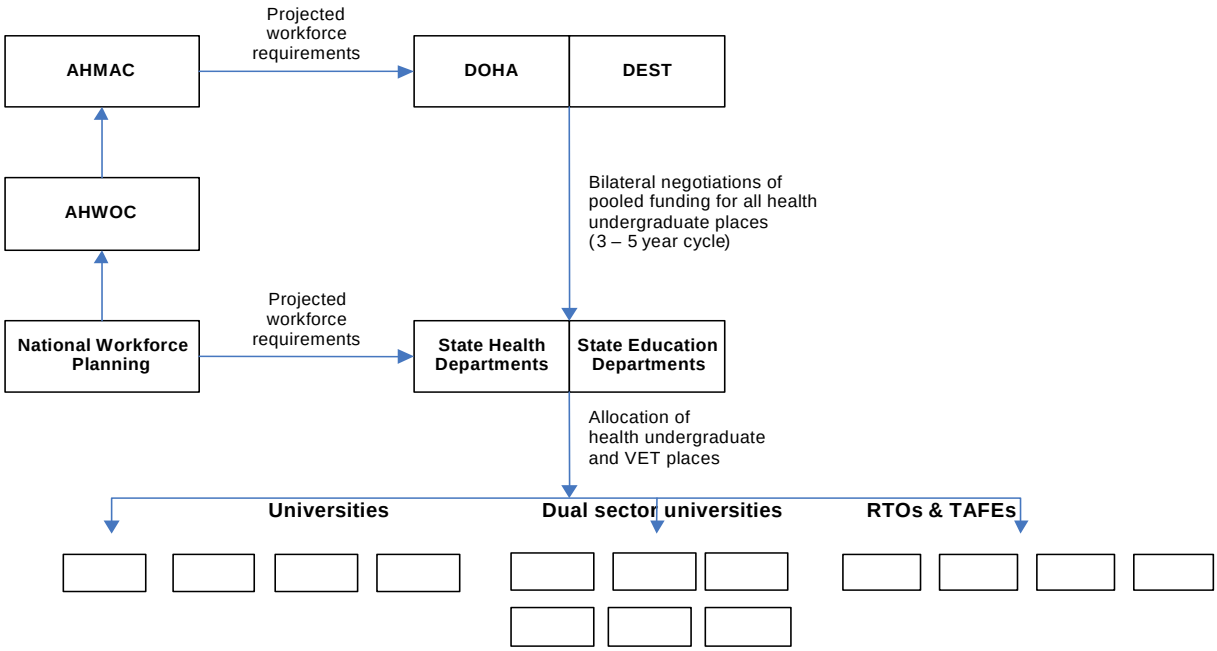
Victoria therefore requests that the Commission review its Draft Proposal and that it consider again Victoria's recommendation that the funding and allocation model for health education be changed to allow State/Territory control over the purchase of health education places from universities (Figure 3). Under this

model the Commonwealth would retain control of the overall budget envelope while each State and Territory would become responsible for:

- Determining and clearly articulating their health workforce needs.
- Determining which health education places should be purchased from universities and VET providers.
- Allocating clinical placements to support delivery of these courses.

A potential model could see the quantum of funds based on identified jurisdictional education and training needs, with these made available for States/Territories to determine the health education places to be purchased from universities and allocate clinical placements to support delivery. The agreement between the Commonwealth and each jurisdiction would clearly outline the purposes for which the funds were being utilised and the accountability and reporting requirements that jurisdictions and funded institutions would need to fulfil. It would provide a vehicle through which national training priorities could be preserved, State and Territory requirements be articulated, baseline training numbers could be negotiated and overall State and Territory education and training priorities could be balanced. It would also take into account the provision of education and training places for those health workforce professions and occupations that are required for service delivery in the smaller States and the Territories which do not have institutions that train the full range of health professionals and occupations

Figure 3: Proposed health undergraduate governance and funding arrangements



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.***

Victoria supports the functions proposed for the health workforce education and training council, but recommends that these be undertaken by the national health workforce and education improvement agency rather than by an additional body. The advantages of such an approach are identified in the response to Draft Proposal 4.1.

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.***

Victoria supports this Draft Proposal in principle, however, believes that:

- The undertaking of such policy work must also be under the auspice of Commonwealth, State and Territory Education Ministers as the current providers of some of the funding for clinical education.
- There is merit in the consolidation of funding responsibility for post graduate clinical health education and training in one level of government. Given the intertwined nature of training and service delivery, such consolidation could only occur at the State and Territory level, as the responsible funders and providers of service delivery. States and Territories do make decisions now around training that provide both educational outcomes as well as complement service delivery. If funding responsibility was vested with the Commonwealth it would simply exacerbate coordination problems and likely result in a situation where one level of government was making decisions on training that did not accord with service delivery requirements and decisions made by States and Territories.
- In considering both the consolidation of funding and explicit payment systems, it would be important for the costs to be formally recognised and accounted for in the overall multilateral negotiations between the Commonwealth, States and Territories for annual health and education budgets.
- Any examination of explicit payment systems for clinical training must be done in a manner that did provide unnecessary burdens on trainees that may further drive them to practise in the private system. This is discussed in more detail in Section 2 of this response.
- The purpose, structure and funding of clinical training – along with the challenges faced within the current system – vary between undergraduate, prevocational (which includes PGY1 and PGY2 years) and vocational (specialist) training components. Given the variation and thus the different potential solutions, there would be merit in recommendations pertaining to clinical training reflecting these components.

  For undergraduate training, the issues relate to:

  - The adequacy of – and responsibility for - funding of undergraduate clinical training
  - Creating capacity to meet forecast demand for clinical placements and as part of this, how a better alignment might be established between growth in training numbers and clinical training capacity.

  For pre-vocational training, there is a need to ensure that jurisdictions who receive growth in medical undergraduate numbers have sufficient capacity in health services to provide quality intern training years.

  For specialist training, the issues are more complex, and include:

  - The question of what clinical training costs, and to what degree those costs are potentially offset by the benefits obtained through the provision of services by trainees.
  - Issues of who should bear the cost of this training (trainees, employers and/or governments).
  - The sustainability of existing training models based on the apprenticeship model, in particular, the capacity of existing specialist training structures (predominantly the medical colleges) to meet forecast growth in workforce demand.

  For both undergraduate and pre-vocational training, establishment of formal governance structures that actively engage State and Commonwealth governments in collaborative workforce planning (such as the Victorian scheme outlined in the response to Draft Proposal 5.1) could improve the alignment between capacity and growth. The issue of specialist training, and in particular, how the costs of this are more equitably met into the future, is however likely to require substantially different solutions (such as those outlined in Section 2 of this response).
- The proposal to enhance transparency and contestability may assist in addressing some of the immediate funding issues, however it will not be sufficient to address the broader issue of effectiveness of clinical training.

  Victoria has spent more than 12 months working with representatives from both higher education and the public health system to examine how the relative costs and benefits of undergraduate clinical training are distributed. This project – and a précis of previous attempts to quantify the costs of clinical training (refer Appendix A) – have highlighted the difficulties in separating out clinical training costs from those of service delivery, and the large variations that exist both in costs to services and the training models themselves.

  Notwithstanding the potential difficulties in making funding more transparent and contestable, the diversity that exists and the likely pressures that workforce growth will place upon health services and

training bodies leads Victoria to advocate for an approach that seeks not just to make funding more transparent and contestable, but also creates capacity to judge effectiveness of clinical training.

Despite the Position Paper's suggestion that current capacity problems stem "from recent increases … that will be resolved over time" (p77), ongoing increases in training numbers will remain an important element of meeting forecast demand, thus jurisdictions will need to develop a clinical training regime that is sustainable in the face of such growth pressures.

Establishing a means through which effectiveness of clinical training can be assessed and models altered to maximise the effectiveness of this will be essential to achieving this goal. It could also provide a means through which the ongoing debate regarding whether existing graduates are 'job ready' could be progressed by codifying what the necessary outcomes are, and then exploring what might be done to optimise the preparation of graduates for work in the health sector, within available resources.

It is thus proposed that consideration be given to expanding Draft Proposal 5.3 to incorporate consideration of the cost effectiveness (rather than purely the cost) of clinical training. Whilst this represents a challenging task, it would assist all interested parties to better understand the relative costs and benefits of different training models and which are likely to be most sustainable into the future.

In conceptualising how outcomes are codified and assessed, consideration could be given to how the core competencies proposed for development as part of Draft Proposal 6.1 might be utilised, given the inherent links between course accreditation and clinical training requirements.

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.

Victoria supports the Draft Proposal for a single national accreditation agency for university-based and postgraduate clinical education and training, however, believes that it would be most appropriate to establish a single body that has responsibility for both accreditation and registration at a national level.

Inclusion of relevant VET courses is considered desirable and, in instances where such qualifications form the basis of statutory registration (such as those for Division 2 (enrolled) nurses) their inclusion will be essential to promote an integrated response.

The details of Victoria's model are contained in its response to Draft Proposal 7.2.

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.

Victoria supports this Draft Proposal.

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.

See response to Draft Proposals 6.1 and 7.2.

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.

Whilst Victoria's supports the Commission's intent to improve the operation of mutual recognition for the registration of the health workforce across Australia, having being commissioned by AHMAC in 2004/05 to develop the framework for implementation of nationally consistent medical registration, Victoria believes that

to extend such an approach to other registered professions will be a lengthy and protracted process as it involves attempting to harmonize existing jurisdictional statutory and policy variations.

Victoria believes that the most effective and efficient way to achieve this would be through the establishment of a national scheme for health practitioner regulation.

Victoria supports the Draft Proposal for a single national accreditation agency for university-based and postgraduate clinical education and training, however, believes that it would be most appropriate to establish a single body that has responsibility for both accreditation and registration at a national level.

The reasoning for such an approach lies in understanding how the current state and territory based scheme operates, and in particular, the relationships between registering and accrediting bodies.

Registration functions

In each jurisdiction, state registration boards grant registration to practice based on an assessment of whether:

- An applicant's qualifications are considered sufficient to equip them to practice safely in that jurisdiction (this may take into account formal qualifications, periods of supervised practice and/or completion of an entry examination).
- The applicant is of good character (or other similar tests that take into account previous disciplinary matters, indictable offences etc).
- The applicant is fit to practice (which involves assessment of whether there are any impairment or health issues).
- The applicant has sufficient competency in speaking or communicating in English to practice.

Whilst the specifics of these requirements vary, they are common to most registration Acts.

In addition to determining who may be admitted to practice, registration boards may perform a range of other functions, including:

- Renewal of registration, which may include assessment of continued competence to practice and/or reassessment of fitness to practice.
- Regulation of professional conduct or performance, which may include investigation, hearing and/or the imposition of sanctions against practitioners who are found to have engaged in unprofessional conduct or unsatisfactory professional performance.
- Management of issues arising from practitioner impairment.
- Promulgation of codes and guidelines regarding standards of practice and professional performance, and other related matters.

As the Medical Practitioners Registration Board of Victoria notes, the policies and statements it has released on "specific issues relating to medical practice… are designed to support the profession by clarifying the Board's views and expectations on a range of issues"[3]. In investigating disciplinary matters, boards will often draw upon relevant policies and statements – as well as information from other sources - in determining whether a practitioner's conduct and/or performance is acceptable.

The scope and specificity of codes and guidelines issued vary between boards. Many of the issues are common to all registered health professions, and relate to issues such as informed consent, infection control, advertising and professional boundaries. In other instances, boards also use these guidelines to provide guidance in relation to specific practice issues. For example, the Optometrists Registration Board of Victoria's *Protocols and Guidelines for Therapeutic Drug Use by Endorsed Optometrists* describe how optometrists with prescribing rights should practice and the Nurses Board of Victoria's *Guidelines Delegation and Supervision for registered nurses and extended scope of practice for the division 2 registered nurse* similarly set standards around what various nurses can do and under what circumstances.

It is also worth noting that in some instances, guidelines issued by registration boards may also use the competency standards developed by the profession and/or a national accrediting body as their basis. For example, the Podiatrists Registration Board of Victoria's *Code of Conduct* requires all registrants to meet the practice standards articulated in the Australasian Podiatry Council's Competency Standards.

Accreditation processes

All bodies undertaking course accreditation have established guidelines which typically outline:

- The process to be followed, including timeframes, information required, costs, membership of accreditation panels, potential outcomes and appeal mechanisms.
- The framework against which the accreditation will be conducted, which would usually include broad statements around what staffing, infrastructure, curriculum and other elements of the course will be required to satisfy.

[3] Accessed from http://medicalboardvic.org.au/content.php?sec=34 on 28 October 2005.

There is a high level of commonality in these guidelines across professions. For illustrative purposes, Figure 4 provides an example of how the Australian Council of Physiotherapy Regulating Authorities, ACOPRA, describes its role and the standards used in the accreditation process

In addition, a range of accrediting bodies utilise profession specific competency standards as the benchmark against which course outcomes are assessed. These competency standards are discipline specific and have typically been developed by the associations representing the individual professions[4].

Recent research commissioned by the Victorian Department of Human Services found that, whilst most health and allied health professions have competency standards or are in the process of developing them, these are not expressed in a consistent form and the level of detail varies significantly.

Figure 4: Accreditation of physiotherapy courses in Australia

The role of ACOPRA is to evaluate the physiotherapy education program and the capacity of the institution offering the award in physiotherapy to do so according to specified standards. Accordingly, ACOPRA will consider not only the curriculum and the process of education, but also the mechanisms employed to ensure quality outcomes, the resources available and the performance of graduates. Issues relating to student selection and progression, staff expertise and opportunities for development, and secure arrangements for supervised clinical practice will be addressed.

ACOPRA in carrying out the accreditation process, evaluates submissions from institutions for accreditation of physiotherapy education programs against two Standards and the extent to which the institution and the program comply with these Standards must be demonstrated.

These Standards are the Standards for Accreditation of Physiotherapy Education Programs at the Level of Higher Education Awards *and the* Australian Physiotherapy Competency Standards*.*

The Standards for Accreditation of Physiotherapy Education Programs at the Level of Higher Education Awards are five in all. These are:

1. The outcomes of the program through the performance of the graduates

2. The process of education

3. The mechanisms employed to ensure quality outcomes

4. The resources and physical environment

5. The curriculum.

Source: http://www.acopra.com.au/accreditation/acopra_role

Relationship between accreditation and registration bodies

Section 8.2 of the Victorian submission to the Commission provided details of the structure of national accrediting bodies. As it noted, these bodies have typically been established through agreement between jurisdictional registering authorities and, in some instances, as an initiative of, or in cooperation with, the respective peak professional associations.

Some are funded through contributions made by the respective registering authorities, as well as by fees charged for examinations and course accreditations. Most are governed by boards comprising nominees that include state registering authorities, although in some instances, such as psychology and podiatry, the respective peak professional associations play a pivotal role and nominate most of the delegates. Relatively few include consumer representatives or members who are not registered in the relevant profession.

A consolidated approach

Whilst the relationships vary between professions and across jurisdictions, it is clear that there are critical interrelationships – and in some instances overlaps – between registration and accreditation bodies:

- Whilst most registration boards maintain statutory responsibility for determining whether qualifications of applicants are suitable for registration purposes, they often delegate assessment of these (and those of applicants with international qualifications) to accrediting bodies.
- The standards upon which course accreditation is based may include use of professional competency standards which have been developed by the profession's representative association and/or the accrediting body.
- Some registration boards also utilise such standards in issuing guidelines regarding expected practice standards and/or assessing allegation that registrants have engaged in unprofessional conduct and/or unsatisfactory professional performance.

[4] The Australian Government funded a project in 1992 to establish entry-level competency standards for the professions and in 1994 funded projects to develop examination procedures to test these competencies. The competency standards for some of the health professions developed through those projects have been revised over time and are those utilised by some of the accrediting bodies.

Under the current scheme, accreditation standards (which often draw upon or refer to professional specific competency and/or professional standards) in effect set qualifications requirements for registration and may also form part of disciplinary processes. Registration boards will issue codes and guidelines which provide advice on issues of interpretation and set expectations around how practitioners will be judged against such standards, where these exist.

It is Victoria's view that to achieve a cohesive, forward focused approach to registration and accreditation, a consolidated approach – in which a single, national body assumes responsibility for both functions - is required. Whilst the identification of competencies, assessment of curriculum and courses and the assessment of qualifications is a large and primarily education focussed task, the development of standards upon which a professional is regulated is inherently linked to professional competencies and the standards of practice they set. It is critical that an integrated continuous feedback loop is provided that ensures that the registration and disciplinary functions relating to good practice inform the review and amendment of national practice and education standards to remain contemporary and reflect changing service needs.

Combining these functions would ensure a more systems based approach to the development and maintenance of professional standards and the range of instruments through which these are given effect (including accreditation standards and disciplinary processes conducted as part of ongoing regulation). Combining the registration and accreditation functions would also ensure that the model would be impartial and independent and could continue to be self funding through practitioner registration fees.

The Productivity Commission's proposal that a cross-disciplinary approach to accreditation has been challenged by a range of parties, citing concerns that it will compromise professional independence, reduce the willingness of practitioners to participate in accreditation processes and/or dismantle a profession-based scheme which is not considered to be broken.

Victoria supports a cross-disciplinary approach to accreditation and registration as it would:

- Promote greater consistency in registration and accreditation processes and professional standards, which would have benefits to consumers, generate economies of scale (with flow on benefits to registrants) and support development of technical expertise in relevant areas.
- Improve transparency and accountability, by ensuring both accreditation and registration processes were subject to an appropriate level of scrutiny beyond the regulated profession
- Support development of interprofessional education models and other developments that promote more client-centred, streamlined models of care

Such a model could build upon the strengths of existing models but improve the consistency of regulatory arrangements across the registered health professions and facilitate implementation of best practice regulation. It would also better support the development and deployment of a more flexible multi-skilled workforce by reducing demarcation disputes between professions and facilitating implementation of more flexible scopes of practice. It could improve transparency by consolidating reporting arrangements for all the regulated health professions, improving procedural fairness of processes, simplifying arrangements for consumers and improving overall confidence in the independence of the regulatory system.

A body set up under such a model would comprise a mix of professional, legal, government, health, education and consumer representation to ensure the public interest remains paramount. The model must have continued involvement of professions it regulates to ensure its effectiveness, safety and quality and engagement of those professions. As the recent review of health professions in Victoria noted, retaining the principles of peer review, and thus active involvement of individuals with professional expertise in regulation of the various professions, is an important element of the existing system that should be retained.

The governance arrangements for the agency should include capacity for appropriate accountability to governments, including the capacity for national Ministerial oversight and direction. Given the range of functions proposed for the agency it will need to have capacity and resources to operate nationally but with an appropriate State and Territory presence.

A well established precedent exists for such an approach in the United Kingdom, where a Health Professionals Council has been established to undertake these functions across a range of the health professions. Details of the scheme are provided in Appendix B.

Whilst the UK Council does not include all health practitioners currently registered in Australia (for example, medical practitioners and nurses are registered by separate councils), given that the number of registered practitioners is significantly lower in Australia and the policy intent is to achieve better cross-disciplinarity, Victoria would advocate for all professions who are registered all in States and Territories to be included[5].

[5] It may not be practical to include professions who are only registered in some jurisdictions, such as occupational therapists and Chinese medicine practitioners.

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.

Victoria has reservations regarding the benefits of such a proposal, and whether it necessitates a legislative solution.

It is understood that Professor Duckett's proposal to legislate for task delegation is based on the model in Ontario, Canada. The Ontario *Regulated Health Professions Act,* 1991 regulates "controlled acts", which may only be performed by certain health professions. In this more restrictive regulatory scheme, the power to delegate tasks is necessary to provide for a degree of flexibility beyond the legislated scopes.

By contrast, the Victorian regulatory model of health practitioner legislation, as with most other jurisdictional schemes, is based on reservation of title only, which provides for a much greater level of workforce flexibility. With the exception of some core practice restrictions for dentistry and optometry, Victoria's registration legislation does not define the scopes of practice for registered health professions.

Some registration boards have, in the past, issued guidelines that have had the effect of restricting scope of practice. However, the *Health Professions Registration Bill* 2005 currently before Parliament would establish requirements for registration boards to seek Ministerial approval and consult widely when setting standards and issuing codes and guidelines that may adversely impact on scope of practice.

Within the Victorian scheme for health practitioner registration, statutory delegation is not considered to be necessary and would require substantial changes to the legislation both to define the scope of tasks to be delegated and who could participate in such a scheme. This would be likely to reduce the flexibility that currently exists.

The concept of providing a statutory mechanism for a professional to delegate a task operates on the assumption that that task is the exclusive domain of that practitioner on the first instance. Under the model proposed by the Commission, and as further proposed in this response, a single Health professions registration, standards and accreditation body would set the standards and competencies for each profession and would be the mechanism by which a professional could undertake an activity in their own right. In this situation delegation would not be required.

People who participate in the health workforce operate at different levels in relation to the complexity of care to be provided, their competencies and experience. Those health occupations providing complex care that involves significant risks need to be able to present themselves to health care consumers as competent and consumers and their advisers need the benefit of assurances to that effect, through statutorily based registration systems that operate in the public interest.

Not all health occupations require the regulatory requirements of a statutorily based scheme or the authority of a statutorily based delegation from a health professional. In support of this the national Community Services and Health Industry Skills Council has developed assessable competencies for a large range of health occupations that provide services as part of the health care system. Health workers who have attained these competencies are, and should continue to be, afforded the right to perform tasks or roles through their employment consistent with the competencies that they have attained without the need for statutory, or a registered health professional, delegation.

The purpose of delegation as proposed by the Commission appears to be based on the need to ensure quality and safety and to provide payer validation in terms of the MBS. In relation to the former, there are a range of factors that operate to ensure that health practitioners provide safe quality care. The legal system imposes a range of obligations through common law and statutory obligations to observe a duty of care and the liability that attaches to failure to meet the required standard. These obligations are reinforced financially through the cost and provision of professional indemnity and other insurances.

Delegation occurs in health services currently in many individual situations. A model of more systematic and effective delegation could be developed through clinical governance regimes within health services. Health service approaches to credentialing and clinical privileging, currently utilised for medical practitioners, could be expanded to provide an effective approach to setting the scope of practice and enabling effective delegation to other health professionals.

In July 2004, the Australian Council for Safety and Quality in Health Care developed a National Standard for credentialling and defining the scope of clinical practice of medical practitioners, for use in public and private hospitals.

- Credentialling is the formal process used to verify the qualifications, experience professional standing and other relevant professional attributes of practitioners for the purpose of forming a view about their competence, performance and professional suitability to provide safe, high quality health care services within specific organisational environments.

- The scope of clinical practice is part of credentialling and involves delineating the extent of an individual practitioner's clinical practice within a particular organisation based on the individual's credentials, competence, performance and professional suitability, and the needs and the capability of the organisation to support the medical practitioner's scope of clinical practice.

The processes of credentialling and defining the scope of clinical practice must enable health services to be confident that health care professionals' performance is maintained. Ongoing performance, however, also relies on support being provided by those services to the extent necessary to enable safe, high quality practice. There is an increasing recognition that health services have a legal responsibility to ensure that services are provided in circumstances where the safety and quality of health care have been properly addressed. Given this, setting the scope of practice and allowing effective delegation to other health professionals may often be in the context of the facilities and clinical and non-clinical support services available to enable the provision of safe, high quality health care in the specific organisational setting.

Organisational governance arrangements must therefore incorporate effective systems for supporting, monitoring and responding to the performance of individuals, clinical teams and the organisation as a whole. Processes of credentialling and defining the scope of clinical practice of practitioners should be integrated within these comprehensive governance systems.

Victoria is of the view that such an approach could be expanded to many health professions and practice situations (include sole practitioners) in a way that would encompass quality and safety, effective scope of practice and efficient delegation in an integrated manner with other quality and safety systems.

Victoria also recognises that there may be scope for considering delegation of tasks associated with the prescribing of drugs, and that this could potentially require amendments to drugs, poisons and controlled substances legislation. There could, for example, be scope to consider empowering practitioners already authorised to obtain, use, supply and sell certain drugs, poisons and controlled substances, to delegate their legislated authority to a suitable trained practitioner. As the practitioner delegating the function retains clinical responsibility, this could potentially facilitate more effective use of available workforce whilst providing statutory protections for those persons to whom the function has been delegated.

Further work is required to progress development of any such delegation proposal. An assessment of the relative risks and benefits would also be essential at an early stage, given the concerns of a range of stakeholders that any such moves would potentially compromise public safety. The question of whether legislation is required to provide sufficient protections for all parties (or whether, for example, the same effect could be achieved through administrative or clinical governance means) also requires further exploration before a final proposal could be progressed. In relation to payment validation for the MBS, Draft Proposal 8.2 outlines a scheme in which delegation would form a mechanism through which non-medical providers could obtain access to MBS rebates. Given the views above, and the additional comments made in the response to Draft Proposal 8.2, Victoria is of the view that delegation may not be necessary to achieve the stated policy objectives and, if incorporated into statute, may actually reduce the current flexibility that exists in the Victorian health practitioner registration system.

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 subsidised 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.

Victoria supports this proposal, considering reform of funding mechanisms to be an essential step towards achieving the best possible utilisation of our health workforce.

It is however recognised that it is likely to take a significant time period to implement these structural reforms, particularly given that it would involve changes to the governance and functions of existing committees. Given the importance of progressing changes to MBS and PBS to address the issues identified in the Victorian submission, Victoria would encourage the Productivity Commission to nominate some areas identified through its study where shorter term changes could be progressed (within existing structures if necessary during the transition period).

This could involve existing committees reviewing MBS funding of specialty services to remove disincentives in areas of known specialty shortage such as geriatric medicine, general medicine, rehabilitation medicine,

paediatric orthopaedics and other paediatric sub-specialties. Since the time the Victorian submission was made, further analysis of trends in the Victorian medical specialist workforce has been undertaken. Whilst it is acknowledged that MBS rebates are not the only drivers of decline in these specialties, changes to remuneration are considered likely to have a substantial impact in arresting current declines.

Figure 5: Victorian medical workforce trends

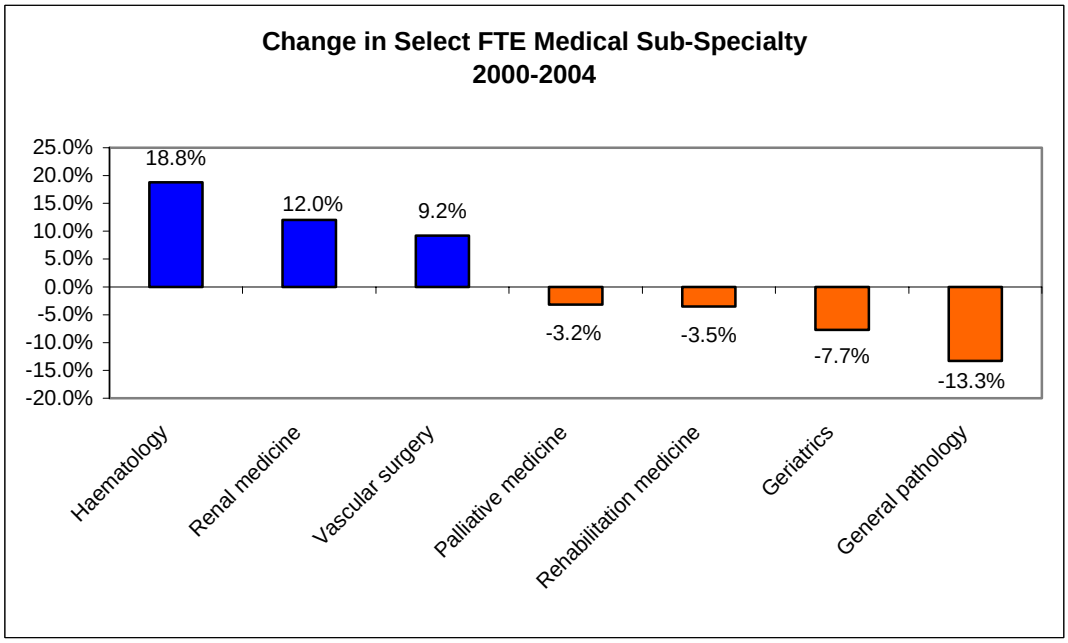


Figure 5 illustrates that, in the 4 year period between 2000 and 2004, there were significant decreases in the number of medical practitioners working in palliative medicine, rehabilitation medicine, geriatrics and general pathology. Whilst Victoria is not suggesting that remuneration is the primary driver of this change, its submission noted that the lower income of the generalist and non proceduralist is a factor in the lack of interest amongst trainees in generalist specialties.

Given the ageing population and forecast burden of disease, it is essential that steps be taken to arrest this decline. Reviewing the system of payments, as proposed in the Victorian submission, to ensure that remuneration does not discourage entry to the more generalist professions is an important element of this.

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.

In principle, Victoria support changes to the MBS where these are likely to create positive incentives to more effective workforce utilisation and ultimately, public access to quality services.

The arguments in support of a delegation proposal cited by the Productivity Commission are acknowledged, in particular the potential for such a mechanism to encourage medical practitioners to utilise other health professionals whilst managing potential financial risks associated with unfettered growth.

Victoria does, however, have concerns that the proposal's continued reliance on the involvement of a medical practitioner would not address current inefficiencies that arise within the current scheme nor address issues raised in the Victorian submission regarding access to services in areas of designated shortage. Where there are shortages of medical practitioners a system of delegation of services is not practicable as medical practitioners may not even be available to provide that delegation.

The Victorian recommendation to trial limited access to medical and pharmaceutical benefit entitlements for non-medical practitioners in areas of designated GP shortages (recommendation 11) was proposed as an alternative means of achieving these goals, but in a manner that enables independent practice to continue for a range of health professions. This is considered essential to improve access to services and make best use of our expert medical workforce. This issue is explored further in Section 2 of this response.

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.

Victoria supports this Draft Proposal, noting that establishment of such a body should be considered as part of a broader review of the scope, function and structure of all national workforce committees.

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.***

Victoria supports this Draft Proposal.

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.

Victoria supports this Draft Proposal.

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***.

Victoria supports this Draft Proposal.

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

Victoria supports this Draft Proposal.

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.

Victoria supports this Draft Proposal.

2 Issues requiring further consideration

2.1 Increasing supply through the use of overseas trained health practitioners

As outlined in its response to the Commission's Draft Proposal 3.1, Victoria understands and considers it needs to operate in a global labour market for health professionals and it is appropriate to draw on suitably qualified, overseas trained, professionals to supplement the locally trained workforce, and to recognise that its own health workers will migrate to other countries.

In the absence of substantial increases in locally trained individuals, Victoria's reliance on internationally trained practitioners will remain and potentially increase. For example, in 2005, 8.5 per cent of the overall Victorian medical workforce is made up of internationally-trained graduates, up by 35 per cent since 2000.

Public health services are not currently funded to meet the significant costs in recruiting, assessing the suitability of, and training and supervising international practitioners, which effectively shifts the cost of medical training from the Commonwealth to the States and Territories.

Use of overseas trained practitioners provides a cost saving to the education system. In the absence of improving local supply, or as an interim measure whilst new graduates are trained, Commonwealth funding to public health services should reflect the additional costs associated with utilising overseas trained practitioners.

Recent events in Queensland have highlighted the need for systems that adequately assess qualifications as well as the clinical skills of practitioners. Victoria has developed a "safe practice assessment" model, which tests the clinical skills, and medical knowledge of international medical graduates prior to registration.

Individual state and or medical specialist college based schemes to assess doctors are in place, however, these are sub optimal as each applies different standards. This requires practitioners to undergo multiple assessment processes if they move interstate. It also may encourage practitioners to shop across jurisdictions to find the least stringent entry requirements.

A model should be developed that allows a consistent standard to be applied across Australia for the assessment of both qualifications and clinical skills. Victoria provided its model of assessment to the Commonwealth in March 2004 and is strongly supportive of establishing national standards.

Recommendations

1. ***That, until the numbers of locally trained health practitioners meet demand, transitional Commonwealth funding is provided to public health services to meet the additional costs associated with recruiting, assessing the suitability of, and training of internationally trained health practitioners.***
2. ***That the Commonwealth lead the development of a national scheme for the assessment of the qualifications and skill of internationally trained practitioners, focussing on medicine in the first instance.***

2.2 Influencing the distribution of the workforce

As previously advised, Victoria is supportive of the Commission's Draft Proposal 10.3 that the Australian Health Ministers' Conference should initiate a cross program evaluation exercise designed to ascertain which approaches are likely to be most cost-effective in improving the sustainability, quality and accessibility of health workforce services in rural and remote Australia.

In its initial submission, Victoria also outlined a number of potential actions that could be taken at a national level that would provide a positive impact on workforce distribution across Australia.

Education and training

The strong clinical focus of health education requires significant involvement of qualified practitioners and health services in education and training.

Students reinforce their theoretical learnings in undergraduate and some post-graduate courses through clinical placements. These compulsory placements vary in length, depending on the course and year level. Their delivery also varies between 'blocks' of clinical study, where the student is attending a clinical setting for a period full time, to a regular weekly or monthly visit spread across the academic year.

Although placing additional obligations on health services, studies have shown that clinical placements are an effective way of attracting staff. This may be particularly important in rural areas, where adequate academic infrastructure will likely attract suitably qualified staff and thereby support clinical placements.

While there are obvious benefits from expanding the current requirements to undertake rural clinical placements as part of the training experience at both undergraduate and post graduate levels, the capacity of some students to do so is limited by factors such as the cost of travel and local accommodation. A subsidy to undergraduate students to support greater uptake of rural clinical placements and training posts should be established as a legitimate component of the funding provided by the Commonwealth.

Victoria believes that that mandatory rural rotation requirements as part of any clinical training program have been one of the more effective strategies to both expose practitioners to the rural environment and rural practice, whilst at the same time providing valuable services to rural communities. These should be applied systematically across all undergraduate and post graduate training programs and increased to a minimum 6-month period wherever possible. Mandatory rural rotations should also be encouraged for advanced training programs.

Trainees advise that, if their broader experience gained from rural rotations (such as the clinical experience, procedural opportunities) were recognised, they would be more sympathetic to rural placements. These incentives could include priority access to sub specialty rotations and merit points towards advancement opportunities (including selection to advanced training positions in sub specialities).

Trainees believe that, despite the promoted benefits of rural training, this is not reflected in the structure of the training program. Their common perception is that rural rotations detract from career advancement (such as recruitment to sub- specialist rotations, advanced training posts) as they are removed from tertiary teaching hospitals. If the benefit of rural exposure was recognised and factored into the selection processes for advanced training and sub specialty training, trainees might consider rural rotations more favourably.

Recommendations

3. ***That the Commonwealth develop options for providing subsidies to students undertaking rural clinical placements to encourage greater uptake.***
4. ***That the Commonwealth, States and Territories negotiate nationally with medical specialist colleges mandatory rural rotations of 6 months or more for vocational trainees provided places are available, and with other professional colleges for rural rotations in the preregistration year or postgraduate courses.***
5. ***That the Commonwealth, States and Territories negotiate nationally with medical specialist colleges to develop advanced recognition/accelerated progression or other similar incentives in their training programs to encourage rural rotations.***

Funding mechanisms

The Victorian submission to the Productivity Commission identified a range of impediments to more effective workforce utilisation within existing funding mechanisms.

With MBS rebates predominantly limited to services provided by medical practitioners, there is a disincentive for patients to seek services from other practitioners (such as allied health providers or nurse practitioners), despite this potentially offering an equivalent – and in some instances, more accessible – alternative.

The potential for these restrictions to actually increase costs was also noted, through duplication of effort, delays in commencement of treatment and suboptimal deployment of skills. As the Victorian submission noted, changes to the MBS could be a positive incentive, particularly in areas of designated workforce shortage to:

- Improve workforce supply by allowing other practitioners (such as suitably qualified nurses and/or allied health providers) to perform substitutable services. This would also improve job satisfaction and ultimately, positively impact workforce retention.
- Encourage health professionals to set up private/public practices in areas of workforce shortage.

Within this context, and taking into account the comments made in response to Draft Proposal 8.2, Victoria would strongly encourage the Productivity Commission to reconsider its recommendation that the Commonwealth trial limited access to medical and pharmaceutical benefit entitlements for non-medical practitioners in areas of designated GP shortage (recommendation 11 in its original submission).

The need to address the current structure of MBS payments (and the disparities between procedural and generalist specialties) was also identified in the Victorian submission, however the current Draft Proposals do not address this. The importance of this has been emphasised in the Victorian response to Draft Proposal 8.1, which advocates for a review of this issue to be progressed as a priority over the short term whilst broader governance reform is progressed.

Recommendations

6. ***That greater alignment be achieved between allocation of MBS funding and service need by trialling mechanisms including:***
    - ***Increased remuneration for consultative rather than procedural items to address the complex needs of the ageing population***

- ***Increased remuneration for less attractive specialties such as geriatrics, psychiatry or specialties involved in prevention activities on agreed targets eg screening.***
- ***Differential payments for items performed in outer metropolitan, rural and regional areas.***
- ***Allocation of provider numbers to take account of relative over and under-supply in a given geographic area.***
- ***Limited non delegated access to medical and pharmaceutical benefit entitlements for non medical practitioners commencing in areas of designated GP shortage.***

Taxation and superannuation

The Victorian July submission proposed that the Commonwealth consider a range of changes to fringe benefits tax exemptions to increase the attractiveness to health professionals of working in areas of designated workforce shortage (recommendation 13). Whilst the Productivity Commission paper noted that taxation policies have an influence on the recruitment and retention of the health workforce, it did not make any recommendations regarding how these might be used to address issues of health workforce distribution.

Given that the health workforce operates in both the public and the private sector, Victorian maintains that Fringe Benefits Tax (FBT) exemptions, appropriately targeted, could be viewed as a cost-effective measure to attract workforce, as exemptions can increase affordability for both employees and employers. For instance, health professionals working in public hospitals and state-funded ambulance services have access to exemptions from Fringe Benefits Tax (FBT) capped at $17,000. This is an important financial attractor that keeps them in the public system. That the Commonwealth Government allows this exemption indicates that it is also aware of the importance of maintaining adequate financial remuneration for health professionals in the public hospital system.

Victoria would also encourage the Productivity Commission to reconsider some of the potential opportunities to more effectively use these levers to effect necessary health workforce change. Research to identify potential opportunities in this area was commissioned by Victoria as part of developing this submission and a copy of this research, undertaken by Ernst & Young, is provided at Appendix C. Options identified in the submission included:

- Introducing annual indexation to the $17,000 FBT cap for public hospitals and not-for-profit private hospitals delivering services in areas of designated workforce shortage. This would allow a higher taxable value of fringe benefits to be made available to employees who were prepared to relocate to regional, country and remote areas without the employer incurring additional FBT. This would enable public hospitals and not for profit private hospital employers to offer more financial support to employees who are prepared to relocate to regional, country and remote areas.
- Broadening the availability of the $17,000 FBT cap to employers other than those that currently qualify for such benefits.
- Exempting or reducing the taxation applied to the provision of housing. Housing benefits to employees in the health sector (for relocation purposes) could encourage more practitioners to move to and remain in regional, country or remote areas. Currently, housing benefits attract FBT in full unless the employee is working in a remote area and certain conditions are satisfied.
- Exempting all relocation and living away from home costs from FBT. At present, only specific relocation costs are exempt and these exemptions are usually bound by specific conditions. Extending exemptions to include paying out the remainder of a rental agreement entered into prior to the relocation, costs to ensure the new house is in a suitable condition to relocate and acquisition of any additional and necessary household furniture or equipment, could provide a beneficial incentive.
- Exempting boarding fees from FBT for children of health professionals. Health care professionals with school-aged children may be reluctant to relocate to regional, country and remote areas due to the disruption of their children's education and the costs associated with placing children in a boarding school. Boarding school fees and the costs of travel between the boarding school and the regional, country or remote area could be exempted from FBT. This would likely provide comfort to health care professionals by allowing them to leave their children in the same educational environment.

The Commonwealth has recently implemented reforms associated with allowing people who are still in the workforce to access their superannuation as a non-commutable income stream once they reach their preservation age. This reform should provide an incentive for older members of the health workforce to stay in the workforce. In light of the workforce pressures facing the health sector (and other industries) it is appropriate for this reform to be reviewed to consider whether further adjustments to superannuation policy could provide additional incentives (and minimise disincentives) for people to choose to stay in the workforce post preservation age.

Recommendation

7. That the Commonwealth consider a range of changes to fringe benefits tax exemptions to increase the attractiveness to health professionals of working in areas of designated workforce shortage and service need.

2.3 Private sector contribution to education and training

The Victorian submission proposed that the Commonwealth, States and Territories work together to develop a national scheme that provides fiscally efficient mechanisms for recouping subsidies to health professional education that leads to private sector employment (recommendation 17).

This was considered to be an important aspect of achieving a more sustainable training and service delivery system, taking into account the increasing number of services being delivered in the private sector and the commensurate increase in the number of practitioners who work in the private sector after completing training in a public health service. It was argued that as private health service providers benefit from the availability of a trained health workforce, they should make some contribution towards the cost of that training.

The Productivity Commission's position paper recognised that public hospitals suffered "a competitive disadvantage relative to their private counterparts because of the greater onus on them to fund clinical training from service delivery budgets" (p82), but concluded that this was due to lack of explicit government funding. In doing so, the assumption was made that government should continue to have sole responsibility for funding such training, and that requiring private providers to contribute to such costs would be inferior to making explicit government support for clinical training. There is also the suggestion that if any party is to be levied, it should be the trainee, to whom the individual benefits accrue.

Whilst Victoria recognises the benefits of making training costs more explicit, it does not believe this will be sufficient to meet current or forecast demands, nor address the recognised disadvantage borne by the public system. Indeed, given the changing nature of the market for health service provision and the workforce challenges faced by the public sector in competing for increasingly scant staff, Victoria maintains that establishing an obligation for the private sector to contribute to training is essential, and that failure to expand capacity and funding in this area will compromise system sustainability and potentially impede delivery of some services through the public health system in the future.

This issue is of particular importance in relation to medical specialist training. Since the time the initial Victorian submission was made, further analysis has been undertaken to examine trends in private sector employment across medical specialties. As Table 1 illustrates, there have been significant changes in the relative proportion of medical specialists working in the private sector over a 4 year period.

Table 1: Trends in public/private work – Victorian medical specialties

	2000			2004		
	Public Only	Private Only	Public & Private	Public Only	Private Only	Public & Private
Anaesthesia	20.6%	15.8%	63.6%	21.1%	25.5%	53.4%
Dermatology	1.0%	49.5%	49.5%	5.4%	47.3%	47.3%
Emergency Medicine	82.4%	8.8%	8.8%	83.9%	1.7%	14.4%
General Practice	8.1%	75.6%	16.3%	7.1%	77.7%	15.2%
Obstetrics & Gynaecology	10.3%	19.0%	70.7%	9.1%	26.9%	63.9%
Ophthalmology	2.9%	35.3%	61.8%	0.8%	36.7%	62.5%
Pathology	43.9%	42.2%	13.9%	40.3%	39.3%	20.4%
Physician	20.2%	21.3%	58.4%	20.1%	27.9%	52.0%
Psychiatry	11.8%	49.8%	38.4%	14.1%	50.8%	35.1%
Radiology	30.5%	33.1%	36.4%	27.5%	39.7%	32.9%
Surgery	10.2%	22.9%	66.9%	9.0%	32.4%	58.6%
Other specialties	17.8%	42.6%	39.6%	41.1%	30.8%	28.0%
Total specialties	13.5%	50.0%	36.5%	13.1%	54.6%	32.3%

Of particular interest is the increase in private only practice in disciplines such as surgery, radiology, anaesthesia and obstetrics and gynaecology, which suggests that in such areas, the relative return on government investment (in terms of return to the public health system) is diminishing with a commensurate growth in benefits accruing to the private system.

This raises a range of challenges for the broader service system. If there are proportionally fewer staff working in public settings, there will be less capacity to solely train in those settings and alternatives (that ensure access to sufficient service volume and appropriately qualified supervisors) will become essential. Given that specialist trainees can generate revenue (in part through Medicare benefits, if they qualify under

s3GA of the Health Insurance Act), it seems reasonable that private providers, like their public counterparts, meet at least some of the costs of training rather than these being met through direct state government investment.

Within this context, Victoria continues to believe that establishment of a national levy or other mechanism to secure a contribution from the private sector for the implicit subsidies to their future workforce is both justified and necessary. As previously stated, such a levy should ideally ensure that the level of training obligation is commensurate with the private sector provision within the market. Thus in Victoria, an area such as pathology, which is largely delivered through the private sector, would have a relatively high level of training obligation compared to other disciplines that predominantly work in the public health sector, such as geriatric medicine.

8. That the Commonwealth, States and Territories work together to develop a national scheme that provides fiscally efficient mechanisms for recouping subsidies to health professional education that leads to private sector employment.

2.4 Trainee contribution to education and training

Victoria acknowledges that service delivery is also supported through the structure of clinical training, particularly for post graduate clinical education and training and that a component of training costs should therefore be funded from service delivery budgets. It should, however, be understood that trainees at the post graduate level, as well as some undergraduates or pre-registrants, are also remunerated for that service delivery function. Whilst the Commission has made reference to a trainee contribution to the cost of clinical training it has not provided any specific proposals in this area.

The Victorian submission proposed that the Commonwealth, States and Territories work together to develop a national approach to ensure that public sector investment in education and training is recognised, particularly for those health professions who gain substantial private practice opportunities as a result.

Victoria believes that increasing the student contribution would provide little immediate impact on workforce distribution and risks encouraging graduates to pursue more remunerative career choices in private practice. The potential for such a trainee contribution to further distort workforce distribution away from public provision and specialty areas such as those discussed in the Victorian response to draft proposal 8.1 is considerable.

Return for service obligations for health graduates could be an alternative mechanism through which governments and the wider community could achieve a greater return on the substantial investment made in education and training. This approach could address current and forecast workforce maldistribution in a similar way to the Commonwealth government's bonded medical places.

Requiring students to commit to work either within the public sector or to treat public patients in their private practice for a defined period after graduation would immediately impact on supply and distribution, particularly in designated areas of need. The length of the public service obligation could be varied to take into account the level of prior public investment to training, the likely opportunities for private practice and the ability to achieve private returns. Graduates could avoid this obligation by repaying a determined fee, which would be used to provide additional training opportunities to future graduates. Similar schemes could also be developed to distinguish the various health sciences professions, in particular those who have a substantial internship requirements as a prerequisite for registration, such as pharmacy, clinical psychology and medical radiation.

Any scheme to offset high private returns gained through public sector training provision should be implemented nationally in order to harmonize relationships with the existing HECS arrangements and to ensure that graduates do not avoid their public responsibilities by moving from one jurisdiction to another.

Recommendation

9. That the Commonwealth, States and Territories work together to explore options for a national scheme that ensures graduates who do not work in the public sector either contribute towards the cost of clinical training, or treat public patients in their private practice for a defined period after graduation.

Appendix A: Clinical training costing studies

Overview

Review of funding of Clinical Training in the Health professions (Coopers & Lybrand 1994)

This study was commissioned jointly by DEET and the Department of Human Services and Health (DHSH) to quantify overall costs of the clinical training across a range of health professions.

The study details a list of national average cost estimates for training specific professions. The more detailed précis in a later section of this Appendix provides more information on determinations around costs and benefits, and also contains a list of the costs determined. It is important to note that some of these have been determined to produce a net benefit rather than cost.

The report notes the heuristic method used in the costing exercise has largely produced results from the pilot sites that have been accepted by the field in regard to the definition of components costed, benefits associated, profiles of structure of clinical training and respective roles of health/education sectors and the resulting estimates.

The measurement of benefits is largely subjective in nature and needs to be recognised as such, although some concern has been expressed that the exclusion of intangible benefits produces higher cost estimates and may thereby encourage hospital administrators to reduce the amount of clinical training. Similarly, the costs produced also persuade non-training agencies (private hospitals) not to enter into clinical training because of the cost imposition. The report therefore recommended further investigation of the range of benefits available.

The report goes on to identify a series of policy issues to be addressed, centering around; changing clinical education (particularly in medicine) to reflect the increase in ambulatory care, research on and development of more cost effective modes of training, and whether funding for clinical education should become "contestable" as an incentive to reduce costs.

La Trobe University (1994)

The purpose of this study was not to determine a cost or methodology for teaching and training, but rather address some of the problems around clinical placements and propose a funding policy. Under the proposed policy, money would have been transferred from health service budgets to universities, in order to enable them to pay health services on a fee for service basis for the provision of clinical training. The paper also discusses various options for the implementation and administration of the policy.

South Australia (1994)

This study set out to attribute specific costs to graduate teaching, training and research. However, teaching and training of undergraduates was not included in the scope of the study.

In regard to graduate medical education, the study notes that costs need to be determined based on specialty or sub-specialty, and accredited and non-accredited programs.

The study made a series of recommendations about costing graduate education, rolling together research and clinical development payments and introducing output funding and performance monitoring processes.

In relation to costing research, the study made the following recommendations:

- Attempting to ascertain the costs of supporting research was dependent on factors such as the accuracy of original estimates in the grant submission, and the subsequent need of the hospital to support the research. While a cost study would give indicative values, it was deemed to be difficult to separate clinical development and research funding. Therefore bundling the two together was recommended, and the resulting amount apportioned by the Health Commission with a staged output funding introduction, while individual hospitals introduced measures to drive efficiency and accountability.
- Hospitals should explore Commonwealth taxation arrangements in order to establish commercial government bodies for research and development syndication purposes.
- Areas exporting research and development should approach the various economic development authorities in order to access export development grants.

While the substance giving rise to these recommendations echo some of the issues raised to date regarding costs of clinical training, the recommendations may be of limited assistance in that they bundle together clinical development with research which is outside of the scope of the current study. The second and third recommendations appear to be aimed more at hospitals accessing additional funds rather than costing research.

Commonwealth and States (1996)

This was a joint national feasibility study that aimed to determine if it was possible, and desirable, to develop a cost allocation method for clinical teaching and training.

The study did not determine a dollar value, but concentrated on reviewing the issues around how a process aimed at determining a dollar value might be carried out. It reviewed the strengths and weaknesses of the various costing models that might be developed. More detail of these is available in the individual précis of the report.

The study did develop a model, which was tested on a few sites. The study contains some critical insights into the whole process that are useful, mainly – costs allocations are inexact and are estimates at best; participants will understand there are funding implications and will complete the model in order to achieve the outcomes they desire; deficiencies in the original datasets kept by hospitals result in deficiencies in the final modelling which is almost impossible to test and therefore correct; and the emphasis of the study was on costs not benefits.

The major finding of the study was that most outputs in the health system involving teaching or training are multiple product activities rather than service a single purpose. For example, clinical teaching involving patients also has the aim of treating the patient and this makes costing one aspect difficult. The study did determine that the process of costing single purpose teaching ad training activities, such as lectures and tutorial, was not difficult.

The study's findings were that there was too much clinician resistance to continuing, and too much investment of time required by both clinicians and hospital administration to complete the survey.

The study did develop a series of recommendations aimed at improving the data collection processes and systems at hospitals.

The study determined that there were conflicting views about slow-down of patient throughput due to the presence of students and noted there was little data to support such a notion.

Similarly, it noted there was scant information to support the notion that teaching and training activities resulted in improve patient care.

Western Australia (1999)

This study set out a methodology for the cost attribution of teaching, training and research and development. The methodology relies on attributing staff time to each type of activity and then costing this at an hourly rate. The formula used then adds an amount for infrastructure and operating costs.

It does not attribute dollar values; instead it produces formulas for cost allocation, by profession, by sub specialty.

The study's findings rely on a series of untested and unsupported assumptions, many of which come out of focus groups held with selected staff at each hospital. The study does not mention testing the input received from the staff groups with other stakeholders.

The study does not set out a clear rationale or aim, is not detailed and does not include an evaluation or critique of its processes, assumptions or models.

Recommendations and conclusions are listed in the individual précis of the report.

Further work indicated in the report comprised a one-page plan around implementation of the costing model.

Detailed analysis

Review of funding of Clinical Training in the Health professions, DEET and Department of Human Services and Health (Coopers & Lybrand 1994)

This study appears to be the benchmark against which the other studies place themselves in regard to the arguments they put forward. The joint feasibility study between the Commonwealth and the States came about as a response to the findings of this study. It was jointly commissioned to quantify the overall costs of clinical training for a range of health professions including:

- Dentistry
- Medical (including vocational trainees)
- Medical Imaging
- Nursing
- Occupational therapy
- Pharmacy
- Physiotherapy

The results were to form the basis of ongoing national discussions over future funding for clinical training in Australia.

The exercise included both undergraduate and post graduate students who require practical experience prior to professional registration. Staff development activities were not included as they were considered part of the normal running costs for all organisations.

The paper developed a series of cost estimates and then sent them out to relevant organisations for feedback. The overall costs were identified as including:

- Salary costs associated with time spent by staff in providing direct clinical training.
- Salaries and allowances paid directly to students themselves.
- Costs of additional materials or other hospital/university materials used by students.
- Corresponding overheads and occupancy costs directly associated with student and staff time in clinical teaching.
- Costs associated with the impact on the services of other staff, (covering time of staff involved in clinical training).
- Other training related costs (payments to outside hours tutors).

Benefits were also included in the estimates such as:

- Service outputs from student clinical load.
- Sundry income received from students or other third parties (student fees).

The study undertook work with a number of pilot sites and received detailed information that was used in establishing the cost estimates. Specific costing results are listed below:

- Dental undergraduate- $156 (over 5 years)
- Dental postgraduate[6] - $814 (per year)
- Medical students[7] - $12,000 (over the three years of clinical training)
- Graduate interns - $47,000 (for single year)
- Clinical post-entry HMOs- $29,000 (for each year)
- Registrars - $5,000 benefit produced (cost negative) [8]
- Medical Imaging- $200 (over life of course)
- Medical Radiation $1,600 (over life of course)
- Nursing undergrad $800 (over 3 years)
- Graduate Nurse $19,000 (each year)
- Occupational Therapy undergrad $2,500(over 4 years)
- Pharmacy $850 (over 3 years)
- Pharmacy intern year $14,500 (each year)
- Physiotherapy - $730 benefit produced (over 4 years)
- Postgraduate physio - $500 (net benefit) each year

Both education and health sectors contribute to the costs of clinical training depending on the type of contribution (examples given of hospital infrastructure and clinical teaching academics).

The education of health professionals takes place largely within acute hospital-based facilities while many practitioners go on to provide ambulatory care or go into private practice. The review points out that the teaching experience should reflect this type of community based experience rather than concentrating on the acute sector, where students are faced with an unrepresentative mix of cases and learn more specialist procedures. Conversely, it was argued that students needed to become skilled in a range of techniques, which were only available in the acute setting.

Curriculum changes are taking place to reflect this and the nature of clinical training is changing, so cost estimates produced should be viewed from the standpoint of being relevant for structures existing in1994 but not necessarily appropriate for directly assessing costs of future changes.

In order to determine a cost-effective basis for training, additional work would be required including evaluation of existing arrangements and use of hospital based facilities.

[6] These figures take into account that even undergraduate dental students are productive (albeit not as productive as an experienced dentist), thereby providing a high level of benefit.
[7] Detailed results included a range between of from $3700 to $27077 (minus estimated benefits of $1347 to $5140).
[8] Higher costs are noted in training pathology and radiology registrars, thereby producing lower benefits.

Other policy matters suggested include consideration of:

- Whether funding should be made "contestable" as an incentive to reduce the overall costs of clinical training and to encourage new players into the training market.
- Whether all sites should continue at the same level, whether economies of scale are achieved which make some hospitals more efficient in training provisions, and/or whether there is potential to make greater use of medical students thereby providing additional service benefits to partly offset the training costs.
- Whether a greater proportion of clinical training should be undertaken in the community.

The report notes the heuristic method used in the costing exercise has largely produced results from the pilot sites that have been accepted by the field in regard to the definition of components costed, benefits associated, profiles of structure of clinical training and respective roles of health/education sectors and the resulting estimates.

The measurement of benefits is largely subjective in nature and needs to be recognised as such, although some concern has been expressed that the exclusion of intangible benefits produces higher cost estimates and may thereby encourage hospital administrators to reduce the amount of clinical training. Similarly, the costs produced were also considered to persuade non-training agencies (private hospitals) not to enter into clinical training because of the cost imposition. The report therefore recommended further investigation of the range of benefits available.

A new clinical education partnership – A Discussion Paper (La Trobe University, Faulty of Health Sciences, June, 1994)

This paper canvasses some of the issues relating to clinical placements. It notes:

- Health services are increasingly turning to universities for funding to support clinical placements.
- Universities would prefer to structure clinical placement learning in preference to its current opportunistic nature.
- Health agencies view students as productivity reducing.
- Students, particularly those in their final years, are able to make a positive contribution to the output of a service.
- The introduction of output based funding, which does not include a specific component for clinical training, has proved to be a catalyst for agencies to reduce their commitment to clinical training. This lends weigh to the notion that where there is no explicit funding, there is no need to provide a service.

The paper argues that explicit funding should be provided to support clinical education built into health agency funding, which can also be based on an output funding model. It argues this will produce greater transparency and eliminate the cross-subsidisation previously used to support clinical placements.

The paper proposes a clear contract between universities and health agencies in regard to the relative roles and responsibilities. It notes there should be some payment from universities to health services for clinical education but the current cost structure of education funding does not include clinical training support. It also notes that historically health services have covered the cost of clinical training and that 'these costs are undoubtedly incorporated within the existing budgets' (p4).

Such an arrangement would require formal recognition of such costs within the existing health service budgets, and subsequent transfer of that funding to universities to allow them to purchase clinical education on an output basis.

In order to do this, the paper notes that the State health authorities would need to be involved. It also notes that health authorities may claw the funding back from the health services and allocate it to the universities in such a manner that it cannot be spent on any activities other than clinical education. An alternate approach of transferring funding from the State health portfolios to the universities via the Commonwealth health portfolio is suggested.

The preferred proposal is for State health authorities to direct the funding to universities using the form of 'redeemable credits' as currency. This would not include capital costs, which would require separate negotiation.

The university would also seek to have the involvement of the health authorities in determining the numbers of students seeking placement through this process and would also be able to use this influence in discussions around intakes into health profession courses.

There is some discussion of the weaknesses of this proposal – such as the situation of clinical placements in the community and private sector where no 'clawback' arrangements are possible.

South Australian Health Commission (Ernst & Young December 1994)

This study was commissioned as part of the introduction of casemix funding into South Australian hospitals. A re-examination of the estimates relating to these payments was committed to by the Health Commission as a result of dissatisfaction with the estimates used in the initial funding formula.

The scope covered:

- Graduate medical education.
- Other health professionals graduate education (excluding nursing).
- Research.
- Clinical development.

The study covered:

- Methodologies used in other national and international jurisdictions for defining payments.
- Defining elements to be included in the formulae.
- Recommending options for calculating costs, or testing formulae based on this analysis.
- Consultation with relevant professional groups to determine support for methodology options.
- A methodology, costing and timeframe for each of the costing options or tests for the proposed formulae.

In the initial stage, stakeholders were consulted in order to determine areas of concern and consensus regarding the principles guiding the formulae and key elements to be included in each payment category. These categories were then used to determine the current costs in order to populate and trial funding formulae models.

In regard to graduate medical education, the study notes that costs need to be determined based on specialty or sub-specialty, and accredited and non-accredited programs.

The study also sought to identify teaching infrastructure costs, including maintenance and operation of libraries and audiovisual aids. Time spent on interdisciplinary education was also considered, since these would be costed differently. Board and College requirements for maintenance of professional standards were also costed.

The report recommended that a mechanism be established to ensure agreed standards of education are adhered to, particularly in relation to those medical staff not affiliated to a College program.

The study also noted that the true cost of the education of graduates and undergraduates should be determined (although the undergraduate costings were outside the scope of this study). The paper notes that information was complied for a 'recent' study by DEET on this.

Attempts to ascertain the costs of supporting research were dependent on factors such as the accuracy of original estimates in the grant submission, and the subsequent need of the hospital to support the research. While a cost study would give indicative values, it was deemed to be difficult to separate clinical development and research funding. Therefore bundling the two together was recommended, and the resulting amount apportioned by the Health Commission with a staged output-funding introduction, while individual hospitals introduced measures to drive efficiency and accountability.

The following recommendations were also made:

- Hospitals should explore Commonwealth taxation arrangements in order to establish commercial government bodies for research and development syndication purposes.
- Areas exporting research and development should approach the various economic development authorities; in order to access export development grants.
- In relation to costing & funding clinical development funding should be combined with research funding.
- Funds be apportioned on the basis of performance.
- Mechanisms should be established to report on clinical development activities in hospitals and an annual review of performance should be introduced and an element of peer review should be incorporated into these processes.

'Cost of Teaching & training activities in Australian public hospitals - a consortium of Australian states and the Commonwealth ' (KPMG October 1996)

The purpose of this study was to determine the feasibility of developing a methodology to cost teaching and training in hospitals. This study came about because of criticisms by clinicians and educators of a previous study (1994) attempting to cost teaching and training after the implementation of case-mix funding in a number of jurisdictions and the subsequent co-payments made to hospitals to offset the costs of training and teaching. Because of the lack of data available to States in determining the size of this co-payment, the study was agreed in an attempt to explore the feasibility of determining a costing method.

The study examined and assessed previous attempts at costing. Stakeholders were consulted and a conceptual framework for the study developed. Instruments were developed and trialled in pilot sites, the results analysed and alternate data sources examined for comparison data. Recommendations for future work were then developed.

The study discussed the ways in which a cost model could be configured and came up with four modelling options.

Aggregate level analysis – which examines the unit cost per separation in "teaching hospitals" and compares them with the same unit costs in "non-teaching' hospitals. Typically these studies have used statistical techniques (regression analysis) to explain the differences in cost between hospitals, thus the studies are dependent on the validity of the hypotheses used. The paper suggested this kind of study was useful in having providing large-scale evidence of the absolute differences in cost between teaching and non-teaching hospitals, however, was assessed as 'problematic' in relation to explaining the differences in cost between the two types of hospital.

Estimation and cost modelling – this method was seen as a set of weightings and measures, utilising direct cost measurement and estimations of cost variables. The direct cost measurement systems were determined to utilise elements of cost modelling to varying degrees. The study suggests that this type of costing system is unable to sufficiently allocate case-mix and non-casemix activities. These have historically been based on patient product definitions, and have included the notion of examining what other hospital products might be. Consequently, the existing models have not considered defining or classifying teaching, training, clinical development of risk management and research. Where studies have attempted to classify costs for teaching and training and research, it has been from the most easily identified cost centre information (i.e. costs for lectures and tutorials). They have not included costing training in a clinical care context.

Direct measurement and costing – the systems of this type existing at the time of writing this paper were seen as too superficial, with cost definitions too limited to be useful in accurately costing training and teaching, and also failed to integrate the close interdependency between case-mix activities and non-casemix activities. This type of system was also determined to fail to recognise that activities (inputs) in hospitals can have multiple outputs, by design, and cannot cost these. In addition, the cost of refining systems to be able to identify and allocate costs appropriately was seen as prohibitive.

Theoretical Modelling – this involves assuming the infrastructure, resourcing and staff of a teaching and non-teaching hospital are identical, so all other variables (casemix, severity) are presumed to be consistent. This notional model was seen to be flawed, raising questions regarding the cause and effect of differences: do they exist because the teaching hospital attracts more complex cases; because the teaching hospitals are the outcome of complex cases or because the teaching hospital creates the complex casemix that would not otherwise exist?

The consultants determined there were a number of caveats to be applied to the model on which their methodology was based:

- Testing was carried out in only a few sites, which provides potential for there to be aspects which may not be applicable more widely to hospitals.
- Estimations and assumptions are by their nature imperfect.
- Outputs from a cost estimation process are not exact, they are indicative only.
- Deficiencies in the initial data sets mean that the accuracy of the findings is difficult to determine
- The emphasis of the study was on costs not on benefits
- There was difficulty in quarantining the study from the heightened appreciation of the subsequent funding implications, and concern that some informants may have modified their input in line with their desired outcomes.

The study found that there is considerable evidence that activities undertaken in public hospitals are of a 'multiple product' nature; that is, they involve clinical care undertaken in conjunction with teaching, training and/or research. The study determined that one quarter of all clinical activity could be described as 'multiple product'.

In determining the nature of clinician work, the study found that there was a range of activities which had previously been ignored, and which they termed 'risk management' activities that account for a significant proportion of clinicians' time (quality assurance, case reviews, monitoring patient care process and protocols, responding/managing/reviewing patient related communications, special studies in quality improvement and risk management, reviewing infection control procedures etc).

The conclusion of the study was that the unbundling of the 'multiple product' patient care, teaching and training cannot and should not be further disaggregated into lower level components for costing purposes. This was because the study's authors felt that only the 'single product' activities in public hospitals can be reliably funded on the basis of costs. The study determined that the likely solution to the funding of teaching and training 'probably lies in other mechanisms' (p2). Reasons cited to support this include:

- Clinician resistance

- Time required from clinicians to complete the surveys
- Administrative burden in completing surveys.

Other recommendations relate to future strategies for improving hospital information systems and further development of clinical activity descriptors and protocols for inclusion of such descriptors in patient costing systems and other routine hospital information systems. Examples are:

- It is inappropriate for hospitals to separately identify teaching and training grants at cost centre level. Instead they should 'roll up' these separately allocated funds into a pool, restricted to clinical units, and then allocated on the same basis as routine clinical care operating resources.
- Patient costing systems should, in principle, be able to identify aspects if the cost of teaching and training if all activities undertaken by clinicians are directly recorded and related to individual patients where relevant. However, these costs can only be understood at the aggregate 'multiple product' level of clinician activity and not at a fundamental component level within multiple product activities.

The study found that, while it may be possible to measure the relative proportion of clinical time spent on various activities through special studies (such as the survey conducted for this study), there was widespread opposition to a task of this nature being added to daily workloads. Therefore larger scale ad hoc surveys were not recommended by the study.

Sampling and methodological issues would also require resolution if the methods were to be sufficiently valid and reliable for broader use. For example, some activities were determined to be low frequency and low magnitude while others were low frequency and high magnitude. In addition teaching and training activities follow peaks and troughs at designated periods of the year, which would need to be accommodated in the surveys.

On the issue of 'slow down' and increased consumption of diagnostics and consumables associated with teaching and training, the study determined that this was largely anecdotal and measurement of such a phenomenon was problematic.

Teaching and training activities were found to be neither reducing or increasing absolute output, and such views were mainly based on perception, with scant supporting data.

Similarly, the data to support the notion of improved patient care through teaching and training activities was also determined to be scant.

Given the study's conclusion that costing all teaching and training activities was not presently possible, it noted that there were implications for funding. The study indicated that it may be possible to fund 'single product' activities, thus allowing these to be the focus of separate funding. The study considered that the solution to funding teaching and training through cost allocation was only partly able to be resolved through the measurement of costs. Instead, it noted that a funding framework may need to be developed based on other criteria, such as through the funding of training positions or other outputs, or by a combination of methods.

Another implication of the desire to unbundle the costs of teaching and training was the potential for "funding inequities" (p69) to develop and other possibly unintended outcomes. As the study noted, "The mere act of categorisation and arbitrary cost unbundling may lead funders and policy makers to assume that hospital-based teaching and training is a discrete commodity, and as such, can be manipulated or shifted between the education and health sectors as deemed appropriate" (p69). The study concluded that while some teaching and training activities can be purchased from the education sector, a significant proportion could not be procured in this way.

The following were suggested in order to develop better understanding of teaching and training costs in the larger context:

- A general review of the definitions of all hospital products.
- Identifying and defining key clinician activities and the relationships between clinician activities.
- Identifying the extent of non-hospital sector involvement in teaching and training where hospitals are involved.
- Development of appropriate data definitions and measurement methods to quantify the non-hospital contribution to health sector related teaching and training costs and benefits.
- Aiming to ensure that new organisation-wide, resource-level and patient-level data definitions are incorporated into the National Health Data Dictionary.
- Ensuring that new data items and supporting data capture methods are incorporated into standard costing protocols for patient costing systems and activity recording systems.
- Ensuring that the revised costing protocols are reflected in changes to the software used in patient costing systems and supporting feeder systems.
- Ensuring that key resource types, which are known, or hypothesised, to be influenced by teaching and training activities, have adequate protocol and control processes developed and implemented.

Review of Teaching, Training, Development and Research within the WA Public Health System (Health Department of Western Australia December 1999).

This study set out to review the activity and costs associated with teaching, training, research and development (TTR&D) in West Australian tertiary institutions (hospitals). The objective was to use the outcomes of the review to influence the methodology used for planning, managing and funding TTR&D. The methodology was to account for and (potentially) purchase TTR&D independently of health services.

An environmental scan was conducted to assess national and international approaches, practices and trends to the issue. The scan resulted in a description of the similarities and differences between funding nationally, a comparison of trends and approaches and discussion of recent and likely developments.

Stakeholders from tertiary hospitals and universities were consulted, as were selected staff from research institutes. A questionnaire was developed from these discussions, which covered:

- Requests for data sets used in R&D project management.
- Sources of funding for each component of TTR&D.
- Methods for controlling and disbursing funds for TTR&D.
- Financial reporting formats and structures.

The questionnaire was sent to a diagonal sample of staff to ascertain their involvement in certain activities. Staff were then organised into focus groups (by hospital) to discuss the results, consider direct and indirect costs of the activities and discuss the benefits of activities. These meetings were used to provide validation and quantification of the direct and indirect cost categories.

Hospitals were contacted to obtain a list of R&D projects that was investigated in individual meetings with research leaders. This data proved to be in many different forms, much was incomplete, and the assessment of the study proponents was that they were not strictly comparable. However, a set of projects was selected from which to develop a strategy for the future, and a set of recommendations developed.

The identified contribution to TTR&D in tertiary teaching hospitals was tagged at $87.8m in 1999. This funding was provided in a block to hospitals and was generally consolidated into hospital budgets. It had no outcomes or other accountability measures attached to it. However, there was no funding provided explicitly for 'non-teaching' hospitals, although the study acknowledged that there were considerable teaching activities occurring in them, despite limiting its investigative scope to tertiary teaching hospitals.

The study developed a series of estimates attributing proportions of staff time to teaching, training and research and development. The study then hypothecated that the major cost in delivery of TTR&D was the staff time involved in delivery, and a resultant reduced service delivery along with increased diagnostics associated with teaching and training protocols.

The study developed a matrix of direct and indirect costs for TTR&D. The direct cost attribution section examined the type of activities, the role of staff involved, the profession involved and the clinical specialty involved. The costs attributable to each of these categories were said by the study to be difficult, but not impossible to separate and measure.

The indirect costs were determined to be the extension of process time, impaired co-ordination of processes (leading to extended patient stays), superfluous diagnostics, increase in adverse events and increased wastage. The focus groups were also asked to estimate the amount of increased time taken to provide services for a 'fully qualified member of staff reasonably applying their skills'.

In evaluating all of these categories of information, the study noted that the greatest on-cost for the hospitals is the reduced throughput, and although the systems are not in place to measure this effect, they should be able to be costed reasonably accurately.

The study concluded:

- That the system was complex and the issues and interactions involved required consideration in any future attempt to determine costs. R&D activities are not co-ordinated and their organisation varies considerably between hospitals.
- The association of T&T with inpatient clinical activities was not a good determinant of the cost of teaching and training. Instead a method of linking teaching and training with funding for staff numbers and specific TTR&D activities was seen as preferable.
- Greater accountability and transparency of the funding for TTR&D is required, since the lack of transparency leads to inefficiencies and ineffective delivery of activities.
- The ability of senior clinicians to undertake R&D or T&T assists in their recruitment and therefore should be supported. The amount of their time taken in TTR&D should be determined on an individual basis, not on the basis of seniority.
- The culture of senior staff having autonomy in relation to TTR&D, which the study said led to a lack of collaborative benefits, should be changed. However, the study noted that medical associations and other senior staff groups were powerful and generally opposed change.

- An accurate and fair methodology will be required to ensure stakeholder buy-in to change the costing model.
- A purchaser provider split between the hospitals and the State was able to produce the most efficient system possible. The model should be similar to that for the delivery of health services. The proposal included the development of annual business plans by clinical streams describing their TTR&D activities and matching this to staff job descriptions.
- Purchasing and funding should be explicitly covered by Clinical Agreements in order to facilitate service wide initiatives such as virtual surgery. Medical and nursing should be funded at a direct clinical stream level while allied health funding should be added to the support service units.
- R&D should be funded through Clinical Agreements that are the result of a competitive tendering arrangement that is subject based.
- Hospital based research should be focussed on developmental work, rather than strategic research, which should be confined to research institutes. Continuation of research should be based on the quality of outputs.
- The university sector should carry the cost of undergraduate and post graduate university based courses while the health sector should carry the cost of other postgraduate training. Explicit contracts should be entered into between the two sectors.

The study provided a series of equations to be used in costing the staff time of certain clinicians involved in undergraduate and post graduate T&T and for R&D. It states which costs should be paid by universities and which by the health sector.

Many of the categories and the assumptions used in the study were derived from the focus groups and therefore represent a set of opinions, rather than an investigative process. These assertions and the logic of the assumptions made is not questioned in the report.

Appendix B: The United Kingdom Health Professions Council

An integrated approach to registration and education has been adopted in the United Kingdom, where the Health Professional Council currently regulates 13 professions. Its stated aims include:

- Maintaining and publishing a public register of properly qualified members of the professions.
- Approving and upholding high standards of education and training, and continuing good practice.
- Investigating complaints and taking appropriate action.
- Working in partnership with the public, and a range of other groups including professional bodies.
- Promoting awareness and understanding of the aims of the Council.

To this end, it has released a range of guidelines and standards which illustrate how a cross-disciplinary registration and accreditation body could function:

- Standards of proficiency have been developed for each regulated profession, and articulate the standards of practice which must be attained for an individual to be granted registration or renewal of registration. These have been developed in consultation with members of the relevant professions.
- Standards for education and training, which are the standards against which the Council will assess whether a graduate from an educational programme will meet the Standards of Proficiency. This encompasses information for all registered health professions.
- Standards of conduct, performance and ethics, which describes the Council's expectations of all registered practitioners and also provides guidance on the types of behaviours that could result in disciplinary action.
- 'The Approvals Process' and 'The Annual Monitoring Process', which describe the processes for approval of an educational programme and the annual monitoring processes are outlined. This document is common to all registered professions.
- Other guidelines which describe common requirements across all professions (such as continuing professional development, to be introduced in the future) or provide advice to all registrants about processes (for example, appeal rights and processes arising from Council decisions).
- Information for the public, which typically addresses issues such as:
  - How do you know if a practitioner is registered?
  - What can you expect from a registered practitioner?

Governance & organisational structures

The Health Professions Council (UK) operates under six guiding principles, which Victoria considers would form useful principles to underpin the activities of any national accrediting and registering body.

- Protecting the public – the Council will have wide powers to deal effectively with individuals who pose an unacceptable risk to patients. It will have clear and well-published complaints and appeals procedures for the public and registrants. It will treat the health and welfare of patients as paramount.
- Transparency - there is public representation on the Council, which aims to operate a fast and transparent complaints procedure. The HPC will consult with key stakeholders and publish any standards and general guidance it develops.
- Communication and responsiveness – the HPC will develop meaningful accountability to the public and the health service, and inform and educate the public and registrants about its work.
- Providing a high quality service – the HPC will ensure that the needs of its customers are met, namely the public, patients, health professionals and the health service. It will seek and utilise regular feedback from its customers to enhance its services. It will support the training and development of HPC staff, as well as registrants.
- Value for money – the HPC will provide a value for money service for registrants and the public. It will be open and proactive in accounting to all its customer groups regarding its work.
- Working collaboratively – the HPC will enable best practice in any one profession to be accessed by all. It will deliver an efficient and unified service as well as focusing on individual issues which are significantly different between professions.

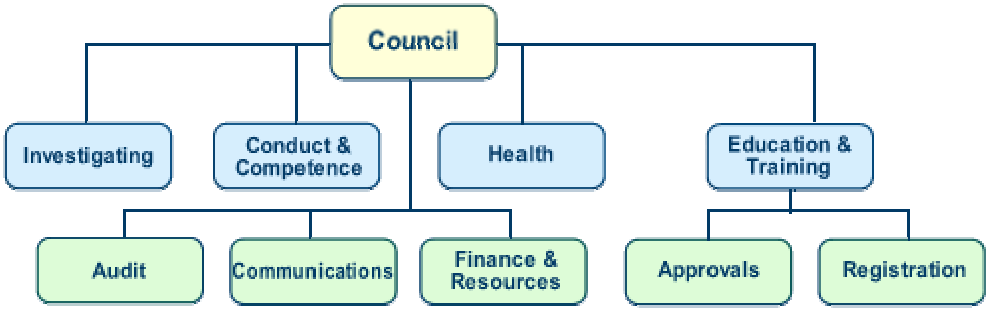
(Source: http://www.hpc-uk.org/aboutus/aimsandvision/)

The Council's organisational structure also provides some insight into how a cross-disciplinary body might be effectively structured. As it's website notes:

- The **Council** of the HPC is responsible for developing strategies and policies and consists of 26 members (made up of one representative from each of the professions regulated and 13 lay members) plus a president. In addition, there are 13 alternate professional members who attend Council and Committee meetings in the absence of the 13 representatives.

- Four **statutory committees** have been set up to deal with conduct and competence, the health of professionals registered with HPC, investigating complaints and the establishment and monitoring of training and education standards.
- In addition, three **non-statutory committees** have been set up: the Finance and Resources committee, the Registration committee and the Communications committee.

Further committees may be set up as the HPC evolves. All committees will be chaired by a member of the Council and they will make recommendations and decisions in consultation with the Council.



- In addition, the Council establishes **professional liaison groups** (or 'PLGs') to provide it or its committees with advice on strategic issues. Either the Council, or a committee can decide to set up a PLG, to look at a specific issue and report back. These PLGs are project-based, and have a defined timescale with specific pieces of work to achieve.

The membership of a PLG can vary depending on its needs. A PLG may need members who can provide expert opinion, members who represent organisations or a combination. When the Council sets up a PLG, it will decide what members it needs, and how it will seek these members. The membership of a PLG may need to include educational institution representatives, employer representatives, patient/client/user representatives, lay members, or other representatives or experts. The convenor of a PLG will normally be a Council member.

Appendix C: Tax, indirect taxes and incentives

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DEPARTMENT OF HUMAN SERVICES

REPORT TO ASSIST IN THE PREPARATION OF A VICTORIAN GOVERNMENT SUBMISSION TO THE PRODUCTIVITY COMMISSION

26 July 2005

Introduction

Setting the Scene – Current Treatment

Fringe Benefits Tax ('FBT') is imposed upon employers who provide fringe benefits to their employees. The Fringe Benefits Tax Assessment Act 1986 ('FBTAA') has been in place since 1986 and applies to all employers. The types of benefits that are taxed include cars, debt waivers, loans, expense payments, housing, living away from home, airline transport, board, meal entertainment, car parking, property and residual benefits.

Generally speaking, the taxable value of fringe benefits is calculated as the cost to the employer in providing such benefits. However, there are a number of benefits which receive concessional treatment in calculating the taxable value (i.e., the taxable value is less than the cost to the employer) or are exempt from FBT.

Examples of exempt fringe benefits include:

- Contributions in respect of an employee's superannuation;
- Fuel, oil, maintenance, servicing and repairs relating to cars which are provided as a fringe benefit;
- Food and drink (provided and consumed on eligible premises of the employer) on a day where a board fringe benefit has been provided;
- Accommodation, meals, food and drink (other than meals) and residential fuel provided to live-in residential care workers;
- Specific expenses associated with the relocation of an employee;
- Compassionate travel;
- Minor benefits; and
- Work related items such as mobile phone for use in an employees employment, protective clothing, briefcase, calculator, tools of trade, computer software for use in an employee's employment, an electronic diary or PDA or a notebook, laptop or similar computer.

Examples of concessionally taxed fringe benefits include:

- Cars;
- Car parking;
- Certain remote area benefits;
- Temporary accommodation relating to relocation;
- Living away from home accommodation and food benefits;
- Overseas employment holiday and remote area holiday transport;
- In-house benefits; and
- Airline transport benefits.

The FBT regime also provides some industry/sectorial concessions for particular employers and occupations including:

- Tax Exempt Body employers such as Public Benevolent Institutions (PBI's);
- Rebatable status employers such as charitable institutions, religious institutions, scientific or public educational institutions (other than an institution of the Commonwealth, a State or Territory), trade

unions, associations of employers or employees registered under a law of the Commonwealth, a State or Territory relating to the settlement of industrial disputes, non-profit non-government schools (including pre-schools, but not tertiary institutions) established under Commonwealth, State or Territory law, and non-profit societies, non-profit associations or non-profit clubs established for:

  - the encouragement of music, art, science or literature;
  - the encouragement or promotion of a game or sport;
  - the encouragement or promotion of animal races;
  - community service purposes (not being political or lobbying purposes);
  - the purpose of promoting the development of aviation or tourism;
  - the purpose of promoting the development of the agricultural, pastoral, horticultural, viticultural, aquacultural, fishing, manufacturing or industrial resources of Australia; and
  - The purpose of promoting the development of Australian information and communication technology.

- Religious practitioners;
- Employees of public hospitals;
- Employees of public ambulance services;
- Employees of private not for profit hospitals; and
- Employees of charitable institutions that promote the prevention and control of diseases in human beings.

The current treatment of FBT in relation to employees in the health sector is reasonably generous. In this regard, employers who qualify as public hospitals or not for profit private hospitals have an amount of FBT free fringe benefits that can be provided to their employees. This amount is capped at $17,000 of the grossed up taxable value of fringe benefits. This equates to a FBT taxable value of $7,984 (assuming that all are Type 1 benefits, i.e., a GST input tax credit is claimable by the employer).

In addition, certain FBT benefits are not limited to the thresholds stated above. These benefits retain their FBT free status (irrespective of the individual grossed up taxable value) in the hands of such employers and include:

- Superannuation (subject to age based deduction limits);
- Minor benefits of less than $100;
- Entertainment by way of food and drink;
- Car parking;
- Remote area housing; and
- Work related mobile phones.

Proposed Changes to the FBT Regime

There are a number of changes that could be made to the treatment of fringe benefits currently offered to health professionals which may provide an incentive for them to move to regional, country and remote areas where there is a lack of skilled health professionals.

The treatment of fringe benefits that could be changed or excluded from the FBT regime, that are likely to encourage employees to move to and remain in regional, country and remote areas are discussed in detail below. We also attach as an Appendix a table for ready reference that indicates the current treatment as against the proposed changes.

Increase in $17,000 cap for public hospitals and not for profit private hospitals

The current treatment of FBT in relation to many employees in the health sector is determined according to those employers that qualify as public hospitals or not for profit private hospitals. These employers are entitled to provide a fixed amount of FBT free fringe benefits. This cap is set at $17,000 of the grossed up taxable value of fringe benefits. This equates to a FBT taxable value of $7,984 (assuming that all are Type 1 benefits).

We note that this $17,000 cap is not indexed. Therefore whilst the cap was introduced effective for the FBT years commencing on or after 1 April 2000 there is currently no mechanism to adjust this amount over time to take into account the ever changing value of money, i.e., inflation. There are many other superannuation, income tax and FBT concessions that that receive indexation (as a minimum) in maintaining the value of the particular treatment for tax purposes. Accordingly it should be considered appropriate for annual adjustments to be made to this cap, rather than leave it to reduce in value over time.

Based on the above we propose changes to increase the threshold either by indexing the threshold annually or by specific value increases (which could be determined by the government following discussions with various health sector employers). This would allow a higher taxable value of fringe benefits to be provided to the employees without the employer incurring additional FBT.

This increase would allow public hospitals and not for profit private hospital employers to offer more financial support to employees who are prepared to relocate to regional, country and remote areas.

Broaden availability of the $17,000 cap

Currently, the $17,000 cap is only available to a limited number of employers within the health sector - public hospitals and private not for profit hospitals. These employers (whilst employing large numbers of employees) do not include all employers in the health sector. There are a large number of employers (in 'private practice') that do not qualify for such benefits. This places them at a disadvantage, as compared to 'qualifying' employers, as they are required to pay a premium over and above that required to be paid by 'qualifying' employers to achieve a comparable 'after tax value' of remuneration in the hands of the employee.

Whilst it is recognised that the $17,000 cap was introduced to provide a level of parity between employers who can claim deductions against assessable income and those that are exempt from income tax (and thus are not concerned with deductibility of expenditure), there may be a preference to be employed by a public hospital or not for profit private hospital to access the concessional FBT treatment as compared to an employer who and cannot access such generous FBT treatment.

Accordingly an extension of the $17,000 cap to employers other than those that currently qualify for such treatment should be considered.

Changes in the calculation of the taxable value for car fringe benefits

Calculation of the taxable value of car fringe benefits, could be altered in specific ways to achieve a lower taxable value for health sector professionals in regional, country and remote areas. There are a number of ways in which both the statutory formula method and the operating cost method of calculating the taxable value of car benefits could be changed to reduce the FBT cost, including:

Statutory Formula Method

- Reduce the statutory fractions that are applied to the base value of the car to determine the taxable value. In this regard, consideration should be given to reducing the current four statutory fractions to two. This could be achieved by eliminating the first two statutory fractions (26% and 20%). The statutory faction could then be determined by increasing the base (annualised) kilometres travelled by a car up to 40,000km – resulting in an 11% statutory fraction and retaining the lowest statutory fraction at 7% for cars that travel annualised kilometres of over 40,000km;
- Offering a reduction in the base value of the car, e.g., a reduction of perhaps 40% of the cost price of the car that is multiplied by the statutory fraction as per above. Alternatively, the base value of the car

could be restricted to the luxury car tax limit (currently $57,009). On this basis, no FBT would be imposed on the value of a car in excess of the luxury car tax limit; and

- Offering a general concession of say, a 50% reduction in the calculation of the taxable value of the car for FBT purposes.

Operating Cost

- Classify travel from home to work as business use not personal use. This would have the effect of increasing the 'business use percentage' and thereby reduce the taxable value of the car benefit provided;
- Decrease the car depreciation rate for FBT purposes to say, 10% from the current 18.75%. This would reduce the operating costs of the car that are subject to FBT; and
- The base value of the car could be restricted to the luxury car tax limit (currently $57,009). On this basis, no FBT would be imposed on the value of a car in excess of the luxury car tax limit. This would reduce the depreciation and interest that is included within a car's operating costs that are subject to FBT.

Based on the above proposed changes in relation to car fringe benefits, the taxable value subject to FBT will be substantially reduced.

An exemption or reduction in taxable value in relation to the provision of housing

Providing housing benefits to employees in the health sector (for relocation purposes) would facilitate more personnel to move to and remain in regional, country or remote areas. Currently, housing benefits will attract FBT in full unless the employee is working in a remote area and certain condition as are satisfied, e.g., there is not sufficient suitable residential accommodation at or near the place of employment. Therefore we recommend consideration of the provision of exempt or concessionally taxed housing benefits for FBT purposes to health sector professionals (free of conditions) who relocate to regional, country and remote areas.

Exemption of loan fringe benefits where the loans are towards specific purposes

If an employer was to loan an employee an amount of money or provide a line of credit for specific purposes as a result of relocating to a regional, country or remote area (interest free or at a reduced rate of interest compared to the statutory interest rate), such a loan would ordinarily be subject to FBT where the deemed interest does not meet the 'otherwise deductible' requirements. We propose that a change be made to the loan fringe benefit provisions to exempt loans to acquire a residential property at a regional, country or remote area. This exemption would be specific to health sector professionals. In this way, such employees may be incentivised to invest at the new location and treat their residential property as a longer term proposition, rather than temporary.

Exemption of debt waivers where the debt relates to medical practices or local housing

There is currently no concessional treatment of debt waivers for FBT purposes. Consideration should be given to providing FBT exempt treatment to debt waivers in relation to funds borrowed for local practices or residential property in the regional, country or remote area. In this way, an employee could enter into an effective salary sacrifice arrangement to have private or business debt waived. Effectively, the employee would be paying off debt with pre-tax income rather than post tax income. Again, this may be an attractive financial incentive to health sector professionals.

Full exemption from FBT for all relocation and living away from home costs

At present only specific relocation costs are exempt for FBT purposes and in addition, such exemptions are bound by specific conditions. These costs include removal and storage of household effects, costs associated with the sale or acquisition of the employee's house, connection or re-connection of certain utilities, leasing of household goods while living away from home and transport throughout the relocation period.

In addition to the above costs that are already exempt, further exemptions on other costs may provide a beneficial incentive to relocate. These costs could include paying out the remainder of a rental agreement entered into by the employee prior to the relocation, costs to ensure the new house is in a suitable condition to relocate for example, cleaning of the house, any immediate maintenance that my be required to the property, (including the garden) and the acquisition of any additional household furniture, equipment etc that may be necessary.

Exemptions up to certain limits for holiday transport for health professionals

Health professionals relocating to regional, country or remote areas could benefit from concessional or exempt FBT treatment of the costs associated with holiday travel. Such treatment is available to overseas and remote area employees who are entitled to a 50% reduction for holiday transport to their 'home' country or city, or alternatively, of an amount that equates to the cost that would have been incurred had they travelled to their 'home' country or city. We consider that it may be appropriate that health sector professionals in regional, country and remote areas be provided with similar treatment in relation to these benefits. However, rather than such concessional treatment be based on the cost to return to their original place of residence, it could be based upon a fixed amount of expenditure, and indexed yearly. An appropriate amount may be based upon the number of people in the family unit that live in the regional, country or remote area, say, $10,000 per person 5 years of age and over and $5,000 per person under 5 years of age. Exemption from FBT for such amounts, will offer employees the flexibility to visit family and friends throughout the period that they remain employed in regional, country and remote areas.

Exemption from FBT relating to boarding fees for children of health professionals

Employees who have school aged children may be reluctant to relocate to regional, country and remote areas due to the quality of schooling that may be available in those areas and the costs associated with placing children in a boarding school. On this basis, there is a strong argument that boarding school fees and the costs of travel between the boarding school and the regional, country or remote area should be exempt from FBT. This would be likely to provide comfort to health sector professionals by allowing the employee to leave the child in the same environment and minimising the disruption to the child's education.

Exemption from FBT relating to accommodation, food and drink relating to tertiary education for children of health professionals

In accordance with the proposed exemption applicable to boarding fees for school aged children, the same exemption would be beneficial if it was also to apply to tertiary eduction costs. In this regard, the same exemption should be available for accommodation, food etc for children studying at universities (or similar tertiary education institutions) for undergraduate courses. This would provide a saving of expenditure that may not necessarily have been required to have been incurred had the parents remained at their original location.

FBT exemption for expenses incurred in obtaining domestic assistance and childcare

An exemption from FBT for costs incurred in obtaining domestic assistance and appropriate childcare for health sector professionals who relocate to regional, country and remote areas would be beneficial for such employees. Currently all such expenditures is subject to FBT in full – except for childcare which is provided on an employers' work premises. Such arrangements may be necessary for additional costs that may be incurred by health sector professionals who relocate to regional, country or remote areas and do not have access to other family members who may otherwise have provided assistance.

Superannuation

Setting the Scene – Current Treatment

Currently, the objective of the Australian superannuation system is to provide Australians with adequate income in retirement. The Australian retirement system has been built around three pillars being:

1. The provision of an adequate public safety net (being the age pension);
2. Compulsory provision for retirement savings (being the superannuation guarantee ('SG') regime which applies to most employees);
3. Voluntary provision for retirement savings (being encouragement for individual's to make additional savings through tax concessions and other incentives such as the Government co-contributions).

To protect the superannuation concessions provided by the Government, the Australian superannuation regime also requires superannuation savings to be maintained in the superannuation environment until the individual has reached his/her preservation age and has retired. In addition, the taxation regime that applies to benefits finally taken from the superannuation environment has been designed to encourage individuals to take pension benefits in preference to lump sum benefits.

The current Australian superannuation legislation both from an operational perspective and concession perspective does not distinguish between categories or locations of individuals/employees. While there are various exemptions and concessions within the superannuation legislation, these are based on each individual's circumstances such as:

- Age (eg. the age-based deduction limits, reasonable benefit limits ('RBLs'), and preservation rules);
- Income levels (eg. Government co-contributions rules, contributions required under the SG rules, and qualification for the age pension); and
- Asset levels (eg. the RBLs and qualification for the age pension).

The only area where there is some distinction between the types of entities involved relates to the rules applying to small super funds (i.e. those with less than 5 members) and in particular, self-managed super funds ('SMSFs'). These funds have a number of investment concessions available to them that are not available to larger funds (eg. small funds are able to purchase business real property from their members).

Over a significant number of years, one of the biggest criticisms that have been aimed at the Australian superannuation regime has been its complexity. Since the mid 1990s, there have been a number of legislative changes designed to simplify the Australian superannuation regime and promote equity between Australians. For example, the introduction of the flat dollar RBL's and the age-based deduction limits replace a complicated RBL and contribution deduction regime whereby every individual had their own unique RBLs (which were calculated annually) and a corresponding contribution deduction limit.

Therefore, it is unlikely that the Government would introduce any changes to the Australian superannuation regime that may be seen to be introducing additional complexity to a regime that is still considered to be complex or that is creating inequity between Australians.

Bearing the above in mind, potential changes to address the existing problems of workforce misdistributions in the health sector to attract individuals to areas of workforce shortage (both geographic and clinical specialty) may still be possible as:

- Any incentives provided by the Federal Government through its retirement incomes policies can be designed to meet two objectives of the Government so as to encourage both re-distribution of the workforce and further savings for retirement (i.e. the Government could effectively "kill two birds with the one stone");
- The Government's retirement income policies extend beyond superannuation and therefore, incentives could be provided in respect of additional savings outside superannuation. The extent of the

concessions could be dependent upon a number of factors including length of service in the desired locations, and so on;

- Any incentives provided by the Federal Government through its retirement income policies will not be costly to the Government if there is no take-up of those incentives. Any take-up of those incentives may represent an immediate benefit associated with the re-distribution of the workforce and level of health care provided in regional, country and remote areas despite being a revenue cost immediately. In addition, the take-up of the incentives would also represent a revenue saving in the future as a result of additional retirement savings;
- There are already reporting mechanisms and various Australian Taxation Office (the ATO) matching mechanisms in place (such as the interest/dividend reporting and contributions reporting regime) which could be used to monitor/deliver the incentives;
- Australians don't mind complexity where they can see that there is a potential benefit to be obtained from that complexity (eg. the Government co-contributions); and
- Any successful incentives put in place to encourage further savings via amendments to the Government's retirement income policies could be used as a template for concessions that the Government may wish to introduce for additional Australians to help them achieve the goal of adequate retirement income.

Possible Retirement Income Policy Changes

Source	Initial Contribution/ Initial Investment	Accumulation Period	Withdrawal of Benefit/ Disposal of Investment	Additional Comment
Superannuation	***Incentives:*** • Age-based deduction limits • Government co – contributions • Removal of the Surcharge • Spouse contributions including rebate ***Disincentives:*** • Up front tax on contributions • Preservation rules • RBL amounts • Self-employed individuals are required to make additional contributions to get the full age-based deduction limit	***Incentives:*** • Low tax rate investment environment (15% on income /10% on most capital gains) • Small funds where they are appropriate for the individual ***Disincentives:*** • Preservation rules • Investment restrictions on small funds regarding the use of fund assets by related parties (eg. use of residential property even if at arm's length market rates)	***Incentives:*** • Transition arrangement between the accumulation phase to retirement phase • Pension RBL compared to the lump sum RBL • Concessional tax rates on lump sums and pensions ***Disincentives:*** • RBL amounts • Restrictions on types of pensions that can be provided by super funds (especially small funds) • Desire/ability to rely on the age pension to top-up retirement income streams	The proposed contribution splitting regime will be an incentive once it is introduced. It will be a more powerful incentive if the splitting occurs when the benefit is finally withdrawn rather than when contributions are made. Unutilised age-based deduction limits are lost and do not take into consideration current work-force patterns or individual cash flows based on changing family requirements. The current RBL system discourages savings (and therefore individuals are more likely to spend). Since the introduction of the Goods and Services Tax ('GST') and reduction in individual and company tax rates, the tax relativities of superannuation has not been maintained. As a result, many individuals do not consider superannuation to be a concessionally treated investment vehicle (particularly when preservation is taken into consideration).

1.2 Current Retirement Income Incentives/Disincentives

Source	Initial Contribution/ Initial Investment	Accumulation Period	Withdrawal of Benefit/ Disposal of Investment	Additional Comment
Non-superannuation				
Self-employed business		***Incentives:*** • CGT small business rollover relief	***Incentives:*** • CGT retirement rollover exemption ***Disincentives:*** • RBL amounts • Preservation	
Family home	***Incentives:*** • First home buyer schemes		***Incentives:*** • CGT exempt ***Disincentives:*** • Absence from family home could jeopardise tax-free status	
Private savings – cash/shares, etc	***Incentives:*** • Negative gearing • Capital gains concessions		***Incentives:*** • Capital gains discounting ***Disincentives:*** • Capital gains consequences • Desire/ability to rely on the age pension to top-up retirement income streams	

1.2 Current Retirement Income Incentives/Disincentives

Source	Initial Contribution/ Initial Investment	Accumulation Period	Withdrawal of Benefit/ Disposal of Investment	Additional Comment
Life assurance policies	***10.***	***Incentives:*** • Reversionary bonus generally not assessable if received after 10 years ***Disincentives:*** • Only tax free after 10 years	***Incentives:*** • Reversionary bonus generally not assessable if received after 10 years ***Disincentives:*** • Only tax free after 10 years	

Conclusion

Following our review of the current treatment of the FBT and Superannuation regimes and the benefits available to employees who relocate, the above proposed changes could provide employees of the health profession, an incentive to relocate to regional, country and remote areas to practice.

The above proposed changes would offer employees greater benefits and support during and following the relocation phase. Employers would also benefit by being able to offer employees such benefits without attracting FBT or other additional costs. The proposed changes to superannuation and retirement savings (in most cases) can be actioned via pre-existing financial infrastructure and monitoring mechanisms currently available to the ATO and other regulators.

In our opinion, the above changes may provide attractive financial savings to employees whilst remaining cost neutral to employers in the health sector. Therefore the inclusion of these proposed changes in the Victorian Government submission to the Productivity Commission may provide an incentive sufficient to secure the relocation of health professionals to regional, country and remote areas. When these proposals have been evaluated we recommend further studies be undertaken to determine to what extent health sector professionals will be influenced by the proposed financial outcomes in estimating the likely ‘take up’ and cost to government.

Appendix 1

Benefit Type	Current Treatment	Proposed Treatment	Retention	Attraction	Admin. Ease	Overall Success Rating
$17,000 FBT exemption cap	Public hospitals and not for profit private hospitals are able to provide exempt fringe benefits to each employee – up to a grossed up taxable value of $17,000 each year.	Increase the $17,000 exempt threshold per employee by the increase in CPI each year or by some other fixed amount. In addition, this exemption could be extended to other health sector employers	☺	☺	☺	☺

Benefit Type	Current Treatment	Proposed Treatment	Retention	Attraction	Admin. Ease	Overall Success Rating
Car Fringe Benefits	Employers are able to use two methods of calculating FBT on cars. The two methods are: > Statutory Fraction Method > Operating Cost Method The taxable value of the car fringe benefits are calculated as follows: **Statutory Fraction Method** ABC - E D A = Base Value of the Car B = Statutory Fraction C = No. of days the car was held in the FBT year D = No. of days in the FBT year E = Recipients payments The statutory fractions are based on the number of km travelled in an FBT year and are as follows: More than 40,000 km = 0.07 Not less than 25,000 and not more than 40,000 = 0.11 Not less than 15,000 and not more than 24,999 = 0.20 In any other case = 0.26 If the km travelled in the FBT year is high, the statutory fraction is lower and consequently this reduces the taxable value of the car fringe benefit.	**Statutory Fraction Method** > Reduce the fractions applicable to car benefits from four statutory fractions to two as follows: * Up to and including 40,000 km = 0.11 * More than 40,000 km = 0.07 > Offer a reduction in the base value of the car to say, 40% of the cost price of the car or limit the cost price to the luxury car tax limit of $57,009 > Offer a general 50% reduction on the calculation of the taxable value of the car fringe benefit	☺	😐	☺	☺

Benefit Type	Current Treatment	Proposed Treatment	Retention	Attraction	Admin. Ease	Overall Success Rating
	Operating Cost Method (C x (100% - BP)) - R C = Operating cost of the car during the holding period BP = Business use percentage applicable to car R = Recipients payment The operating cost method calculates the operating cost of the car during the year, taking into account car expenses such as petrol, oil, registration, insurance, depreciation and deemed interest on the depreciated written down value of the car in a particular year. This amount is then multiplied by the applicable statutory fraction. The recipient contribution is then subtracted.	**Operating Cost Method** > Decrease the car depreciation rate from 18.75 to 10% > Classify travel from home to work as a business expense not a personal use expense. > Limit the base value of the car to the luxury car tax limit of $57,009 to reduce the depreciation and interest.				

Benefit Type	Current Treatment	Proposed Treatment	Retention	Attraction	Admin. Ease	Overall Success Rating
Housing Fringe Benefit	The employee is provided with a right to use a unit of accommodation and the unit is the employee's usual place of residence. The taxable value is calculated by determining the market rental value on the open market less any consideration paid by the employee. Unless the employee is working in a remote area and certain conditions are satisfied, FBT will be payable on the taxable value.	Exempt from FBT the taxable value of the housing fringe benefit	😐	☺	☺	☺

Benefit Type	Current Treatment	Proposed Treatment	Retention	Attraction	Admin. Ease	Overall Success Rating
Loan Fringe benefit	Where an employer provides an employee with a loan at an interest rate that is lower than the statutory rate of interest (or no interest at all) FBT is payable on the taxable value of the loan balance at the end of the FBT year. The taxable value of a loan fringe benefit is the difference between the interest that would have accrued during the FBT year if the statutory interest rate was used on the outstanding loan balance every day and the amount of interest actually paid.	To exempt from FBT, any loan provided to an employee for a specific purpose such as a loan to acquire residential accommodation at the regional, country or remote area.	😐	😐	☺	😐
Debt Waiver Fringe Benefit	A debt waiver fringe benefit arises when the employer has repaid a loan for an employee or has waived the repayment of the loan. FBT is payable on the amount of the debt that has been released. If an employee has a principal and interest amount outstanding (that is forgiven) then the entire amount would be included in the taxable value and subject to FBT.	To exempt from FBT any debt waived, that was in respect of the medical practices or local housing at the regional, country or remote area.	☺	☺	☺	☺

Benefit Type	Current Treatment	Proposed Treatment	Retention	Attraction	Admin. Ease	Overall Success Rating
Relocation Fringe Benefits	Currently only specific relocation costs are exempt from FBT. They are: > Removals and storage of household effects; > Sale or acquisition of the employee's house; > Connection or re-connection of certain utilities; > Leasing of household goods while living away from home; and > Relocation transport	To make all relocation costs exempt from FBT. Other costs could include: > Paying the remainder of a rental agreement entered into by the employee prior to the relocation > Costs to ensure the new house is in a suitable condition to relocate i.e. cleaning of the house, maintenance, gardening or acquisition of additional household furniture or equipment that may be necessary.	N/a	😐	😐	😐

Benefit Type	Current Treatment	Proposed Treatment	Retention	Attraction	Admin. Ease	Overall Success Rating
Living Away From Home Allowance Fringe Benefit	An employee is living away from their usual place of residence due to having to work temporarily in a different locality and the employer pays the employee an allowance for additional expenses incurred and any disadvantages suffered by the employee as a result of living away from their usual place of residence in order to employee as a result of living away from their usual place of residence in order to perform their employment related duties. The taxable value is the amount of the allowance less any part of the allowance that is reasonable compensation for the cost of accommodation of the employee and for additional expenditure on food.	To exempt from FBT all the living away from home allowance.	N/a	😐	😐	😐

Benefit Type	Current Treatment	Proposed Treatment	Retention	Attraction	Admin. Ease	Overall Success Rating
Expense Payment Fringe Benefit	An expense payment fringe benefit can arise when an employer reimburses an employee for expenses incurred or when the employer pays a third party in satisfaction of expenses incurred by the employee. These expenses can be both for business or private purposes. The taxable value of the expense payment fringe benefit is the amount the employer reimburses or pays, subject to the 'otherwise deductible' rule. In house expense payment fringe benefits are taxed concessionally.	To exempt from FBT the following expenses: > Holiday transport expenses; > Boarding fees for employees children; > Accommodation, food and drink for tertiary education for employees children; and > Domestic assistance and childcare expenses > Local club and community memberships.	☺	☺	😐	😐