James Cook University
Faculty of Medicine Health and Molecular Sciences

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

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James Cook University supports much of the analysis and many of the conclusions and draft proposals in the Commission's Position Paper on health workforce. The document is, in general, a sound analysis of a complex policy environment. Given the complexity, the potential for harm and the powerful section interests involved, we are offering a brief response to: underline a number of conclusions which we agree are vital in formulating sensible policy direction; identify areas where conclusions or actions could be strengthened; alert the Commission to possible gaps or omissions; raise a few notes of caution in difficult areas; and offer suggestions on a some matters where we might draw different conclusions or regard as errors of fact. More detail is contained in the JCU July submission.

1. Conclusions that are strongly endorsed

We would particularly emphasise the following conclusions:

- Recognition that *education and training in regional, rural and remote areas* is a proven and vital strategy to improve rural and remote access to health workforce in the medium to long term.
- The conclusion that achieving *meaningful flexibility in clinical practice* among various 'middle-level' health professional groups will, from an early stage, need both: a clearer legal framework to support local delegation of clinical tasks by medical practitioners; and financial incentives (eg: in the form of appropriately discounted rebates) for clinical tasks that are performed under delegation.

2. Areas where conclusions or actions could be strengthened

A number of areas of analysis could go further or have a more explicit action-orientation. Without this, there is a risk that matters of strategic importance may be nominally supported but falter in action because of confused stakeholder responsibilities. Issues falling into this category include:

- While the particular *needs of rural and remote communities* are canvassed, there is little detail on specific actions that need to be taken other than an evaluation of current programs. The weight of evidence is strongly supportive of current policy of encouraging retention from and training in, regional and rural locations and this should be reflected in formal recommendations to extend this investment (see below). The need for evaluation of all programs should not be taken as a reason to slow or suspend expansion of training in rural and remote locations, given the compelling national and international evidence. In addition, discussion of quality and safety of healthcare in rural areas needs to emphasise the point that clinical teaching and research is the bedrock upon which reflective practice and maintenance of professional standards are built.
- The need to balance investment in *subspecialist versus generalist medical workforce* is discussed. We emphasise that while this is a particularly pressing

issue for rural and remote communities, in a climate of global medical workforce shortage and growing demand, access and affordability are increasingly global issues. Major gaps have been appearing for some time in the highly-skilled generalist domain (both for GPs and generalist specialities). It will take concerted and deliberate policy effort to reverse this trend. This should be a specific recommendation.

- Achieving reasonable *parity in access to needed health services in rural and remote communities* requires appropriate investment of health care resources. In the allocation of national pooled revenue, the Commonwealth Grants Commission applies the principle of fiscal equalisation to ensure that each state or territory government is receives the funds required to provide an average standard of state-type public services to all its citizens, given average operational efficiency and effort to raise revenue. However, the accountability for equity outcomes *within* state and territory jurisdictions (through investment choices on health care, infrastructure, industry development, education, health services, public housing, law enforcement and so on) pretty much stops at the state border. Mechanisms to systematise equity in regional healthcare investment is lacking in most jurisdictions and rural communities often lack electoral clout. For this reason, a move to regional weighted capitation-based resource allocation formula funding is required, backed up by agreed standards of 'universal service obligation' in healthcare. Without this, inequity in access tends to become self-perpetuating as overstretched rural health services struggle to retain skilled staff, resulting in downgrading and closure, and further decline of rural communities and 'blame-shifting' between state and federal governments. There should be agreement on what sort of health care should an isolated town of 5000 with 100 births per year should reasonably expect as a service benchmark.
- The paper notes that *Aboriginal Health Workers* (AHWs) could take on a wider range of tasks with 'fairly modest' additional training. There has been considerable confusion on the policy direction for AHWs and the issues are best articulated in the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2002. In short, expanded clinical roles for AHWs have existed for many years, particularly in northern Australia and the Aboriginal community controlled health service sector. However, in other areas there is inconsistent use of the 'AHW' designation and the term is often loosely applied to Indigenous workers with liaison, transport or advocacy functions who either have no formal training or no clinical training. There are already examples where AHWs are providing advanced functions in emerging areas of need such as haemodialysis as well as advanced roles in community midwifery. However, established clinical roles for AHWs have been under pressure from public-sector employers who have become increasingly preoccupied with clinical credentialing and protocol as well as from organised nursing in some instances. The exclusion of AHWs from the recent 'practice nurse' Medicare item numbers (that apply only to RNs and ENs in spite of the fact that doctors can employ AHWs with 'practice nurse' incentives funding) is regrettable and could be specifically addressed in the report.

3. Gaps in analysis or recommendation

- The paper does not deal with the *inequities in DEST funding* of undergraduate health professional programs. In particular, the relative inequities between medicine (and to a lesser extent, nursing) and allied health disciplines is out of step with what it costs to provide education and training in clinical disciplines. The discounting of DEST funding, based on an assumed 75% annual compounding retention rate, is manifestly wrong for health professional programs (where retention rates in excess of 90% across an

entire course are the norm). The result is that up to half the student body is 'unfunded' by the time they are in their final year. These should be matters for specific recommendation.

- The issue of *student accommodation* in rural, remote and Indigenous communities is not addressed. Lack of suitable accommodation is one of the principal barriers to utilisation of clinical teaching opportunities in many sites. Most jurisdictions have been decommissioning on-site accommodation at public hospitals (often related to ambivalence on clinical teaching as core business) or have become so reliant on itinerant workforce that nurses quarters and any other available accommodation are entirely given over for use by short-term staff. It is important that the student accommodation issue is explicitly discussed. A national stocktake of accommodation availability for undergraduate students undertaking clinical rotations in rural, remote and Indigenous communities should be considered. Re-construction of physical infrastructure will require substantial capital investment and therefore clarification of the respective roles of state/territory and federal governments.
- Along with accommodation, there has been a widespread loss of tutorial space and teaching facilities in public hospitals. Again, the 'tooling up' of the health system for clinical teaching will need clarification of roles and substantial capital investment.
- The *existing rural teaching infrastructure* in the form of University Departments of Rural Health (UDRH), Rural Clinical Schools (RCS), GP training through Regional Training Providers (RTP), new health programs in regional universities and others comprise an important base for further development of the rural and remote academic clinical backbone. These developments are not discussed. The existing rural programs should be summarised in the paper. Specific proposals to expand on this investment with further roll-out of integrated, multi-professional rural and remote academic infrastructure is required.

4. Notes of caution in difficult areas

- *New agencies to undertake health workforce analysis and provide policy advice*

  Re-structuring in response to operational challenges is unfortunately common in public health systems (as the Commission has previously noted). It is important that we do not fall into the same trap with the proposed new structures to oversight health workforce analysis and planning.

  It is not clear that the failings of the Australian Medical Workforce Advisory Committee in analysis of GP workforce in 2000 were due to inherent structural problems with mission, professionalism, rigour or methodology. In retrospect, there were obviously significant errors made. However (as recent events in Queensland illustrate) political interference is a powerful source of distortion, when there are major financial or political implications of a supposedly 'technical' exercise. The key question for the Commission is whether the single national secretariat that is to undertake numerical analysis of health workforce and report to the Australian Health Minister's Advisory Committee would be *more* or *less* prone to capture by political interests than the agencies it replaces.

  Similarly, the proposed Health Workforce Education and Training Council that is to consider new approaches to health workforce and the implications for "courses and curricula, accreditation requirements and the like" appears to have little compelling structural merit as described, and there are significant

overlapping roles with the proposed 'National Health Workforce Improvement Agency'.

This said, it is appropriate that planning processes concentrate on undergraduate entry for the major health workforce groups as proposed, with regular updates feeding into education and training planning cycles, and analysis for smaller groups from time to time as needed.

- *Innovation and a National Health Workforce Improvement Agency*

  It is not clear that the proposed 'National Health Workforce Improvement Agency' (with a national committee comprising a selection of experts and stakeholder representatives) could ever be an engine to drive health workforce innovation. Genuine innovation in healthcare delivery works best where it is informed by local community needs, is taken up by passionate individuals and backed by coalitions of support and regional relationships between agencies. It often occurs 'under the radar' of peak bodies and regulators.

  Engagement at the jurisdictional or national level to drive innovation tends to run foul of powerful professional or organisational interests, legal or regulatory obstacles, risk-averse departmental staff and the generally high turnover of participants. The fate of the UK National Health Service Modernisation Agency is a case in point. There is also a risk that the 'innovation' agenda will over time be captured by handful of individuals or agencies and that this may actually stifle genuine regional innovation. Changes delivered by such structures are likely to be 'safe', consensus-based and minimalist.

  Rather, the focus for driving innovation in healthcare delivery should be on supporting regional innovation in areas of need (especially in rural, remote and Indigenous communities) and disseminating the lessons learnt. In this respect, northern Australia is of vital importance to the national innovation agenda. Half of all Australians who reside in outer regional, remote and very remote areas are from northern Queensland, the Northern Territory and the northwest of WA (1.27M of 2.57M). In the south, these communities comprise only 7% of the population (and are therefore a lesser policy focus) as against making up 86% of the population of the north. Some 40% of Aboriginal peoples and Torres Strait Islanders are from the north where they account for 11% of the total population, as against 1.3% in the south.

  This is not to say that national mechanisms for analysis, strategic investment, and dissemination of information should not be considered. Rather, we advise caution in framing terms of reference and recommend that the region be the primary focus for generating, implementing and evaluating health workforce and service delivery innovation. Rather than a national body dominated by urban and professional interests being tasked with considering (among other things) "major job re-design opportunities specific to rural and remote areas", the flow of innovation is likely to be in the other direction.

- *Skills escalator*

  The model of 'skills escalator' (as articulated in NHS reforms in the UK) is now being reconsidered by many analysts. There are superficial attractions to the 'bolt-on' approach to training and credentialing (whereby workers can exit training programs at a number of levels, return to pick up progressively higher qualification increments and so move up to the next level of clinical responsibility). However, there is recognition of the problems with real-world educational design and efficiency inherent in this clinical training model as well as a better appreciation of the layers of red-tape that such arrangements

bring (in multiple outcome assessments, recognition of current competence mechanisms, employer and community education etc).

Articulated training pathways do have a place (eg: enrolled nurse to registered nurse programs). A single generic 'Clinical Assistant' training outcome on top of a variety of basic health qualifications (modelled on the US Physician Assistant) has merit as we have previously discussed. However, this is little future in complex, multi-step health qualification pathways across professions as a means of expanding scope of practice in the workplace. Skills escalation in the workplace is most flexibly achieved through the introduction of local delegated practice arrangements with medical practitioners. Similarly, delegation arrangements could be more broadly applied (eg: dentistry, pharmacy and other professions).

- *Transparency and contestability of training resources*

  We agree that there needs to be a greater transparency of clinical training resources. In particular, the lack of clarity around clinical training responsibilities of state jurisdictions under Australian Healthcare Agreements is a continuing problem.

  However, it is also clear that clinical training is significantly under-resourced across the board (particularly in regional areas). Increasing *transparency* of what little notional 'training' funding exists within an over-stretched district health service budget will not fix the problem. Imposing *contestability* along with transparency in this environment is likely to have unintended negative consequences by driving costs up (as clinicians withdraw from pro-bono roles) and by reducing the viability and, just as importantly, *sustainability and predictability* of local arrangements.

  Having clinical training resources follow individual trainees (a 'voucher system') would most certainly result in further maldistribution of health workforce to high-status, subspecialist-orientated urban hospitals. Such administrative arrangements should not be implemented without appropriate mechanisms to ensure regional equity in training investment on the basis of community need.

  Benchmarking of hospital-based clinical training costs (through say, a 20% loading on clinical service delivery budgets) together with accountability for performance in clinical training outcomes, regional-level analysis and planning, and regional stakeholder engagement and cooperation, is a better approach to improved accountability and efficiency for public investment of training resources. As previously discussed, there is a strong case for the Australian Government to assume responsibility for funding medical specialist registrar salary costs, *planned and allocated at a regional level*.

  For example, it is widely accepted that with allocation of necessary resources and some reform to supervision arrangements, The Townsville Hospital could immediately double the number of specialist training positions which would have a substantial impact on the specialist health workforce in the region. Without a strong regional program, some of the value of investment in undergraduate medical education at JCU could be lost as graduates are forced south to access training posts.

5. Areas of difference or factual error

- *Single agency accreditation of all professional education and training programs*

  A proposed 'National Accreditation Agency' is to assume responsibility for accreditation of education and training programs as well as harmonising standards and processes for professional registration between jurisdictions.

While a national mechanism to harmonise professional registration arrangements is welcome, national accreditation across all university and professional college-based health professional programs within a single agency is a different matter. The VET-sector approach of training provider audit and registration under the Australian Quality Training Framework standards is an example of the problems inherent in a 'nationalised' agency approach:

- Firstly, there is currently a lot of pro-bono work (much performed by university clinical academics) in the various current professional program accreditation arrangements. In the VET sector, compliance audits are performed on a commercial basis by auditors contracted by responsible state agencies. There would be a very considerable expense involved in applying this model to all undergraduate professional programs in the university sector and post-graduate professional training arena.
- Secondly, VET-sector AQTF standards are almost entirely generic – that is, they are not informed by content expertise in the particular vocational discipline relevant to the audit. In this way, an auditor with primary expertise in hairdressing (and generic training and assessment qualifications) may undertake an AQTF audit of RTO delivering a health-related program. This emphasis on form rather than content accounts for a lot of the continuing unease amongst employers and vocational bodies regarding VET-sector qualification standards.
- Thirdly, there is a risk that generic, government-auspiced standards mechanisms can result in an undue emphasis on cost control at the expense of quality. There are examples already from the VET sector where, for example, a state Enrolled Nursing program was dramatically cut by a government-run VET standards agency and only the intervention of the state Nurses Board prevented significant damage to professional and community interests.

There is need for reform. However, the problems inherent in a single national accreditation agency make this a high-risk approach.

- *National self-sufficiency in health workforce*

  The Commission has taken the view that national self-sufficiency is "not an appropriate objective" for national health workforce policy. We do not argue that healthcare labour is increasingly an international commodity and that Australia should not be restricted to employment of local graduates. However, the national aim should nevertheless be to produce the quantum of local workforce to meet local needs, even if there is two-way flow across national borders. Not only is this an appropriate ethical position for an affluent nation in the Asia Pacific region, the local production of health workforce has important flow-on impacts on regional community viability, innovation, clinical and research excellence etc.

- *Opportunities for interaction across professional disciplines in rural and remote areas*

  We do not agree with the conclusion that education and training in rural and remote areas does not "… benefit from interaction across professional disciplines, or from opportunities for higher levels of clinical training." (p178). The experience through University Departments of Rural Health, Rural Clinical Schools and other programs suggests that in most cases, quite the opposite is true. 'Silo' based undergraduate education and training for medicine, nursing and allied health is more entrenched in larger population centres and urban institutions. In regional universities (such as JCU) such programs are often co-located in the same Faculty. Not surprisingly, the most exciting innovations in

multi-professional approaches to education has often come from UDRH and RCS sites in rural and remote locations, where medical, nursing and allied health students are often co-taught, formally share small-group learning activities and undertake community clinical placement together.

Increasingly, pathways into post-graduate clinical training are strongly linked with undergraduate training (in particular, General Practice training with Rural Clinical Schools). There are problems with regional accessibility to specialist medical and nursing programs, although (as discussed in our July submission) this should be a specific focus of recommendation for reform of medical specialist training programs and as well as post-graduate nursing training in areas such as midwifery.

- *Indigenous health*

  The statement that "per capita spending on Indigenous health care is considerably higher than for the rest of the population" (p189) – needs correction. Analyses performed by Deeble et al suggest that while global spending is some 22% higher on average, ***considerably more per person is spent on the non- Indigenous population with a similar socio-economic profile*****,** let alone with a higher burden of disease and geographical remoteness. Reputable estimates (such as that performed for the Australian Medical Association by Access Economics) put the underspend on primary health care for Aboriginal populations at around $450M per year.

  A statement is made that improved education of Indigenous people will impact on health "through improving health awareness and dietary practices". Unqualified, this claim tends to reinforce the widely held but demonstrably incorrect view that poor outcomes in Indigenous health have their origins in the 'unhealthy' choices being made by individuals. The evidence points to fundamental structural determinants such as overcrowding, educational and employment opportunity, unaffordable or unavailable healthy food, economic exclusion and social inequality. The power of economic uplift and opportunities on Indigenous populations is already being seen in provincial centres, but this is not shared by Indigenous communities in many inner urban or remote areas.