RESPONSE TO THE PRODUCTIVITY COMMISSION STUDY IN RELATION TO THE POSITION PAPER RELATED TO THE HEALTH WORKFORCE STUDY

Professor Joan McMeeken
Head of the School of Physiotherapy
Faculty of Medicine, Dentistry and Health Science
The University of Melbourne
November 2005

INTRODUCTION

The School of Physiotherapy at the University of Melbourne appreciates the Productivity Commission's comprehensive Position Paper and considers that it provides recommendations that can lead to constructive changes to improve the delivery of healthcare to the Australian community. Our views below are supported by the Heads of Physiotherapy Schools around Australia. The Productivity Commission's recommended changes are crucial for a School responsible for producing graduates that well fit workforce needs and have the capacity to adapt to changing requirements in the future. As it is the Commission's intent to move to a more adaptable system of health care delivery, with a focus on the needs of the community and of the individual health care consumer, a broader perspective of the contributions and needs of all members of the professional health care team, including physiotherapy, is required rather than a focus generally from the perspective of medicine.

1. Some errors and omissions within the Position Paper

It is noted that there is an incorrect component in the paper in relation to physiotherapy: page 93, Box 6.1 states "Using hours is a fundamental yardstick, e.g. in Radiography and Physiotherapy, is inappropriate in a work environment where processes and practices have changed radically in the last 20 years, and which is also fundamentally inhospitable to the trainee. (Monash University, Faculty of Medicine, Nursing and Health Sciences, Sub.89, p. 6-7).

As Chairman of the Accreditation Committee for the Australian Council of Physiotherapy Regulating Authorities (ACOPRA) which is charged by the Federal Government to maintain educational standards in physiotherapy, I can attest that the accreditation processes for entry level physiotherapy education programs in Australia have <u>never</u> used hours as a requirement for accreditation. Our process strongly encourages best educational practice, variety and innovation and focuses its assessment on the performance of graduates in the workforce. A recent report indicates that this is the case.[1] The Commissioners have commended the accreditation model of the Australian Medical Council (AMC), with a suggestion being made that this model should form the basis for a national model of accreditation. The outcomes focused accreditation model for physiotherapy education programs extends beyond that of the AMC in terms of its focus on outcomes. Of particular note is that the physiotherapy accreditation process includes evaluation of first year graduates and their employers to assess whether the university program is producing graduates who can fulfil generic expectations such as communication, problem solving and adaptability as well as practise safely and effectively as a physiotherapist in the current Australian health care settings.

Chapter 5 does not consider the fact that postgraduate clinical training for physiotherapists is entirely self-funded, despite specialist physiotherapy expertise being essential in many areas including the management of major surgery (such as heart, liver and lung transplants, tendon and

[1] **McMeeken JM** Webb G Krause KL Grant R: 2005 Learning Outcomes and Curriculum Development in Australian Physiotherapy Education, Australian Universities Teaching Committee www.carrickinstitute.edu.au/carrick/go/pid/65.

joint surgery), rehabilitation following stroke and other neurological conditions, and the management of complex musculoskeletal injury.

SPECIFIC COMMENTS ON DRAFT PROPOSALS

2. Comments in relation to draft proposals 3.1 & 3.2

These first two draft proposals regarding COAG endorsement and review of the National Health Workforce Strategic Framework are supported.

My experience as an educator and clinician indicates that health professional graduates who have been educated in Australia are well prepared for the Australian health workforce and I suggest that they continue to be given priority for entry into Australia.

3. Comments in relation to draft proposals 4.1, 5.2, 9.1 & 9.2

These proposals are most welcome as there is an urgent need for greater coordination and management of health workforce planning and innovation at all levels, local, State and national. Three new separate bodies may not improve the existing situation and a single overarching body, which includes representation from education and health bureaucracies as well as the largest groups of health professionals, may yield an improved outcome.

Currently here are no Australia-wide or state-specific coordinating strategies for the whole health workforce. The lack of coordination has been problematic in many disciplines, particularly those that are attractive to students and have high entry scores, such as medicine and physiotherapy. The availability of clinical education opportunities, academic and teaching workforces, existing university-hospital relationships, postgraduate preparation and longer-term career paths for graduates have not been considered. At present the lack of planning the introduction of new programs and/or additional health professional students has put long term valued relationships under stress with some already fractured.

During the Productivity Commission's process there has been little effort to address the needs for interprofessional education or new models of practice rather there has been attention paid to a generic health practitioner. This latter proposal has been on and off the agenda for 40 years. In Australian there are already programs that prepare generic health science graduates and there is no evidence to suggest that these people enrol in more advanced or specialized areas such as physiotherapy or medicine. There is also a very limited transfer of nurses into these disciplines. There is underused capacity for graduates of the existing disciplines to work in a more cost effective manner rather than introducing new disciplines – nurse practitioners provide an example of how this can be achieved. There are some useful physiotherapy models in the United Kingdom. Within Australia significant trial activity related to physiotherapists in the public sector is in progress. In many instances the activities reflect those that have been occurring within specialist private practice physiotherapy for decades. They could therefore be translated into the public sector efficiently, effectively and at modest cost.

Interprofessional learning models, as well as core learning within health education programs, where the mix of students appropriately reflects the intellectual capacity of students and the needs of the health system are both desirable educational innovations.

Universities offering physiotherapy education engage collaboratively with the employers of physiotherapists to ensure the graduates' suitability for the workforce. The current accreditation process facilitates this. Under current education and registration requirements, physiotherapists graduate as generalist practitioners with clearly demonstrated capacity to move into more specialist areas. Increased course length is supported due to the expanding knowledge base in biomedical, behavioural and clinical science. Increased course length is already achieved through the graduate entry Masters programs that produce work ready physiotherapists who have undertaken a relevant three or four year Bachelor degree followed by a two (calendar) year Master of Physiotherapy degree. Current funding models for graduate entry physiotherapy, unlike that for graduate entry medicine, do not provide Commonwealth Government supported places despite the fact that these

programs are normally of shorter duration and provide an opportunity for a more rapid response to workforce shortages.

Although the "skills escalator model" and recognition of prior learning have some merits in being able to provide a more adaptive workforce, it is important that these approaches do not simply focus on competencies in terms of a knowledge and skill set, but require the achievement of clinical competence and the clear capacity for making informed and appropriate clinical decisions.

The repeated references to 'university-based training of health workers' deny some of the important elements of a university education. Universities are clearly more than workforce training institutions – a central role of universities is to undertake research to provide evidence for the most cost effective and efficient health practices and to imbue graduates with the capacity to continue to learn and incorporate new developments into their own practice. Therefore a model that focuses on "training" of the health workforce may not produce an effective adaptable health workforce. It is important to develop educational models that adequately provide for the duration of education that is required to develop expert clinicians who can meet the increased demands of providing quality clinical services today and in the future.

There are presently available a number of exit points so that students can obtain a qualification recognising a more limited skill set and the ability to practice under supervision of staff who have completed more extensive education.

4. Lack of access to clinical education for physiotherapists

There appears to be a continued lack of understanding by the Commission of the crisis situation affecting clinical education in physiotherapy. This is not a short term problem as evinced by continuing difficulties in Queensland. It can only be resolved with funding to support current clinical educators and to increase the numbers of clinical educators both in the public and private sectors. It has been noted that with the increase in student numbers, there is an increasing additional educational burden on clinicians in preparing recent graduates for the workforce[1]. A funded intern year as is available in medicine could obviate the need for an increased course length and new graduate additional clinical preparation.

Involvement of the private sector in clinical education will require negotiation with private health insurance funds and other third party payers to pay for services provided by students under the supervision of a physiotherapist. A recommendation from the Productivity Commission to support such changes would be desirable.

5. Insufficient funding for clinical education for physiotherapists

For universities offering physiotherapy to make a contribution to clinical education it must be funded. There remains an urgent need for the Federal Government to review the Commonwealth Course Contribution Schedule and reclassify physiotherapy as a clinically based medical science. Without the additional funding that this reclassification would provide, it will be impossible to maintain clinical education programs in the future. The current course funding relativities of $15,000 per year per student place for medicine, $9,700 for nursing, and $7000 for physiotherapy highlight the problem. There is no acknowledgement that the biomedical sciences required for physiotherapy are on a par with those for medicine and in some universities are co-taught. Furthermore, there is an explicit clinical training component in the Government's contribution to medical and nursing courses, but none for physiotherapy. The current DEST funding is not sufficient for both the payment of clinical education placements and the delivery of high quality pre-clinical teaching and learning programs. For this reason, entry-level programs need to be subsidised from alternative revenue sources.

All physiotherapy postgraduate education is delivered by universities on a 100% user pays basis. This has resulted in a significant reduction in the number of Australian physiotherapists completing professional Masters programs since 1997, reducing the specialist physiotherapy care provided to the Australian community. Already there are serious workforce shortages throughout the country in

[1] op cit

metropolitan and rural areas of physiotherapists with expertise in paediatric and cardiorespiratory physiotherapy.

A potential solution may be supported by section 73-5(1) of the Higher Education Support Act 2005. This section provides all individuals with a Student Learning Entitlement equivalent to 7 years of study. While it is not specifically excluded in the Higher Education Support Act 2005, the Department of Education, Science and Training (DEST) does not permit students to use this learning entitlement for postgraduate study. The Commission is strongly encouraged to recommend that students in health related courses be permitted to use part of their learning entitlement for postgraduate study since a more highly trained workforce will clearly be of benefit to the broader community. Such a change would also permit more students to enter accelerated graduate entry masters programs with the benefit of being able to provide a more rapid response to workforce needs in health disciplines such as physiotherapy with critical shortages.

6. Comments in relation to draft proposal 5.1 & 5.3

The lack of planning for physiotherapy in the health workforce and health system, indicates a need for engagement the Department of Health and Ageing (DOHA), State Government health departments and representatives from the private health sector in determining the number of student places in health disciplines in Australian universities. This engagement should also consider the needs of physiotherapy postgraduate education in specialist domains.

The proposal to transfer allocation of the quantum of funding to DOHA is not supported and it is strongly recommended that the Department of Education Science and Training (DEST) retain control of funding distribution and student enrolments. The involvement of DOHA in the allocation of medical student places is said by the Committee of Deans of Australian Medical Schools submission to have produced “chaotic effects”. Furthermore DOHA has also been responsible for the allocation of funding to Rural Clinical Schools. Outcomes in this area indicate that it is not as the Commission suggests; DOHA is likely to focus almost exclusively on medicine and that interprofessional activities and other disciplines would not be supported.

Experience in physiotherapy in England where health trusts fund physiotherapy education in universities, demonstrates that short term workforce drivers have been responsible for big swings in demand and funding, creating chaos in planning, staffing and professional linkages. It mitigates against engagement between health professional schools and the rest of the university. It also undermines the critical connections between education and research. University medical/health science schools are responsible for much of Australia’s internationally renowned medical and health research and there are clear, evident links between the conduct of research and the quality of teaching.

Quality standards of health, education and research would be best served by remaining within the current policy and funding framework for higher education, with the health and education sectors working together to facilitate and integrate health professional education.

7. Comments in relation to draft proposal 5.3

This proposal is strongly supported as it reinforces the importance of a comprehensive physiotherapy clinical education program and advocates the greater use of explicit payments to those providing support for clinical training. Explicit funding should be allocated to universities to manage the allocation to their clinical education providers – in particular, to support additional staff members who have a primary responsibility for supervision of clinical education. This explicit funding is essential to break the current nexus between service delivery by the current health workforce and clinical education of the future health workforce.

It is this nexus that is the primary source of workplace pressure and stress for many physiotherapists in the public sector who are expected to manage both a full patient load and teach students. Whilst there may be a continuing role for some *pro bono* contributions to clinical education a model such as currently occurs that relies almost totally on such contributions is not sustainable. For provision of these services within public hospitals and health care locations with educational responsibilities, adequate funding must be available to meet the needs of physiotherapy.

Outside these public institutions, creation of a contestable funding pool would provide an appropriate means to remunerate individual practitioners for these services. Ensuring that Commonwealth-State funding agreements obligate State-based hospitals to provide for education and research as core business and adapting case-mix funding to include a component for education and research would demonstrate that education is a core activity and responsibility of all health professionals. The preferred model is to embed education and research into the core business of health facilities and to make explicit provision for remuneration of practitioners and facilities in the private sector. Provision of a contestable pool of funding for these services would provide the flexibility, which is now needed to have appropriate ‘learning in context’. There will need to be additional funding to ensure that this occurs – a redistribution of current funding will only lead to intense internal wrangling between professions. There is already insufficient funding in the system.

8. Comments in relation to draft proposal 6.1 & 6.2

A national across-profession approach to develop accreditation policies and to set standards to achieve consistency and best practice is desirable. However a single national accreditation agency such as that proposed by the Commission would be large and unwieldy with the potential to develop a significant bureaucracy and the potential to make accreditation processes slower. Professions such as physiotherapy need to retain autonomy in accreditation processes. Consistency of approach across various accreditation agencies is desirable but retention of profession specific mechanisms to implement accreditation are necessary to maintain best practice and quality control in the health professions and safety and quality of health care.

A national body to oversee the national accreditation bodies in the specific disciplines could establish guidelines for accreditation processes and promote consistency of approaches and development of best practices by the various accreditation bodies. It will be vital that professional expertise is structured into the national body, with specific additional expertise called upon as issues arise.

Physiotherapy, through ACOPRA, has implemented, and continues to implement, a consistent national approach to accreditation. ACOPRA is committed to continuous quality improvement of its outcomes-based system of accreditation, undertaking regular reviews of its guides and systems. Implementation of accreditation processes in accordance with a consistent national approach should be the responsibility of the professions who would report accreditation activity to the national accreditation advisory agency. Involvement of another professional discipline/s in the accreditation process may be a means of removing some of the ‘silo’ concerns.

The national accreditation advisory agency should develop guidelines for a nationally consistent approach to the assessment of overseas trained health professionals and have oversight of the mandatory development of profession-specific processes that comply with the guidelines.

9. Comments in relation to draft proposal 7.1, 7.2 & 7.3

A nationally consistent approach to the registration of physiotherapists in Australia that assures high standards of physiotherapy for the Australia community is essential. The development of national standards should be by the Registration Boards and State and Territory Governments and not by the accreditation agency. The profession has already worked together across the States to achieve this within the constraints of State registration requirements. The limited registration model enables overseas trained physiotherapists to work for up to one year under the supervision of a fully registered physiotherapist. A nationally consistent approach to the regulation of physiotherapy assistants and the regulation of extended practices is under development.

Task delegation is already required within registration acts for physiotherapy as well as other professions and additional requirements are redundant.

Furthermore a consistent national approach to regulation of extending the scope of professional practice will assist in enabling physiotherapists to contribute to a more efficient and cost effective health workforce by providing additional services. It should be noted that medical practitioners may refer patients for physiotherapy but cannot delegate tasks to physiotherapists in the manner

described in Chapter 8 of the Position Paper. It is recommended that the Commission, in its final report, distinguish between task delegation and referral of clients between health professionals.

10. Comments in relation to draft proposal 9.1 & 9.2

A single national body with responsibility for coordination of all aspects of innovation, planning and education and training of Australia's health workforce is strongly supported. Had this approach been taken in the past, there might have been a more rational basis for the decisions which have been taken recently in relation to the opening up of new Schools and new places in physiotherapy, medicine and dentistry.

11. Comments in relation to draft proposal 10.1, 10.2 & 10.3

The rural workforce would benefit from these three draft proposals. Whilst over recent years medical schools have become the leading sites for programs specifically aimed at increasing the rural and remote medical workforce, they have not adequately provided for the health care team and other disciplines have generally been ignored. They are not currently truly reflective of health care needs of the community.

There is a clear need for a national project to develop a national data collection process and database for a longitudinal tracking system to evaluate the outcomes of health education programs. This should apply to all the major health disciplines.

12. Comments in relation to draft proposal 11.1

This draft proposal is strongly supported.