PRODUCTIVITY COMMISSION POSITION PAPER:

"AUSTRALIA'S HEALTH WORKFORCE"

Response by the

Faculty of Medicine, Dentistry and Health Sciences
University of Melbourne

in support of the Response by the
Committee of Deans of Australian Medical Schools
(CDAMS) & with additional comments

November 2005

INTRODUCTION

The faculty of Medicine, Dentistry and Health Sciences (MDHS) welcomes the release of the Productivity Commission Position Paper "Australia's Health Workforce" and has contributed to, and supports, the response made by CDAMS on behalf of its constituency. Together with CDAMS, MDHS commends the Productivity Commission on their analysis of a set of complex and challenging issues. We wish to make some additional comment with particular reference to those proposals and recommendations relating to the continuum of the health professions.

As it is the Commissions intent to move to a more adaptable system of health care delivery, we seek a recognition of the need to focus on the needs of the community and of the individual health care consumer. In that context a broader perspective of the contributions and needs of all members of the professional health care team is required.

DRAFT PROPOSALS

In relation to Draft Proposal 4.1, 5.2, 9.1 & 9.2

As articulated by CDAMS, there is a strong level of support within CDAMS, and the medical education sector more broadly, for better coordination of health workforce planning, innovation, development and implementation. There is an urgent need for greater coordination and management of health workforce planning and innovation at national, State and regional levels.

As articulated in the Position Paper, the Commission is proposing the establishment of three separate, distinct entities:

- an advisory health workforce improvement agency;
- an advisory health workforce education and training council; and,
- a single workforce secretariat (to replace AMWAC and AHWAC).

There is concern that this proposed tripartite model could replicate the current separation between the various levels and sectors in the education, training and practice continuum. Furthermore, there is no coordinating strategy for the whole health workforce. Planning has not taken place at a national or state level and the outcome of the rapid and nonconsultative expansion of additional schools is problematic in many disciplines, particularly those that are attractive to students such as medicine and physiotherapy, where growth has been uncontrolled.

We recognise, together with CDAMS, that there has been no long-term planning associated with new medical schools and additional places in existing schools and that there are the concerns regarding the availability of clinical training opportunities, academic and teaching workforces, existing university-hospital relationships, intern training places, appropriate opportunities for postgraduate vocational training and longer-term career paths for medical graduates. In parallel, there has been no opportunity to consider new models of practice across the various linked health professions.

Together with CDAMS, MDHS believes that 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 proviso that the health and education sectors work more closely to streamline and integrate health professional education. This might be facilitated by actively involving DEST and other education stakeholders in any health workforce agency or agencies as proposed in the Position Paper. We hold that the research-education nexus is vital and should not be unduly influenced by short term workforce drivers and resources that can cause major effects on teaching/research staff and their productivity.

In relation to Draft proposal 5.3

MDHS supports the position stated by CDAMS on the further complex issues around funding for clinical training. However, MDHS draws the attention of the Commission to the crisis situation affecting clinical education in many health profession sectors, as is now approaching in medicine. This is not a short term problem - the situation will continue as a critical problem in disciplines such as physiotherapy unless there is funding made available to increase the numbers of clinical educators. The critical situation in clinical education may well result in a lack or preparedness of some graduates for the required scope of entry-level expectations of the workplace. This has the effect of shifting an additional educational burden onto the clinicians.

We would propose that, in conjunction with supporting initiatives to increase access and provide funding to clinical education opportunities within the private sector, private health insurance funds, Workcover insurers, motor accident insurance authorities and other agencies that fund health care services in the private sector agree to pay for services provided by a student under the supervision of a registered practitioner.

With the exception of medicine, the postgraduate education of health professionals has a significant university component. A range of providers may be desirable for postgraduate and vocational specialist training domains, related to the professional rigour required in accreditation/registration in health professional disciplines.

Whilst there are disciplines with some funding for clinical training still largely embedded in the State-based funding of those institutions, for many disciplines within the health professions there is no explicit funding for clinical education. A contestable funding pool would need to be distributed in a fair and equitable manner.

Within public hospitals and health care locations with educational responsibilities adequate funding must be available to meet the needs of identified health professional disciplines. Outside these institutions, creation of a contestable funding pool would provide an appropriate means to remunerate individual providers for these services. As stated by CDAMS, provision of a contestable pool of funding for these services would provide the flexibility which is now needed to have appropriate ‘learning in context’ We draw attention to the need for additional funding to ensure that this occurs with efficient use of funds in all health disciplines with a clinical teaching component.

CDAMS urges the Commission to review the draft recommendation #5.3 to consider whether it might be strengthened to recommend that a contestable funding pool is created in the medium term. MDHS supports the allocation for clinical education through the CSP contribution which the universities [with responsibility for clinical education] then direct to appropriate providers. Additionally, this model could apply at postgraduate level for most health disciplines whose postgraduate education is university based. These include physiotherapy, psychology, audiology, nursing, and dentistry.

In relation to Draft Proposals 6.1, 6.2

CDAMS draws attention to the need for specific mechanisms to address the particular needs of the health professions within a unified national system of accreditation. MDHS would support a model for a national policy setting body for oversight of accreditation. Physiotherapy has a very effective system which is based on outcomes and the principles include the encouragement of innovation in achieving educational objectives. Where good models exist they should be used to construct national principles. Involvement of another professional discipline in the accreditation process may be a means of removing some of the 'silo' concerns.

The Commission addressed the issues of job re-design and 'skills escalators' in the Position Paper, and the proposals relating to national accreditation and registration processes are intended to address these areas. MDHS believes there is much capacity to use graduates of the existing disciplines in a more cost effective manner rather than introducing new disciplines. Nursing provides an example of how this can be achieved and within Australia significant trial activity is in progress.

We may be better served with development of interprofessional learning of topics such as ethics, legal health, quality and safety, communication, as well as core learning within health education programs, where the mix of students appropriately reflects the needs of later stages of the students' programs, the intellectual capacity of students and the needs of the health system.

In relation to Draft Proposals 10.1, 10.2 & 10.3

In their response and in previous submissions, CDAMS has pointed out that the more multidisciplinary University Departments of Rural Health and the Rural Clinical Schools are well placed to provide a 'vertically-integrated 'teaching health system' in rural Australia led by the universities'. MDHS emphasizes that theses must adequately provide for the health care team and other all disciplines to be reflective of the health care needs of the community.

CDAMS draws the Productivity Commission's attention to the Medical Schools' Outcomes Database project, a joint initiative between CDAMS and DHA, as the foundation for a longitudinal tracking system to evaluate the outcomes of medical education programs, particularly those related to rural medical education. MDHS would support a wider approach to tracking all major health disciplines; currently undertaken by individually by State and federal professional bodies.