Productivity Commission Study

into the Health Workforce

Joint State and Territory Health CEOs'
response to the Commission's Position Paper

14 November 2005

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1 Overview

Introduction

In this response to the Productivity Commission's Study into the Health Workforce, State and Territory Health CEOs indicate their broad support for many of the major structural and systemic changes proposed by the Commission.

Need for urgent action

The urgency of addressing the workforce issues facing the Australian health system is more immediate than it was when the Council of Australian Governments (COAG) requested the review into health workforce some 16 months ago. The Productivity Commission has recognised the national importance of this issue in their 2004/05 Annual Report where it is highlighted that:

> "*the most significant sources of potential stress on government budgets are health and aged care, with the former contributing most to the expected increase in government outlays. Health care costs are projected to rise by about 4.5 percentage points of GDP by 2044-45, with ageing accounting for nearly one-half of the increase, or some $40 billion of extra spending*" (Productivity Commission 2005, Annual Report 2004-05, Annual Report Series, Productivity Commission, Canberra p 22)

State and Territory CEOs request the Commission to consider further specific reform to improve the health workforce in regional, rural and remote areas. If significant and expeditious reform is not achieved, workforce issues in those parts of Australia will further impact on the already limited capacity to respond to health needs in these areas, particularly for Aboriginal people.

This is demonstrated in provision of oral health services in rural and remote areas. In NSW for example every rural dentist is trying to service 1500 more patients that their metropolitan counterparts and still only half the required number of dental student training places is available.

The health workforce is ageing, more so in rural and regional areas. Added to this the effects of decreasing participation of younger generations and their access to a wider range of job opportunities and Australia's status as having *one of the best health systems in the world* (COAG 2005) could be compromised.

The Commission has chosen to focus on development of systems facilitating longer term reform. While this is important, guidance is also necessary to meet the health needs of the community in the short term as outlined in the Commission's terms of reference so that achievement of health reforms agreed by COAG can be supported.

The need for a better integrated health care system, the need to focus on preventive health and strengthen primary care has been recognised across most submissions and the availability of a skilled and flexible workforce is fundamental to maintaining and improving population health outcomes.

National Priority for the Health Workforce and Ongoing Engagement

The potential to pursue new directions for the future health workforce only exists because these matters have been afforded priority by, and are being addressed at, the most senior level of government (COAG).

This is an acknowledgement of the fact that at least two levels of government must participate and co-operate in decision making and that no one sector, whether education and training or health, can effectively resolve the issues and take appropriate action in isolation from the other.

States and Territories consider that national priority must be afforded to the education, training and maintenance of the health workforce and the manner and extent to which this is resourced, must be a matter of ongoing whole of government consideration.

State and Territory Health CEOs agree that to achieve necessary change and long term reform, a whole of government perspective must be taken with direction provided by COAG.

Effective and ongoing engagement with the education and training sector is essential.

State and Territory governments run hospitals, employ nurses doctors, allied and other health professionals but have only limited influence on how many or the type of health professionals to be trained. Funding bureaucracies currently have no requirement to act on local identified need.

Final proposals from the Commission must correct these imbalances and reverse any fiscal and regulatory processes put in place to restrict supply.

Apart from reporting to COAG on the implementation of the National Health Workforce Strategic Framework, the new arrangements proposed by the Commission currently leave accountability and implementation arrangements with the health sector.

Without ongoing whole of government accountability for any new arrangements, the States and Territories are concerned that the issues of disconnect between the health and education and training sectors that have required the current consideration of these issues will simply re-emerge in the future.

New Agencies – Principles of Governance and Support

The proposals in the Commission's paper outline the broad directions that need to be followed to achieve essential change, but need to go further in strengthening the connection between establishing new bureaucracies and action that will see results at a local level.

States and Territories note that to achieve effective change, these reforms will require adequate resourcing, careful change management processes and well-crafted governance arrangements.

In terms of governance, States and Territories consider that overriding principles about the governance of any new bodies created at a national level should include:

- membership representative of all jurisdictions (and community interests where relevant)
- actions implemented through an identified national decision making forum
- support provided by an independent secretariat with adequate resources
- a clear focus of effort on areas where national cooperation is required
- the priorities of the participating jurisdictions are to be reflected in work and directions
- new governance bodies only being established after considering opportunities to abolish or amalgamate any relevant existing bodies
- meaningful engagement with health occupational groups to support innovation and a future sustainable, quality health workforce

Conclusion

The proposals and recommendations contained in this response seek to build on the directions outlined and effect some short, as well as longer term, relief in the provision of health services for the community.

While there are a range of views about the precise details of the reforms and their implementation, this response represents the broad collective view of all State and Territory Health CEOs.

2 The Joint State and Territory Health CEOs response to Draft Proposals

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.

Joint State and Territory Health CEOs' response 3.1

State and Territory Health CEOs support the proposal for COAG to adopt the NHWSF.

In regard to broadening the self sufficiency principle it is recommended that COAG, through its senior officials, should gain agreement on wording to better reflect the imperative to increase local capacity at the same time as interacting in a global workforce market.

State and Territory Health CEOs seek an explicit recommendation that addresses the current shortfall in the provision of funded undergraduate health places available in universities.

While State and Territory Health CEOs support the Council of Australian Governments (CoAG) endorsing the National Health Workforce Strategic Framework (NHWSF), State and Territory Health CEOs believe that broadening of the self sufficiency principle warrants further clarification.

State and Territory Health CEOs understand and consider that they need to operate in a national and world labour market for health professionals. In this context, 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, they are 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. State and Territory Health CEOs agree that collectively they should aim to produce sufficient number of health workers net of migration inflow and outflows.

State and Territory Health CEOs contend 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 a range of health disciplines eg nursing, podiatry. 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.

State and Territory Health CEOs, however, believe 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. There is also a need to consider any impact that the rise in overseas full paying university places has had on access by local students.

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.

Joint State and Territory Health CEOs' response 3.2

State and Territory Health CEOs support this Draft Proposal.

The regular reviews of progress should also 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 any 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.

Joint State and Territory Health CEO's response 4.1

Due to the inherent linkages between health workforce design and innovation, and education design and innovation, State and Territory Health CEOs support the proposed establishment of a national health workforce improvement agency that includes those functions proposed by the Commission for an advisory health workforce education and training council. Linkages with the accreditation agency will be important.

The suggested approach is seen to have a number of benefits, including:

- Allowing local innovation to be supported and gain traction at a national level
- A more integrated approach to progressing workforce innovation in which educational reform responds to changing health care needs.
- Education and training required to support development of new or amended roles across services streams that 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.

Both formal 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.

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. 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 fall into VET curriculum areas and it will be critical that such training is developed in an integrated manner with higher education.

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, nurse practitioners in NSW or the greater use of dental therapists and hygienists for oral health services highlights 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.

Essential to the success of the agency will be adoption of the governance principles outlined in the overview to this response, and adequate resourcing.

For an agency such as this to be fully effective, however, there would be a need for its findings to be implemented. By reporting through a national decision-making forum, the suggested States and Territories approach would enable the agency to identify what is possible and demonstrate such reforms in action and 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.***

Joint State and Territory Health CEO's response 5.1

State and Territory Health CEOs support the establishment of a process which identifies a separate quantum for health workforce education and training linked to health service need.

Whilst State and Territory Health CEOs support 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 adequately 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 them. Over the medium to long term, decisions regarding training numbers and their distribution influence the capacity of health 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, individual State and Territory health sectors attempts to engage the Commonwealth in such an exercise in relation to a range of health occupations has been unsuccessful.

This leads the States and Territories 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.
- Successful implementation of the Commission's Draft Proposal 5.3 will be highly dependent on the capacity of all parties to effect change across the various aspects of curriculum, clinical training and funding. An integrated planning and allocation process will be critical to this.

Under the suggested process 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.

The process would see the quantum of funds based on identified jurisdictional education and training needs informed by health need and service planning.

It should be noted that State and Territory Health CEOs do not support linking funding for health workforce education to the Australian Health Care Agreement. The acute care focus of the Agreement does not reflect the breadth of health workforce education and training and acute care financing is not well aligned to education and training considerations.

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.***

Joint State and Territory Health CEOs' response 5.2

State and Territory Health CEOs support the functions proposed for the health workforce education and training council, but do not support the establishment of a separate agency.

Instead, State and Territory Health CEOs recommend that these functions be undertaken by the national health workforce improvement agency. 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.***

Joint State and Territory Health CEOs' response 5.3

State and Territory Health CEOs support policy effort to improve transparency in determination and allocation, contestability and evaluation of cost effectiveness of funding for all aspects of education and training of the health workforce

State and Territory Health CEOs support this Draft Proposal in principle, however, believe that:

- The undertaking of such policy work must cover all aspects of clinical training including that provided by the education and specialty college sectors.
- As many sectors are involved then the policy effort should be directed at a whole of government level
- Funding responsibility for medical specialist training should be consolidated at a State and territory level. 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.
- Any examination of explicit payment systems for clinical training must be done in a manner that does not provide

unnecessary burdens on trainees that may further drive them to seek the financial incentives to practise in the private system.

- 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 allow active engagement of State and Commonwealth governments in collaborative workforce planning 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.

- 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.

Work undertaken by Victoria has 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 indicates that not only should funding be more transparent and contestable, but that there must be a capacity to judge the 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.

Joint State and Territory Health CEOs' response 6.1

State and Territory Health CEOs except the South Australian CEO support the establishment of a single national accreditation agency for university-based, postgraduate and VET health workforce education and training that also has responsibility for multiprofessional registration at a national level, whilst ensuring appropriate involvement of relevant professional expertise.

The South Australian CEO supports a single national multiprofession accreditation agency and a single national multiprofession registration agency, but not the creation of a single combined agency to undertake both functions.

The details of the proposed model are contained in the response to Draft Proposal 7.2.

As indicated previously, States and Territories consider that there is benefit in the early inclusion of VET in the responsibilities of the national agency.

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.

Joint State and Territory Health CEOs' response 6.2

State and Territory Health CEOs support 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.

Joint State and Territory Health CEOs' response 7.1

State and Territory Health CEOs do not support this proposal. Refer 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.

Joint State and Territory Health CEOs' response 7.2

State and Territory Health CEOs do not support this proposal. States and Territory Health CEOs support establishment of a national multiprofessional registration authority responsible for health professional registration and accreditation of educational courses.

The South Australian CEO supports a single national multiprofession accreditation agency and a single national multiprofession registration agency, but not the creation of a single combined agency to undertake both functions.

Whilst State and Territory Health CEOs support the intent of the Commission to improve the operation of mutual recognition for the registration of the health workforce across Australia, they believe 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. This view is informed by the work that Victoria has undertaken on behalf of AHMAC to develop the framework for implementation of nationally consistent medical registration.

State and Territory Health CEOs consider that the most effective and efficient way to achieve this would be through the establishment of a national scheme for health practitioner registration.

State and Territory Health CEOs support the Draft Proposal for a single national accreditation agency for university-based, postgraduate and VET health workforce education and training, however, believe that it would be 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 schemes operate, and in particular, the relationships between registering and accrediting bodies.

In establishing the body it will be important to ensure appropriate involvement of relevant professional expertise in accreditation and registration activities, such as development of professional standards and grievance and disciplinary process, so that access to relevant expertise is retained.

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 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"[1]. In investigating disciplinary matters, boards will often draw upon relevant policies and statements – as well as information from other

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

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.

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 the 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

Bodies undertaking course accreditation have established guidelines that 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.

There is a high level of commonality in these guidelines across professions.

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[2].

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 1 provides an example of how the Australian Council of Physiotherapy Regulating Authorities, ACOPRA, describes its role and the standards used in the accreditation process).

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2 The Australian Government in 1992 funded a project 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.

Figure 1: 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

There is an existing system for accreditation of VET courses which includes consultation with stakeholders including employers, although it operates for a different purpose to accreditation of health courses for registration purposes.

Relationship between accreditation and registration bodies

Section 8.2 of the Victorian submission to the Productivity 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.

They are funded in certain circumstances 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, for example, in 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 professional competency standards in issuing guidelines regarding expected practice standards and/or assessing allegation that registrants have engaged in unprofessional conduct and/or unsatisfactory professional performance.

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 that provide advice on issues of interpretation and set expectations around how practitioners will be judged against such standards, where these exist.

With the exception of the South Australian CEO, it is State and Territory Health CEOs' view that to achieve a cohesive, forward focused approach to issues of 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 reflective of 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 Commission's proposal for 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.

State and Territory Health CEOs support the proposal that the approach to accreditation and registration be cross-disciplinary 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

This model would also 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, improve procedural fairness of processes, simplify arrangements for consumers and improve confidence in the independence of the regulatory system.

The body set up under this model must have continued involvement of professions it regulates to ensure its effectiveness, safety and quality and engagement of those professions.

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. Relevant details of the scheme are noted in both Victorian and NSW submissions (Appendix A) 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, the States and Territories would advocate for all professions who are registered all in States and Territories to be included[3].

The governance arrangements for the agency should include capacity for appropriate accountability to governments, including the capacity for Ministerial oversight and direction through AHMC.

As for the health workforce improvement agency, essential to the success of the agency will be adoption of the governance principles outlined in the overview to this response and ensuring that the public interest remains paramount.

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.

Joint State and Territory Health CEOs' response 7.3

State and Territory Health CEOs do not support any proposal that provides rigid demarcation between and within professions, either through legislation or policy.

State and Territory Health CEOs have reservations about 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

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

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, under most jurisdictional schemes, the regulatory model of health practitioner legislation 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 professions such as dentistry and optometry, jurisdictional health practitioner 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. Victoria's recent Review of the Regulation of Health Professions, has involved a detailed analysis of the role and function of registration boards. As a result of the review, a proposal is currently under consideration in Victoria that would require registration boards to consider external broad public interest issues when setting such standards and issuing codes and guidelines.

Within most jurisdictions' schemes 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. A model of effective delegation, however, could be developed through sensible and effective 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.
- Credentialling is a matter for employers with appropriate involvement of professional expertise. This is separate to the

accreditation of educational courses leading to a qualification or registration of professionals for independent practice.

- The scope of clinical practice supported for any particular individual 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 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 therefore incorporate effective systems for supporting, monitoring and responding to the performance of individuals, clinical teams and the organisation as a whole. State and Territory Health CEOs are of the view that such an approach could be expanded to many health professions and practice situations 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.

State and Territory Health CEOs also recognise 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.

There may also be scope to consider applying this principle to circumstances where individual State licensing requirements restrict rather than facilitate suitably qualified workers undertaking necessary activities eg operating ionizing radiation apparatus.

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, State and Territory Health CEOs are of the view that delegation may not be necessary to achieve the stated policy intents and, if incorporated into statute, may actually reduce the current flexibility that exists in the jurisdictional health practitioner registration systems.

There are several other factors that need to be taken into account in considering these issues.

It must be acknowledged that 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. AHMAC has already established criteria and a process for considering whether a health occupation falls within this category and should be subject to registration requirements.

But 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 approach it must be acknowledged that 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.

Finally there are a range of factors that operate to ensure that people in health occupations provide safe quality care. The legal system imposes a range of obligations through the common law and statute 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.

While supporting the need for quality and safety in health care, the States and Territories consider that any regulatory arrangements

are carefully linked to the complexity of the care involved and that the flexibility of the health workforce to provide care is maintained.

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.

Joint State and Territory Health CEOs' response *8.1*

State and Territory Health CEOs support this proposal, considering reform of funding mechanisms to be an essential step towards achieving the best possible utilisation of the health workforce.

In supporting this proposal, consideration must be given to how other key functions of MSAC including assessment of technologies and procedures, assessment of nationally funded centres and support for the health policy advisory committee on technology are provided.

It is 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 this submission and previous State and Territory submissions, State and Territory Health CEOs 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, for example, involve existing committees reviewing MBS funding of specialty services to remove disincentives in areas of known specialty shortage such as geriatric medicine, general medicine, mental health, rehabilitation medicine, paediatric orthopaedics and other paediatric sub-specialties.

Whilst State and Territory Health CEOs are not suggesting that remuneration is the primary driver of this change, the Victorian 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 to ensure that remuneration does not discourage entry to the more generalist professions, as proposed in this submission, is an important element to progress.

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.

Joint State and Territory Health CEOs' response 8.2

State and Territory Health CEOs support both delegated and direct access to MBS rebate for a range of health professional services consistent with agreed models of care

In principle, State and Territory Health CEOs support changes to the MBS where these are likely to create positive incentives to more effective workforce utilisation and ultimately, better public access to quality services regardless of location.

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. This system would

appear to have merit as it strengthens the general practitioner role in primary care and can enable transition to new roles.

State and Territory Health CEOs do, 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 regarding access to services in areas of designated shortage such as currently exists for outer metropolitan rural and remote communities. Where there are shortages of medical practitioners a system of delegation of services is not practical as often there is no medical practitioner available.

The process could be informed where relevant by the work of the health workforce improvement agency. For the short term, there are a number of applications that could be trialled and these are further explored in the additional recommendations section 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.

Joint State and Territory Health CEOs' response 9.1

State and Territory Health CEOs support this Draft Proposal with reporting to the Australian Health Ministers' Advisory Council and other bodies. The proposal should ensure new models of care and roles can be appropriately incorporated in projection modeling and should value the input of specialised stakeholder groups.

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.***

Joint State and Territory Health CEOs' response 9.2

State and Territory Health CEOs support workforce projections being undertaken for major professions. These projections must be undertaken through a multidisciplinary approach using emerging models of care as identified by local service planning.

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.

Joint State and Territory Health CEOs' response 10.1

State and Territory Health CEOs support this Draft Proposal but have made a range of recommendations to better support rural and remote communities later in this response .

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***.

Joint State and Territory Health CEOs' response 10.2

State and Territory Health CEOs support 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

Joint State and Territory Health CEOs' response 10.3

State and Territory Health CEOs support evaluation as an ongoing quality mechanisms but suggest that evidence exists on what is effective. Additional measures including the use of taxation and superannuation levers have been incorporated into the State and Territory Health CEOs recommendations later in this response.

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.

Joint State and Territory Health CEOs' response 11.1

State and Territory Health CEOs support this Draft Proposal.

States and Territories as primary employers should identify priority areas for the work of any newly established agencies having regard to special needs groups identified by the Commission.

3 Issues requiring further consideration

3.1 Increasing supply through the use of overseas trained health practitioners

As outlined above in relation to the response to the Commission's Draft Proposal 3.1, State and Territory Health CEOs understand and consider they need 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 our own health workers will migrate to other countries.

In the absence of substantial increases in locally trained individuals, it is likely that State and Territory Health CEOs' reliance on internationally trained practitioners will remain and potentially increase. As described by the Commission 25 per cent of the overall Australian medical workforce are internationally-trained graduates.

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 is a significant 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 supporting and supervising overseas trained practitioners.

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.

State and Territory Health CEOs perceive benefits in developing a model that allows a consistent standard to be applied across Australia for the assessment of both qualifications and clinical skills. Coupled with a national registration system this should maximise use of this important workforce while ensuring minimum standards are maintained.

State and Territory Health CEOs' Recommendation 1

ST 1.1 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.

ST1.2 That the Commonwealth lead the development of a national scheme for the assessment of the qualifications and skills of internationally trained practitioners, focussing on medicine in the first instance.

3.2 Influencing the distribution of the workforce

As previously advised, State and Territory Health CEOs are 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.

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.

State and Territory Health CEOs believe that mandatory rural rotation requirements as part of clinical training programs 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, pre-registration and post graduate training programs and increased to a minimum 6-month period wherever possible. Rural rotations should also be required for advanced training programs where possible.

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. Trainee incentives to undertake rural rotations could include priority access to sub specialty rotations and merit points towards advancement opportunities (including selection to advanced training positions in sub specialities).

Medical trainees believe that, despite the promoted benefits of rural training, the structure of the training program does not encourage rural rotations. Their common perception is that rural rotations detract from career advancement (such as recruitment to sub-specialist rotations, advanced training posts) as they are geographically 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.

State and Territory Health CEOs' Recommendation 2

ST2.1 That the Commonwealth develop options for providing subsidies to students undertaking rural clinical placements to encourage greater uptake.

ST2.2 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.

ST 2.3 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.

ST 2.4 That Commonwealth, States and Territories consider specifying rural practice experience as a desirable attribute for career advancement.

Funding mechanisms

There are a range of impediments to more effective workforce utilisation within existing funding mechanisms (for example, see Victoria's July submission).

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.

There is also potential for these restrictions to actually increase costs, through duplication of effort, delays in commencement of treatment and suboptimal deployment of skills. As a result, 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, State and Territory Health CEOs recommend that the Commonwealth trial changed arrangements for access to medical and pharmaceutical benefit entitlements for non-medical practitioners both in areas of designated GP shortage and in areas of specialty shortage to better meet community need.

Primary Care Services

Governments have increasingly focused on ensuring that the health system is able to work across primary and secondary care boundaries to effectively manage demand and create a better focus on health promotion, disease prevention and management of chronic and complex conditions in the community.

People access the primary care services they need from a range of locations that are funded through different sources. Problems with this are:

- Inequitable access to health care services and correspondingly greater use of emergency services

- Inappropriate use of hospital services for ambulatory care sensitive conditions resulting in a high proportion of avoidable and unnecessary admissions
- A lack of integration of primary medical services with other parts of the health system.

Flexible use of health funding, notably the MBS and PBS, will ensure that access to services the schemes are funding, is not limited by the location the service is delivered in, for example, that primary medical care services can be funded by the MBS and be provided from state operated services. This is particularly important in the development of integrated primary health and community care services that seek to increase the capacity of the primary and community health care sector to provide affordable, accessible and comprehensive care in the community.

There are opportunities to support new models of care through more targeted use of access to MBS. This is illustrated in the current work that NSW is undertaking with integrated primary health and community care services (IPHCCS).

There is also a need to address the current structure of MBS payments (and the disparities between procedural and generalist specialties). The importance of this has been emphasised in the State and Territory Health CEOs' 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.

State and Territory Health CEOs' Recommendation 3

3. ***That greater alignment is achieved between allocation of MBS/PBS funding and service need by trialling mechanisms including: -***

3.1Creating incentives for practise in areas of known speciality shortage including

3.1.1 Increased scheduled fees for consultative items that promote coordinated multidisciplinary care rather than procedural items to address the complex needs of the ageing population

3.1.2 Increased scheduled fees for less attractive specialties such as geriatrics, psychiatry or

specialties involved in prevention activities on agreed targets eg screening.

State and Territory Health CEOs' Recommendation 4

4.1 Creating incentives for practise in areas of known geographic shortage, including

4.1.1 Differential payments for items performed in outer metropolitan, rural and regional areas

4.1.2 Allocation of provider numbers to take account of relative over- and under-supply in a given geographic area

4.2 Flexible use of health funding, including the MBS and PBS funds, to ensure appropriate services are available irrespective of where they are delivered

4.3 Limited non delegated direct access to medical and pharmaceutical benefit entitlements for non medical practitioners, commencing in areas of designated GP shortage.

Taxation and superannuation

State and Territory Health CEOs consider that there is scope for 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. 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, particularly in rural and remote areas of Australia.

Given that the health workforce operates in both the public and the private sector, State and Territory Health CEOs maintain 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 attraction that assists to retain these employees in the public system. That the Commonwealth Government allows this exemption indicates that it is also aware of

the importance of maintaining an adequate financial remuneration for health professionals in the public hospital system.

State and Territory Health CEOs 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. Possible options include:

- 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, rural and remote areas without the employer incurring additional FBT. It 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, rural 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 taxable value in relation 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, rural 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 for children of health professionals from FBT. Health care professionals with school-aged children may be reluctant to relocate to regional, rural 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, rural 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.

- Exempting any child care expenses currently subject to FBT which are incurred by public health care workers.
- Reducing HECS debt consistent with every year of completed public health service in a rural or remote area.

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 minimal disincentives) for people to choose to stay in the workforce post preservation age.

State and Territory Health CEOs' Recommendation 5

ST5.1 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, including rural and remote areas.

ST5.2 That the Commonwealth consider reducing HECS debt consistent with every year of completed public health service in a rural or remote area.

3.3 Private sector contribution to education and training

State and Territory Health CEOs consider that there would be benefits in the Commission recommending 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.

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 a contribution towards the cost of that training.

The Commission's position paper recognises 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 concludes 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 State and Territory Health CEOs recognise the benefits of making training costs more explicit, they do not consider that 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, State and Territory Health CEOs maintain 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. As an example, Victoria has recently analysed 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 four 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 the commensurate growth in benefits accruing to the private system.

This presents 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, State and Territory Health CEOs maintain 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 some States, 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.

State and Territory Health CEOs' Recommendation 6

ST 6.1 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

3.4 Trainee contribution to education and training

State and Territory Health CEOs acknowledge that service delivery is also supported through the structure of clinical training, particularly for post graduate 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.

State and Territory Health CEOs consider that there would be merit in the Commonwealth, States and Territories working 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.

State and Territory Health CEOs believe 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. 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 within the public sector 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.

State and Territory Health CEOs' Recommendation 7

ST7.1 That the Commonwealth, States and Territories work together to consider options for a national scheme for graduates who have trained in the public sector who do not subsequently work in the public sector to:

- ***contribute towards the cost of clinical training, or***

- ***treat an equivalent value of public patients in their private practice for a defined period after graduation, or***
- ***contribute service in the public sector commensurate with the investment in their training.***

APPENDIX A

An integrated approach to registration, and accreditation 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; and
- 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 could 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.

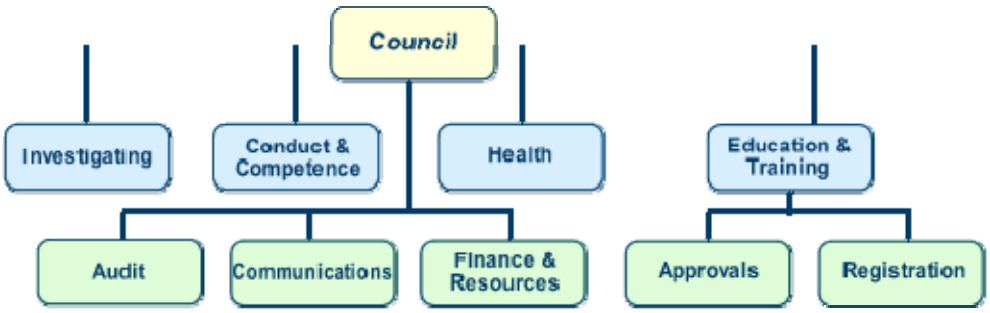
- Working collaboratively – the HPC will enable best practice in any one profession to be accessed by all. It will deliver an efficient and unified service as well as focusing on individual issues which are significantly different between professions.

(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 its 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.