PRODUCTIVITY COMMISSION POSITION PAPER:

"AUSTRALIA'S HEALTH WORKFORCE"

Response by the

Committee of Deans of Australian Medical Schools (CDAMS)

November 2005

INTRODUCTION

The Committee of Deans of Australian Medical Schools (CDAMS) welcomes the release of the Productivity Commission Position Paper "Australia's Health Workforce". CDAMS sees this review having the potential to address many of the long-standing and inherent difficulties relating to Australia's health workforce and, reflecting our constituency, to the education and training of Australia's future health practitioners.

CDAMS commends the Productivity Commission on their analysis of a set of complex and challenging issues. In general, CDAMS supports much of the general thrust of the Position Paper and the draft proposals for reform. We are pleased to see that some of the points raised by CDAMS and other contributors concerning education and training have been reflected in the Position Paper. Our response focuses on the Commission's draft proposals and recommendations, with particular reference to those relating directly to the continuum of medical education and specifically to undergraduate and graduate entry medical education.

DRAFT PROPOSALS

#3.1 & 3.2

CDAMS supports the first two draft proposals regarding COAG endorsement and review of the National Health Workforce Strategic Framework (NHWSF). The Framework was the subject of lengthy consideration and collaboration amongst a diverse range of stakeholder bodies, and CDAMS welcomed its release as providing a blueprint for the future development of the health workforce. Since its release, however, there has been little evidence that the Framework has the support of governments and there appears to have been little imperative or incentives for actual implementation of the many excellent recommendations in the Framework. CDAMS would strongly support initiatives to endorse and implement the Framework, and believes that leadership on this should be taken by COAG.

CDAMS also agrees with the analysis that the self-sufficiency principle in the Framework should be broadened. The statement in the Position Paper is entirely reasonable 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". It needs to be pointed out that there is a group of international health professional graduates who have recently been given greater access to practice in the Australian health system, namely those who have come to Australian health professional courses as international students. As these people have been trained in the Australian system, we would suggest that in the future they should continue to be given priority for entry into the Australian workforce ahead of those who have been trained in other countries and migrate to Australia as graduates.

#4.1, 5.2, 9.1 & 9.2

There is a strong level of support within CDAMS and the medical education sector more broadly for better coordination of health workforce planning, innovation, development and implementation. As pointed out in our original submission, for many years health workforce planning and development has occurred on an uncoordinated, reactive and seemingly ad hoc basis. There is an urgent need for greater coordination and management of health workforce planning and innovation at national, State and regional levels.

Draft proposals #4.1, 5.2, 9.1 & 9.2 are therefore welcomed by CDAMS as going a long way towards addressing the currently disorganised state of health workforce management. CDAMS supports each of the proposals separately. However, as articulated in the Position Paper, the Commission is proposing the establishment of three separate, distinct entities:

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

CDAMS is concerned that this proposed tripartite model could replicate the current separation between the various levels and sectors in the education, training and practice continuum.

In the first consultation round of the Review, CDAMS argued that:

> …there is currently no coordinating strategy which links all aspects of the overall consideration of the medical workforce, its size, distribution, training needs and linkage of the various levels of training so that efficiencies may be appropriately considered and to ensure that training is appropriately provided in the context of practice. (CDAMS submission, p. 11)

Universities face a specific problem in planning for medical school places, particularly in the disjunction between student places and workforce needs. Some of the more recent decisions about new medical schools appear to have been motivated more by political reaction than by identified need. There has certainly been no long-term planning associated with these new schools or with the additional places in existing schools concerning the availability of clinical training opportunities, academic and teaching workforces, existing university-hospital relationships, intern training places, appropriate opportunities for postgraduate vocational training, and longer-term career paths for graduate doctors. At the same time there has also been no opportunity to consider new models of practice across the various linked health professions.

While the establishment of any one of the three proposed workforce bodies would be welcomed by CDAMS (particularly for education and training), we believe that broad cross-sectoral coordination would be better served by a single national agency, supported by a national secretariat, with responsibility for coordination of all aspects of innovation, planning, and education and training of Australia's health workforce. To guarantee its effectiveness, such an agency should have high-level representation from across the education, training and practice continuum. Additionally, it could be established as a statutory authority with semi-autonomous powers, accountable directly to COAG, AHMC or similar cross-jurisdictional body. In any case, the agency or agencies should be seen as more than advisory bodies responsible only for the development of policy advice.

Alternatively, the proposed agencies should be structured in such a way as to support and strengthen communication and collaboration between them. At the very least, CDAMS strongly urges the Commission to pay particular attention to ways in which forward planning for education and training can be integrated with the development of the health workforce and the actual health needs of the broader community.

#5.1 & 5.3

Over many years, the medical Deans have discussed a variety of different funding models for medical education, one of which has been transferring responsibility for allocating "the quantum of funding available for university-based education and training of health workers" from DEST to DHA. For the sector more broadly, this proposal is inextricably linked to issues concerning the funding of clinical training, the role of clinical teachers, and the responsibilities of health care providers in the provision of education and training, not just for university-based education and training but also for further education and training in the postgraduate domain which is currently to a large extent the direct responsibility of the health services. Another associated issue is that of determining the 'true' costs of clinical training, or 'unbundling', which is essentially addressed under recommendation #5.3, which considers "the transparency and contestability of institutional and funding frameworks".

CDAMS endorses the *intent* of ***draft proposal #5.1***, in that it seeks to provide greater connection between health workforce education and training with workforce requirements. Drawing all health education funding together under the aegis of one portfolio department would certainly expedite vertical integration, which will be impeded by the current funding split between DEST and DHA. Overall, CDAMS can see some advantages in this proposal in relation to better coordination of health education with health workforce outcomes.

Nevertheless, CDAMS does not support the explicit proposal to shift funding responsibility from DEST to DHA. There is a very real risk that this system would create winners and losers amongst medical schools who vary in their DEST/DoHA income ratio, or whose internal university funding formulae retain large proportions of funding for central university purposes. In general, such a shift would run the risk of creating deep educational and organisational rifts between medical/health schools and faculties and other faculties in the universities.

It would also threaten to undermine the very important connections between teaching and research. University medical schools are the site for much of Australia's internationally renowned medical research. Within the higher education sector more broadly, there are clear, evident links between the conduct of research and the quality of teaching. This connection could potentially be threatened by creating a false distinction between research and teaching activities and outcomes, as overall policies and funding for research, research training and research infrastructure in universities are predominantly administered through DEST, with additional research grant funding available through the NH&MRC (within the Health portfolio).

CDAMS believes that quality standards of health education and research would be best served by remaining within the current policy and funding framework for higher education, with the proviso that the health and education sectors work more closely together to streamline and integrate health professional education. This might be facilitated by actively involving DEST and other education stakeholders in any health workforce agency or agencies as proposed in the Position Paper. Another way forward would be to require more formal negotiations between DEST, DHA and education stakeholders (including medical/health faculties) about major funding and educational developments.

Draft proposal #5.3 addresses some of the further complex issues around funding for clinical training. As a general rule, CDAMS supports the recommendation for "enhancing the transparency and contestability of institutional and funding frameworks", provided that current funding levels are maintained as a minimum, and preferably increased commensurate with demand. Any attempt to identify the true costs of clinical training (at all levels) can only work in practice if it is matched by a serious commitment from funding bodies to adequately support those costs.

What might be a more palatable approach, and one which has the advantage of spreading the costs of clinical teaching, would be greater deregulation in the clinical training area, allowing alternative training providers entry to the postgraduate and vocational specialist training domains. CDAMS addressed this issue at length in our original submission, outlining the interest and expertise of universities in education at all levels. In this context, CDAMS supports the recommendation that the AHMC should address regulatory impediments to competition in the delivery of clinical training.

CDAMS also supports the proposal to "examine the role of greater use of explicit payments to those providing infrastructure support or training services". There is a greater imperative to undertake this examination and make the subsequent necessary changes than the recommendation currently suggests. The context of clinical practice is irrevocably shifting away from teaching hospitals. However, funding for clinical training is still largely embedded in the State-based funding of public hospitals. As the Position Paper states, this makes it much "more difficult to mobilise training resources in a coordinated way".

A move to provide a contestable pool of funding for infrastructure support and training services would obviate the need for piecemeal solutions such as the Practice Incentive Payment scheme for teaching in general practice and its possible extension to specialist practice, as well as the recent creation of the Medical Specialist Training Taskforce. In addition, there is an urgent need to attract more practitioners to clinical teaching at a time when there is greater demand on limited clinical teaching staff and facilities due to the creation of additional medical school places. A contestable funding pool would enhance such recruitment.

CDAMS disagrees with the conclusion that the system "will continue to rely on considerable pro bono provision of services'" and objects to the term and concept of "pro bono" work. At the present time, clinical teaching appears to be largely dependent on the goodwill of individual practitioners who have a genuine interest in the education of the next generation of practitioners. In fact, there is very little true pro bono provision of services. The pro bono concept only relates to individuals who are private practitioners who provide teaching services without any remuneration. For those practitioners employed by public hospitals, the provision of teaching services is built into hospital funding and is therefore already paid for. Although the provision of these services is often not explicitly acknowledged in employment contracts, and therefore these services might more appropriately be considered in-kind or "hidden" services, it is an expectation of public hospitals that they have a legitimate role as education providers. Likewise, university-employed clinical academics who contribute to College-based postgraduate vocational education are essentially donating university time and resources to these programs, almost invariably with no direct negotiation with the universities for provision of these services.

This broad principle should be affirmed more strongly in the Position Paper, Final Report and review recommendations. At the present time, Australian Health Care Agreements between the Commonwealth and States do not obligate State-based public hospitals to acknowledge and provide for education and research as core business. In contrast, it is CDAMS strong view that education *must* be seen as a core activity and responsibility of medical practitioners in all sites. Delegates at the recent 10th National Prevocational Medical Education Forum (6-9 November, Perth) overwhelmingly reiterated their support for and understanding that one of the core responsibilities of a medical practitioner is as a teacher and educator, not only of their patients but of the next generation of practitioners.

CDAMS' preferred model is to embed education, and for that matter research, into the core business of health facilities and to make explicit provision for remuneration of practitioners and facilities in the private sector. Provision of a contestable pool of funding for these services would provide the flexibility which is now needed to have appropriate "learning in context". The notion of 'pro bono' teaching work as an additional, non-core responsibility undermines the proper role of doctors and other health practitioners in educating the next generation of practitioners.

CDAMS is surprised that the ***draft recommendation #5.3*** falls short of addressing the point made in the Position Paper that "the Commission sees general merit in the approach where the government contribution towards the cost of clinical training in lieu of wider public benefits follows the trainee, rather than being directed to particular institutions or service providers. In combination with charges levied on trainees, this would provide a contestable pool which could be accessed by new as well as existing service providers". CDAMS would urge the Commission to review the draft recommendation #5.3 to consider whether it might be strengthened to recommend that such a contestable funding pool is created in the medium term.

#6.1, 6.2

As pointed out by the Commission, there are multiple different bodies for accreditation across the various health professions and over 90 registration boards. To address these inherent inconsistencies and inefficiencies, CDAMS has already argued that there needs to be rationalisation at the national level of the accreditation and registration systems for health professional programs and health professionals in Australia. CDAMS agrees in principle with the proposed approach across all health professions through a "single national accreditation agency for university-based and postgraduate health workforce".

Nevertheless, the proposal should explicitly incorporate the AHMAC suggestion of a "staged move towards a national accreditation model"; and should include specific acknowledgement that the excellent achievements of current accreditation processes, particularly those of the Australian Medical Council, be used as a base on which to build the overarching national system. In implementing a staged move towards a national accreditation model, there will need to be co-ordination between professional accreditation bodies in the short term. This might be dealt with by an overarching coordination committee which facilitates dialogue between different accrediting bodies, rather than establishing an overreaching body which has primary responsibility for multi-disciplinary professional accreditation in the first instance. In any case, transparent, accountable and inclusive consultation processes are necessary with relevant stakeholder organisations. There will also need to be specific mechanisms to address the particular needs of the health professions within a unified national system.

Despite supporting the overall recommendation in principle, CDAMS would not support the abolition of the AMC's accreditation process until such time that it is proven that a single national agency and process is workable, achievable and would be a substantial improvement on the current processes. As indicated, the AMC's history of excellent service and standards in the accreditation of Australia's undergraduate and more recently specialist medical education must be acknowledged in any reform process. In particular, the very successful AMC processes for accreditation should be used as a template for processes adopted for the other health professions.

Although the Commission addressed the issues of job re-design and "skills escalators" in the Position Paper, and the proposals relating to national accreditation and registration processes are intended to address these areas, CDAMS does not consider that they have been reflected directly enough in the draft proposals as written, and modifications could be considered to make specific recommendations about the need for innovative, flexible career pathway models.

In addition, we wish to comment on the descriptions in the Position Paper concerning the UK modernisation agency and the "skills escalator" concept. It should be noted that these pilot programs are now called "new career frameworks and role designs" rather than "skills escalators". The new "changing workforce program" is in its infancy, albeit some interesting models of new health workers have been provided. It should be noted that there were very substantive costs to develop the UK agency and run the pilot programs. More importantly, there has been little or no work on the accreditation, credentialing and sustainability of these new models. Currently, health workers in the UK are trained locally and have no credentials to practice elsewhere, have no professional affiliation or support, and no career path. There is no evidence yet as to whether these workers wish to remain in these posts once trained. There is, however, good evidence relating to nurse practitioners who have prospered as they build formal accreditation and professional support.

Australia can learn much from the UK experiences. The challenges lie in:

- professional identity – what does this health worker do that others don't?
- how can health workers be accredited and credentialed to work elsewhere?
- where do health workers get professional supervision and support and continuing professional development?

A worthwhile exercise would be to define what it is that each specific health professional does that is unique to health care delivery. In association with this will be better definitions of generic health care worker competencies (eg. ethics, legal health, quality and safety, communication, etc.) and allowing cross-accreditation of these competencies that may be delivered by a number of different providers, eg. a medical school, a college, a postgraduate medical education council, a VET course, etc.

Draft proposal #6.2 is also supported by CDAMS as being eminently sensible. There will however need to be processes established to manage the specific needs of individual professional groups. Medical schools have been facing particular problems when recruiting overseas-trained academics. There are a number of instances of highly qualified and experienced overseas-trained doctors who have been offered clinical academic appointments in Australian medical schools but have then been denied specialist recognition in Australia without undergoing further rigorous additional training and assessment.

CDAMS has been raising this issue with government, specialist colleges and accreditation bodies for several years, and is pleased to see the Productivity Commission supporting the development of a streamlined national approach. In the meantime, CDAMS and the Committee of Presidents of Medical Colleges (CPMC) have formed a joint Working Group on the accreditation of overseas-trained academics to address this issue, and we would be happy to keep the Commission and government informed of progress on this initiative. Specifically in relation to medical education, appropriate processes for recognition and respectful acceptance of overseas-trained clinical academics into Australian medical practice has become a necessity with the need to find staff for increasing numbers of new medical schools.

#7.1, 7.2 & 7.3

CDAMS is strongly supportive of these recommendations relating to a national focus for registration and mutual recognition. We understand that a substantial amount of work has already been undertaken under the auspices of DHA, AMC and other stakeholder groups to advance a workable system of mutual recognition, and we would support the continuation and implementation of this initiative in addressing these issues. It would be helpful to have the support of the Productivity Commission and COAG in bringing the various State Registration Boards and State governments to a point of agreement on national registration for each health professional group.

#8.1 & 8.2

In as far as CDAMS has a view about the operation of the Medicare Benefits Schedule, CDAMS supports these two draft proposals.

#9.1 & 9.2

As indicated previously, CDAMS supports ***recommendation #9.1*** to create a single national secretariat reporting to AHMAC for numerical planning in relation to the health workforce. The proviso should be that the outstanding work already undertaken by AMWAC and AHWAC should be built upon in the establishment of this new single secretariat. As we have already suggested previously in this response, this planning secretariat could be more efficiently linked to a "single national agency, supported by a national secretariat, with responsibility for coordination of all aspects of innovation, planning, and education and training of Australia's health workforce".

CDAMS is also strongly supportive of ***recommendation #9.2*** in relation to the focus of numerical workforce projections to be undertaken by the proposed single national secretariat. Had this approach been taken in relation to AMWAC's work to date, there would have been a more rational basis for the decisions which have been taken in the recent past in relation to the opening up of new places in existing medical schools and the creation of new medical schools.

#10.1, 10.2 & 10.3

CDAMS strongly supports these three draft proposals in relation to the workforce requirements in rural and remote areas. Over recent years medical schools have become the leading sites for programs specifically aimed at increasing the rural and remote medical workforce, either by recruiting greater numbers of students from a rural background or by exposing more students from all backgrounds to rural experience during their studies. The Rural Clinical Schools initiative is of particular note in this regard. The Rural Clinical Schools are now well-established and there has been a high level of support and uptake from students for their programs.

In addition, the Rural Clinical Schools have an increasingly important role in providing medical, teaching and research services to their local communities. CDAMS commends the Australian government for continuing to support the various rural programs. As pointed out in our previous submission, the more multidisciplinary University Departments of Rural Health and the Rural Clinical Schools are well placed to provide a vertically integrated teaching health system in rural Australia led by the universities'.

In endorsing ***draft proposal #10.3***, CDAMS would like to draw the Productivity Commission's attention to the Medical Schools' Outcomes Database project, a joint initiative between CDAMS and DHA. The project aims to develop a national data collection process and database as the foundation for a longitudinal tracking system to evaluate the outcomes of medical education programs, particularly those related to rural medical education.

CDAMS raised this in our original submission, reproduced here:

> Currently there are no national longitudinal data on the career profiles of medical graduates and no mechanism to understand either whether initiatives such as the Commonwealth-funded rural incentives to medical schools or the bonded medical student programs will produce the desired outcomes. There was no planning for such long-term evaluation mechanisms when these programs were initiated.
>
> CDAMS has been an advocate for ensuring that such information is collected and utilised for effective long-term planning. With the assistance of the Department of Health and Ageing (DHA), CDAMS is now engaged in a project involving all medical schools to produce a uniform data source relating to all entrants to and graduates from Australia's medical schools, the Medical Schools Outcomes Database (MSOD) project (see CDAMS website, www.cdams.org.au,) which will serve as the basis for a much-needed longitudinal tracking study. AMWAC is one of the major supporters of the MSOD project. *CDAMS looks to the Productivity Commission to ensure through its recommendations that adequate long-term government funding is provided for this project to ensure the ongoing availability of this information source which will be an important component of the continuing dynamic process of medical workforce planning*. (CDAMS submission, p. 9, italics added)

CDAMS has recently been informed by DHA that our proposal for a further 2.5 year Stage 2 of the MSOD project has been successful, and we will shortly commence negotiations with DHA over the project contracts. CDAMS would be happy to provide copies of the Stage 1 Final Report and Stage 2 proposal for the information of the Commission.

#11.1

CDAMS strongly supports this draft proposal, particularly as it relates to Indigenous health education and health outcomes. Over recent years CDAMS has been the lead partner in the Indigenous Health Curriculum Framework project, funded by the Office of Aboriginal and Torres Strait Islander Health (OATSIH). This project has developed a national curriculum framework which provides guidelines for medical schools to integrate core content in Indigenous Health into all aspects of medical curricula.

The curriculum framework was launched in September 2004, and was endorsed by the AMC for formal inclusion in their revised accreditation guidelines for medical schools. Through national accreditation processes, all medical schools are now required to demonstrate their active implementation of the framework in their curriculum. CDAMS is now actively engaged in strategies to implement this curriculum framework across all medical schools.

More recently, CDAMS has worked to support the Australian Indigenous Doctors' Association (AIDA) in their OATSIH-funded project to develop best practice in the recruitment, retention and support of Aboriginal and Torres Strait Islander students in medical courses. AIDA launched their project report in October this year, entitled *Healthy Futures: Defining best practice in the recruitment and retention of Indigenous medical students* (http://www.aida.org.au). At a joint meeting of CDAMS and AIDA at the same time, both organisations signed an agreement of collaboration expressing the mutual intent to work in partnership in the area of Indigenous health for all medical students, and in progressively increasing the number of Indigenous doctors as one of the long-term strategies to improve the health expectations and outcomes for all Indigenous people.

CDAMS suggests that the Productivity Commission recommend that COAG formally endorse both the CDAMS Indigenous Health Curriculum Framework and the AIDA Health Futures report as templates for strategic educational approaches that could be extended to all other health disciplines.