Health Sciences Australia

Australian Council of Pro Vice -Chancellors and Deans of Health Sciences

Summary

The Australian Council of Pro-Vice-Chancellors and Deans of Health Sciences (ACPDHS) is the peak representative body for Australian universities that provide undergraduate education in the clinical allied health sciences. The Council is a forum for representation, coordination and information sharing with the aim of strengthening the training of allied health practitioners in Australia to meet the needs of communities.

The ACPDHS welcomes the opportunity National Health and Hospitals Reform Commission. We believe that the time is right for a fresh approach to the funding of health care across the spectrum, and that an integral part of national health policy is recognition that training the future health workforce will require investment in both human and capital infrastructure to ensure a sustainable health system.

Given the national shortages in the allied health workforce, we believe that an important part of the review of the Australian Health Care Agreements (AHCAs) should be to support the training of a competent allied health workforce. The growth of chronic disease in Australian society can only increase the importance of the allied health disciplines to national health care strategies. We believe the critical issues are:

- embedding an education, training and research culture into all aspects of health service delivery;
- defining appropriate levels of health service for different communities that are cognisant of particular needs and ensuring access to those services ; and
- ensuring the quality and safety of our health services.

A health workforce package that includes a clear commitment to clinical education, training and research should be included in the new AHCAs including the provision to establish new concepts for education such as teaching health systems, as well as teaching hospitals. The new AHCAs should include clear performance indicators for the States including the number of clinical places provided across all the health professions, the various levels of training places provided, e.g. undergraduate, graduate, postgraduate and specialist places, and continuing and in-service education provision, the geographic distribution of the places provided and the amount of money directed by the States to clinical education and training for all the different health professions. These places should match the number of Commonwealth Supported places in universities.

Training the future allied health workforce

Allied health workforce planning and coordination across education and health sectors is relatively poorly developed when compared with medicine and nursing. This is reflected in the lack of current national statistics on the allied health workforce. Nevertheless, anecdotal experience and the available data suggest that both workforce undersupply and geographical maldistribution in the allied health professions are similar to those seen in nursing and medicine. As with other professional groups, services in rural, remote and Indigenous communities appear to be most affected.

The capacity of universities to train an adequate allied health workforce is compromised by the level of funding they receive from the Commonwealth government for allied health students. Overall funding for health programs is inadequate and based on an historical model (Relative Funding Model), developed over 15 years ago, that does not recognize the real costs of educating and training a modern allied health workforce. All modern allied health programs have a substantial component of basic and applied science, the need for small group teaching, and a requirement for substantial amounts of clinical laboratory work to provide students with enough of a basic skill set in their discipline to enable them to undertake clinical placement and perform clinical tasks on "live" patients. The current relativities do not reflect the high costs associated with delivering allied health courses.

Allied health programs receive no specific Commonwealth funding for clinical education, despite the requirement of accrediting bodies for substantial clinical experience in all allied health degrees. However, facilities that provide clinical placements for the allied health disciplines are increasingly charging universities for student placement or refusing to accept students on placement due to a lack of resource support. This is a major issue in securing appropriate, adequate and required clinical placements for registration and accreditation. The recent move by the Victorian Department of Human Services to charge universities a per capita fee for all health student placements is a worrying trend, despite the need acknowledged by COAG in July 2006, for the States and Territories to provide high-quality clinical placements for Commonwealth-funded students.

Education and training of the allied health workforce is responsive to changing health needs, but it costs money to develop new curricula and change existing curricula, and the less well funded allied health professions struggle to achieve this.

Placement in rural areas costs more because smaller and more geographically dispersed placement sites increases the costs per student to provide adequate training; there are fewer opportunities for economies of scale. However, it is in the national interest to encourage training in regional/ rural/remote locations for long-term workforce retention in these areas.

Clinical disciplines cannot be taught without students participating in a structured apprenticeship based on real patients in a context of care that is relevant to their future practice. Across all clinical disciplines, the availability and capacity of quality clinical teaching placements are key rate-limiting factors in training and therefore the ability to

grow health workforce. Given the scale of health workforce shortage, access to quality clinical teaching placements is likely to emerge as the major rate-limiting factor in efforts to ramp up professional health education and training programs. There has been too great a reliance on gaining clinical experience in metropolitan teaching hospitals with attendant problems of sub-specialty practice and lack of exposure to other practice models, most importantly, primary health care.

However, the role of public tertiary hospitals has been undergoing rapid change. The pattern of shorter and more intensive hospital stays, more highly selected patient groups and a greater emphasis on subspecialty practice, means that there is less opportunity for clinical teaching on cases that are relevant to health care practice in the local hospital or community setting.

In spite of increasingly critical workforce supply problems in hospitals, there is still widespread institutional ambivalence regarding clinical teaching and research. Commitment from individual hospitals and regional health administration to policy directives on teaching, research and development (including professional development) is often inconsistent if it is perceived to be too hard or costly to implement.

A narrow market ethos in health service management reforms over the last 15 years has undermined partnerships between health professionals, health institutions and universities that are critical to patient-centred care. Health service executive management incentives to contain labour costs, to maximise throughput and reduce elective surgery waiting lists have not been balanced with incentives to invest in education, training, recruiting, retaining and developing people (and in particular, local health workforce). As a result, Australia relies heavily on short-term employment contracts, agency health staff, and international graduates. Staff continuity and a culture of teamwork, ownership and reflective practice have suffered.

As a consequence of the above, universities now struggle to find adequate clinical placements for health professional students at the district and individual health service level. The wholesale de-commissioning of hospital-based accommodation for students in regional areas of Australia is a case in point: it demonstrates the general lack of strategic commitment to regional teaching and development of the next generation of rural and regional health practitioners, let alone support for research and evaluation activities. The role and status of clinical academics within many public hospitals has also been undermined. These factors have contributed to an exodus of senior health professionals from the public system and from clinical teaching and peer support roles.

The situation is generally worse for allied health professions given the lack of a history and culture of hospital professional education and training outside of medicine and nursing. There are fewer organised high-level agreements governing the clinical training of allied health students. Allied health students are generally regarded as the last priority in terms of access to clinical experience, teaching facilities and student accommodation.

Meanwhile, the capacity of the private sector for clinical teaching is underutilised. This is particularly important in areas such as physiotherapy where a significant private workforce has been developed. There is a need for the private sector to be an integral part of the education and training of all health professionals across all training levels, including access to private patients. The private health system needs to acknowledge their responsibility to training the nation health workforce given the large public subsidies it receives.

Need for a 'teaching health system'

The changing role of tertiary hospitals, the increasing recognition of the value of rural training experience for producing rural workforce and the need to harness the capacity of the private sector - all make a transition to a 'teaching health system' in Australia a critical policy priority.

A 'teaching health system' as opposed to the existing 'teaching hospital system' is required to develop health **systems** that are committed to education and training. Increasingly, more health care is occurring in community-based settings; therefore education and training also needs to occur in these settings. To support this, resources will be required to build and sustain appropriate teaching infrastructure within primary health facilities, staffing levels to ensue appropriate supervision and recurrent funding to support teaching and learning activities. Primary health care facilities are the environments where multi-disciplinary health teams are most likely to be functioning successfully; an added benefit of increasing clinical placement opportunities in primary health settings is the greater exposure of health professional students to this model of health care provision.

Importantly, specific investment is needed to develop Aboriginal and Torres Strait Islander community controlled health services as key strategic teaching sites for Indigenous health to ensure students have positive clinical learning experiences in Indigenous health.

Given that the recently released report from the National Health and Hospital Reform Commission "*Beyond the Blame Game"* suggests that primary health should be a Commonwealth responsibility, there is opportunity for the Commonwealth to develop funding methods for education and training within the primary health sector for all health professions, through expansion of existing Practice Incentive Program payments to include primary health facilities in the private, public and not-for –profit sectors.

Horizontal and vertical training opportunities

The creation of vertically and horizontally integrated clinical schools involving all of the health professions would support the clinical training of students in the final years of their degree, dovetailing seamlessly with their early postgraduate clinical experience. Expanding the existing Rural Clinical School structure to encompass other underserved populations such as Indigenous communities or disadvantaged urban areas through the establishment of "teaching health practices" in Aboriginal Medical Services or other community based health facilities, would help to ensure all health students gain important clinical placement experience that may help alleviate health workforce maldistribution.

A new funding mechanism would be needed to facilitate these changes; not only capital funding would be required, but a commitment to long term recurrent funding that recognises the importance of supporting teaching and research within a "Teaching Health System". Capital investment alone will not be sufficient to effect sustained long term change. The proposed new GP Super Clinics would be ideal locations for multi-disciplinary teaching and learning to occur; it is important that the many possibilities this new initiative offers for integrating the teaching of health professional students with service delivery are utilised to their full potential and underpinned with appropriate recurrent funding.

Support for research in health services

The importance of research to ensuring the quality of health services should be recognised through specific funding arrangements in the AHCAs. Research as a process for enquiry, for translation of new knowledge and ideas into clinical practice across all health professions is essential for a high quality, innovative healthcare system. Research as an integral part of practice needs to be driven across all health care delivery sites. The introduction of new technology should be driven by evidence and cost –effectiveness, but there is a clear need for health systems research, especially research focused on primary health care, prevention, chronic conditions and the interface between ambulatory and hospital care. Proposed funding models for research that emphasise research impact will not adequately support health service research where there is a potential for real health gain. Practice based evidence, knowledge translation and clinical research and development activities across all health professions need to be embedded in health service delivery and adequately funded.

Quality and safety framework

Health system restructure through the 1980s and 90s focused on quasi-market reforms to health financing with the introduction of output-related funding, purchasing, meeting external performance standards and benchmarking. Management incentives to contain labour costs and maximise throughput have not been balanced with incentives to invest in education, training and research, activities that help recruit, retain and develop the local health workforce. Partly as a result of this, there is now heavy reliance on agency staff and short-term employment contracts as well as institutional ambivalence regarding teaching and research. This has had a negative impact on teamwork, ownership of outcomes and a professional culture of openness and self-reflection.

Clinical teaching and academic capacity is critical to quality and safety of health care. Public inquiries into incidents of poor healthcare practice triggered by whistleblowers in Australia (e.g. Campbelltown and Bundaberg hospitals) and overseas (e.g. Bristol) have demonstrated that institutional accreditation, external reporting and mere existence of quality systems are not an assurance of institutional quality and safety. External performance indicators are not an appropriate substitute for a local culture of trust and excellence among clinicians and managers in relation to quality and safety of health care. Clinical teaching is the bedrock upon which a culture of reflective practice and continuous enhancement is built. The integration of education, research and practice is a requirement for high quality health services not least because of the independence of the sectors.

Equity

The geographical spread of the Australian population necessitates the need to determine the quantum of health care available as a right; this may vary depending on community size and morbidity. What then is the level of health service provision required to provide that quantum – what is the staffing level and mix, what is the appropriate level of resourcing and what is the training required to deliver the workforce? These are issues for all communities including outer metropolitan, regional and rural locations. Establishing universal service obligations for communities of various sizes would help to de-politicised the provision of health services and manage community expectations.

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