

***Submission to The Crossroads Review
of Higher Education***

From

Council of Deans of Health Sciences

September 2002

Executive Summary

- Health Sciences education functions at the intersection of the tertiary education sector and the health sector. It is important that policy developments in each sector are consistent. The *Crossroads* Review and the reviews as part of the development of the new Australian Health Care Agreement are both examining important issues which could impact on health sciences education.
- The renegotiation of the Australian Health Care Agreement can be used to ensure appropriate provision for the costs of clinical education.
- The workforce in nursing and many of the allied health professions are currently undersupplied. The current workforce situation is likely to deteriorate with increasing demand and population ageing. Unanticipated consequences of changes in health or education policy could severely impact on health services.
- The issues paper *Setting Firm Foundations: Financing Australian Higher Education* proposed four different funding models. In response to that paper the Council of Deans of Health Sciences:
 - supports the development of new, nationwide discipline weights provided they take full costs into account;
 - notes that if a flat-rate public investment level approach is adopted, or if the public investment levels do not adequately reflect discipline costs, health sciences' students might be required to make an additional contribution to cover the costs of their education;
 - notes that if additional student contributions are made, even if they are accompanied by a system of income contingent loans, courses where private returns to education are relatively low compared with other health sector courses will be adversely affected. These difficulties apply notably to nursing and a number of allied health professions; courses at rural and regional campuses may suffer similar problems;
 - draws attention to the fact that if student demand declines in nursing and allied health professions the impact on the health sector will be significant;
 - recommends that a compensating system for students (such as scholarships or HECS waivers) be implemented in parallel with any changes which might lead to additional student contributions in areas of high workforce need but low student demand;
- The issues paper also canvassed issues relating to research funding. The Council of Deans of Health Sciences supports the development of a Research Assessment Exercise covering the University sector subject to the conditions below;
- If a Research Assessment Exercise is developed, it must cover coherent groups of disciplines and in particular, the Council of Deans of Health Sciences supports four major groupings of health sciences disciplines:
 - Medicine
 - Allied health
 - Nursing
 - Public health
- The review of discipline weights and the development of a Research Assessment Exercise are interlinked as it is important that academic staff be appropriately funded to undertake research underpinning professional education.

1. The Council of Deans of Health Sciences represents those universities which have a significant commitment to health sciences education, principally in disciplines other than medicine and nursing (although a number of the Faculties involved in the Council also incorporate nursing and medicine). The Council of Deans of Health Sciences thus complements the Council of Deans of Australian Medical Schools and the Australian Council of Deans of Nursing. Health Sciences Faculties provide education in a range of health professions including nursing, physiotherapy, occupational therapy, social work, speech pathology, medical radiation sciences, exercise and sport science, and health information management.

The importance of health science education

2. Demand for allied health and nursing professions is increasing rapidly. Older people comprise up to half of their clients and the need for these professions is rising along with population ageing. The new directions in health care include health promotion, rehabilitation, community care, mental health, and other areas where allied health and nursing play an increasing part in the health workforce. An adequate supply of skilled health professionals is essential to the effectiveness of health care.
3. Graduates of health sciences faculties have high rates of employment and are essential for the ongoing staffing and operation of health services. Even small perturbations in the output of universities can impact significantly on operational capacity and efficiency in the health sector. For example, ongoing shortages of radiation therapists have critically restricted the provision of cancer treatment services.

Policy integration

4. Health sciences education functions at the intersection of the tertiary education sector and the health sector. Health sciences faculties often provide a model of good relationships between universities and industry. Faculties of Health Sciences have close relationships with health services in terms of research, health services providing a venue for clinical education, universities providing postgraduate opportunities for staff, staff at universities providing advice and clinical services in a range of areas, etc.
5. The relationship between tertiary education and health policy at the national level has not always produced seamless policy applying to both sectors. The same is true at the state level. Policy decisions by state health authorities, for example, in reducing expenditure in hospitals have impacted significantly on universities. As funding in the health sector is squeezed, health services have been limiting clinical placements and looking to health sciences faculties to pay for clinical education. At the same time university funding has also been squeezed.
6. Health services are changing rapidly as a result of a new clinical and management technologies, and changing demand because of demographic changes including ageing of the population, migration, etc. These changes impact on universities and lead to changes in course design, assessment processes, research priorities, and so on.
7. Changes in tertiary education policy can impact significantly on the supply of the health workforce which will in turn impact significantly on the health sector. It is therefore important that policy development in the tertiary education sector takes account of health workforce needs, and that policy developments in the health sector take into account issues relating to workforce supply.
8. The major agreement between the Commonwealth and states in health is the Australian Health Care Agreement. The current Agreement expires on 30 June 2003. The Commonwealth and state health ministers have established a process leading up to the re-negotiation of the Agreement that involves a series of working parties, two

of which involve workforce issues and research. It is not clear to the Council of Deans of Health Sciences to what extent there is a close relationship between these working parties and the *Crossroads* review. It is important that policy developments in each sector are not working at cross-purposes.

9. Traditionally, health services had an interest in provision of clinical education. Prior to the transfer of health science education to the higher education sector, hospitals (especially) were direct providers of nursing education and occasionally of other health professions. Following the transfer, health services still welcomed involvement in clinical education both because of the immediate benefits (the presence of students challenges staff to maintain skills, some staff enjoy teaching and feel a responsibility to impart knowledge to the next generation) and the long term benefit of ensuring an appropriately trained workforce.
10. Funding cuts of the early-mid 1990s have changed the environment. Work intensification has meant that staff give priority to what is seen as the immediate core business of the health service: prevention, care or cure.
11. Increasingly, Faculties of Health Sciences cannot find adequate clinical placements and they are being asked to pay for clinical placements. Payments to universities have not been adjusted in response to this changed environment. The coincidence in timing between the *Crossroads* review and the renegotiation of the Australian Health Care Agreement provides an opportunity to emphasise the importance of clinical education through recognition of the importance of this role and earmarked funding.
12. *The Council of Deans of Health Sciences recommends that the new Australian Health Care Agreement:*
 - *should explicitly recognise the role of health services in clinical education;*
 - *should include, as a joint role for the Commonwealth and state governments, the promotion of clinical education;*
 - *should include an earmarked provision of funds for undergraduate clinical education across all health science disciplines, with states to report annually on activity in this area.*
13. *Further, the Council of Deans of Health Sciences recommends that, whatever the financial mechanism, the public investment levels for health science education be increased to cover the increasing costs of clinical education*

Funding models

14. The funding environment for health sciences education is critical to the delivery of high quality education to our students. The Council of Deans of Health Sciences has considered the issues paper *Setting firm foundations: Financing Australian higher education*. The Council has noted the different funding models and the different options within those funding models including:
 - options where the public investment level is determined on the basis of discipline weights and an option where there is a flat rate model for determining the public investment level;
 - options where university load is determined by history or negotiation between the Commonwealth government and universities; and
 - options where there is a greater level of student choice in the determination of the availability of university places at each university.

15. The attached table summarises some of the impact of the different funding models on health sciences education in terms of appropriate recognition of costs and impact on students.
16. The analysis underpinning the original relative funding model for universities was undertaken in the late 1980s at a time when most of the health sciences disciplines were still at the early stages of transition from provision in Colleges of Advanced Education to university-based courses. In Colleges of Advanced Education there were limited expectations on academic staff to undertake research. Accordingly, the cost profile for these disciplines was based on the employment pattern where staff were not expected to devote time to research and these courses come out as cheaper than traditional university courses with similar face-to-face teaching requirements. The funding model has not been revised since the widespread incorporation of these disciplines into universities.
17. The contact hours for health sciences disciplines are very similar across most disciplines, for example, medicine as compared to physiotherapy as compared to nursing. In other areas, such as the radiation therapies, there are requirements for expensive equipment and technologies that are not recognised in the funding models
18. Further, many universities have adopted the old relative funding model weights for internal resource allocation purposes which, because of the requirements of teaching, has hindered the availability of time for staff in the health sciences to undertake research. Funding constraints in the health sector have also meant that staff in health sciences faculties have had to devote more time to clinical education and industry liaison, thus further increasing pressure on staff. Increasingly, universities are expected to pay health services for clinical education.
19. *The Council of Deans of Health Sciences would welcome a proper and thorough review of discipline weights, provided that such review takes into account the full costs of education including the costs of clinical education and the costs to staff of the multiple demands of teaching, research and clinical education.*
20. Two options in the Discussion Paper (Models 2 and 4) provide a framework for universities to charge fees above the base level.
21. If new discipline weights do not adequately reflect the full cost of health sciences education, universities will need to charge fees to cover the gap between the public investment level and the cost of providing health sciences education.
22. Many health sciences disciplines are very popular with students (reflected in higher ENTER ranks) and students who graduate from some of these courses receive significant private returns from their education. In these circumstances, supplementary charges, provided they are covered by income-contingent loans, may not have an impact on either overall demand for places or equity.
23. However, there are a number of disciplines within the allied health sciences and related areas where the private returns from education are low or demand for education is below industry workforce requirements. The most notable example is nursing.
24. In courses with low private returns from education or low demand, an additional student contribution is likely to impact significantly on demand for places and in turn on workforce supply. In areas such as nursing where there is an undersupply, reduction in graduates will have a critical impact on health services. In the absence of adequate nurses and other allied health disciplines, consumer access to health services will be adversely impacted. This is an area where it is critically important that government health education and health policy are harmonised. Government decisions in the tertiary education sector could very quickly negate decisions of the

same government in the health sector, for example, in terms of improving access to services.

25. Workforce requirements can change rapidly and so workforce planning needs to be undertaken on a regular basis. *The Council of Deans recommends that methods to compensate for the existence of additional contribution payments which may impact on demand for places should be developed alongside any change in tertiary education policy.* Problems in workforce supply can appear rapidly and need rapid responses. Even a one-year problem with reduced intakes can impact significantly on health services three years later.
26. A number of compensating systems could be contemplated. These include:
- scholarship schemes to ensure that all students in nursing and other relevant courses receive scholarships to cover all or a significant component of the student contribution requirement; these scholarships could be provided by state governments and other employers, in order to address critical labour force shortages, as well as the Commonwealth government on equity as well as workforce grounds.
 - HECS waivers for courses of high national priority so that the effect of the HECS waiver negates any impact of additional student contributions (i.e. the net debt accumulation by students is at the HECS level);
27. The Council of Deans of Health Sciences notes that one of the funding model options (Model 3) provides for "learning entitlements" set at a flat rate. This option would allow universities to set fees above the voucher level to cover the full cost of education.
28. If a flat-rate reimbursement model is introduced it would need similar compensating mechanisms as if the public investment level is inadequate.

The needs of rural and regional Australia

29. The health workforce needs in rural and regional Australia have been recognised as requiring specific policy attention. There is a shortage of health professions in rural and regional Australia and rural and regional campuses (and universities) provide a particularly important role in helping to assist in meeting workforce demand in these areas.
30. Courses in rural and regional areas often face financial disabilities relative to courses in larger metropolitan areas. These disabilities include smaller class sizes (because they are drawing on smaller populations) and higher costs (e.g. longer average travel times to clinical placements). The cost structures for these programs may therefore be higher than metropolitan programs, and in the absence of any other public compensation, the student contribution payments will be higher than for metropolitan courses. This may impact on student demand and subsequent workforce supply. Again, compensatory mechanisms may need to be developed for these courses.

Research

31. The Council of Deans of Health Sciences supports performance-based funding in research with targeting to areas where knowledge can improve the effectiveness of health service delivery.
32. A number of countries have now further strengthened performance-based funding for research through the use of Research Assessment Exercises (e.g. the United Kingdom, New Zealand). The United Kingdom Research Assessment Exercise has developed significantly since it was first implemented. It is important that any

Research Assessment Exercise introduced in Australia would build on the experiences of similar exercises overseas.

33. The validity of the Research Assessment Exercise is in part based on ensuring that like disciplines are compared with like. In the health sciences, the nature of the research undertaken, and the research productivity, is very different between those disciplines which have a long tradition of university research (such as medicine) and those disciplines which have more recently entered the university sector
34. Coherent groupings are necessary to ensure appropriate composition of Research Assessment Panels (peers who are sufficiently familiar with the fields to make appropriate judgement) and also that disciplines are not disadvantaged because of their history.
35. *In order to ensure coherent groups of disciplines, the Council of Health Sciences Deans recommends four major groupings of health sciences disciplines for any Research Assessment Exercise:*
 - *Medicine*
 - *Allied health*
 - *Nursing*
 - *Public health*
36. As indicated in point 16 above, existing funding relativities used in the relative funding model have been based on a historic position where staff in health sciences disciplines were not expected to undertake research. This is clearly not the current situation.
37. It is important that funding decisions with respect to the new discipline weights and funding decisions related to the introduction of a Research Assessment Exercise be undertaken conjointly to ensure that the health sciences disciplines are not doubly disadvantaged through for example, a claw back of funding for research when they were originally not funded for this research.
38. It is also important that government recognises that many of the health sciences areas are still developing their research profile and specific additional research funding is needed to support and nurture research in these areas (see for example, discussion in the recent Senate Report on Nursing Education).
39. Protection of developing disciplines could be achieved by creating funding pools for each Research Assessment Exercise discipline area with allocation from the pool being made on relative performance as reviewed by the Research Assessment Exercise.

Evaluation of potential funding models

	Effect on recognition of costs	Effect on student demand
Model O 'Current system'	<ul style="list-style-type: none"> ▪ Public investment levels in health sciences have weak relationship to discipline costs. 	<ul style="list-style-type: none"> ▪ High demand for many aspects of health professional education. ▪ Weak demand in some important areas (e.g. nursing).
Model 1: 'Discipline based'	<ul style="list-style-type: none"> ▪ Public investment levels to reflect discipline costs. ▪ Need to ensure that costing study recognises full costs, including costs of clinical education and service contribution of staff. ▪ Current cost structures may represent internal university power distribution and occasionally leads to excessive hours being worked by staff to meet research and teaching expectations. 	<ul style="list-style-type: none"> ▪ No change from present.
Model 2: 'Fee deregulation'	<ul style="list-style-type: none"> ▪ Public investment levels to reflect discipline costs. ▪ Need to ensure that costing study recognises full costs, including costs of clinical education and service contribution of staff. ▪ Current cost structures may represent internal university power distribution and occasionally leads to excessive hours being worked by staff to meet research and teaching expectations. 	<ul style="list-style-type: none"> ▪ Depending on adequacy of public investment level, students might be required to make additional student contributions albeit covered by income-contingent loans. This would adversely impact on courses with low/soft demand or where private returns are low for example, nursing and social work. Scholarship support would be required to ensure health workforce requirements are met.
Model 3: 'Flat-rate learning entitlements'	<ul style="list-style-type: none"> ▪ Universities required to set fees to cover costs. 	<ul style="list-style-type: none"> ▪ Similar effect to Model 2. ▪ Despite availability of income-contingent loads, there would be adverse impact on courses with low/soft demand or where private returns are low for example, nursing and social work. Scholarship support would be required to ensure health workforce requirements are met. ▪ It should be noted that many health professionals require longer (on average) education than other students, both in initial preparation and in postgraduate specialisation. Flat-rate entitlements

		will have a cumulative adverse impact on the health sector because of the higher costs of courses and the longer duration of study.
Model 4: 'Variable rate learning entitlements'	<ul style="list-style-type: none"> ▪ Public investment levels to reflect discipline costs. ▪ Need to ensure that costing study recognises full costs, including costs of clinical education and service contribution of staff. ▪ Current cost structures may represent internal university power distribution and occasionally leads to excessive hours being worked by staff to meet research and teaching expectations. 	<ul style="list-style-type: none"> ▪ It should be noted that many health professionals require longer (on average) education than other students, both in initial preparation and in postgraduate specialisation. Flat-rate entitlements will have a cumulative adverse impact on the health sector because of the higher costs of courses and the longer duration of study.