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

Submission to the House of Representatives Standing Committee on Education and Employment *Inquiry into innovation and creativity: workforce for the new economy*

Executive summary.

Demand for health professionals is projected to continue to be amongst the highest of any employment sector for the foreseeable future. Population growth and structural ageing, increasing chronic disease, the needs, expectations and preferences of the community and persistent workforce shortages in rural and remote Australia are among the many factors influencing this demand.

Allied Health Professionals play an essential role ensuring Australians have access to the best health care available, including the important areas that contribute to preventative health care, early identification and treatment, rehabilitation and recovery. Allied Health professionals have crucial roles in preventing and addressing the impacts of chronic disease in areas such as diabetes, arthritis and cardiovascular disease.

Key recommendations

Develop a health care workforce that will meet the increasing and changing demands on the health system.

Consider the health workforce mix required to provide improved health outcomes effectively and efficiently.

Systematically address the barriers that limit for example, innovation in student clinical placement, (e.g. accreditation) and extension of scope of practice for the allied health workforce (e.g. legislation such as the Drugs and Poisons acts).

TOR SUMMARY

TOR 1: Students are graduating with skills needed in contemporary practice, however there are numerous barriers that need to be systematically addressed to ensure health students continue to graduate with skills to relevant to the future. Examples include accreditation requirements and availability and funding of clinical placements.

TOR 2: Several areas of law and regulation, at both state and national levels, act as barriers to offering qualifications in health programs to meet the increasing health needs of our population and that are responsive to changing demand. Accreditation and legislation limiting extension of scope of practice (e.g. Drugs and Poisons Acts) are two such areas.

TOR 3: Clinical placements with industry partners provide students with the opportunity to integrate theory with practice, and are critical for work ready graduates. Current funding models and a reliance on traditional partners are two of the factors that discourage closer partnerships with industry.

TOR 4: There is scope to develop relationships between public and private programs and organisations, including in the provision of health care, and in the education of future health professionals.

TOR 5: There may be scope under this TOR for the Committee to identify some of the broader structural issues that, if addressed, would promote an operating environment where a creative and innovative labour force strategy could have most impact. Clarity in the roles and responsibilities of the spheres of government, including the areas of policy identified as priorities in the Reform of the Federation process, notably Health and Education.

This submission is structured in two parts:

1. The first provides **contextual information** about the health workforce generally and the allied health workforce more specifically, including background to the barriers to innovation that are addressed more specifically in the response to each of the Terms of Reference (TOR). **pp3-8**

2. The second addresses each of the TOR more specifically**. pp9-14**

1. CONTEXT

Demand for health professionals is projected to continue to be amongst the highest of any employment sector for the foreseeable future. Industry Employment Projections by the Department of Employment (March 2015) suggested employment in Health Care and Social Assistance would account for 20.9 per cent of *all* Australian employment growth in the five years to November 2019.

- ***Health Care and Social Assistance*** *is projected to make the largest contribution to employment growth (increasing by 258,000), followed by* ***Education and Training*** *(142,700),* ***Construction*** *(137,900) and* ***Professional, Scientific and Technical Services*** *(136,600).*[1]

- ***Health Care and Social Assistance*** *has been the primary provider of new jobs in the Australian labour market since the 1990s. Over the next five years, employment in the industry is projected to increase by 258,000 (or 18.7 per cent).*[2]

Health workforce development reform – context and continuing need

High, persistent demand for health professionals is driven by a range of factors which have been documented extensively[3]. Those factors include population growth and structural ageing, changes in the burden of disease, and in the needs, expectations and preferences of the community, persistent workforce shortages in rural and remote Australia and in certain care settings (such as aged care).

The need to address health workforce shortages became particularly evident to Governments in the mid-2000s. This coincided with the release of a major Research Report by the Productivity Commission, *Australia's Health Workforce* (2005)[4]. The agenda resulted in a range of reforms, under COAG and otherwise, which successfully supported workforce growth and flexibility measures, including bolstering (an existing trend of) increased enrolments in university study toward practice as a health professional. Similarly, enrolments in VET health courses increased. Enrolments in university health courses have essentially doubled over the past decade. In addition, various policy initiatives were introduced to increase the flexibility and productive/service capability of the health workforce such as, the National Registration and Accreditation Scheme (NRAS) for health professions, which largely replaced State and Territory based schemes, which had contributed to restricting movement and practice.

An innovative and adaptive health workforce is fundamentally important for the Australian health system to meet a range of long term challenges, including how well we are able to deal with and contain the growing burden of chronic disease; timely access to services wherever people live; the ageing population; and the cost of new health technologies. The 2005 Productivity Commission recognized that "*it is critical to increase the efficiency and effectiveness of the available health workforce*"[p. xiv] and noted at that time, that the United Kingdom "*considered that expanding the workforce would not, by*

[1] See - http://lmip.gov.au/default.aspx?LMIP/EmploymentProjections
[2] Ibid
[3] For example, *The Intergenerational Report* (2015) and its predecessor reports http://www.treasury.gov.au/~/media/Treasury/Publications%20and%20Media/Publications/2015/2015%20Intergenerational%20Report/Downloads/PDF/2015_IGR.ashx; (among others).
[4] Productivity Commission 2005, *Australia's Health Workforce*, Research Report, Canberra http://www.pc.gov.au/inquiries/completed/health-workforce/report/healthworkforce.pdf

itself, be sufficient to deliver the desired improvement in patient service" and through a series of pilot programmes found that "*role redesign and changes in the scope of practice had made a difference and led to service improvement*'.[5] Changes to the scope of practice within sectors of the health workforce will continue to be a key contributor to optimizing use of efficient use of the health workforce. However, expecting health reforms to have any impact, in the absence of adequate and complementary health workforce initiatives, is illogical. The health workforce is, and will remain, the primary means of delivering healthcare, regardless of technological or other systems developments. Consequently they need to be understood and treated as a critical resource, not just a cost. The contribution of students in the delivery of health care is considerable and should also be considered as a valuable resource. Equally, the education of health professionals should be viewed as an investment in critical resource development rather than a cost.

Other initiatives included work developed and promoted through the now disbanded Health Workforce Australia (HWA), which included support for innovative practice trials and models, multi-disciplinary care and other initiatives designed to improve access and practice in areas of under-servicing. Many of these initiatives involved innovative models of education for allied health students (and practitioners), often in conjunction with other health professionals. Over recent years funding for these initiatives has been substantially withdrawn, along with the capacity of many universities and their health service partners to develop or maintain innovative educational experiences that align with workforce needs. While not all projects funded through HWA projects delivered innovative, sustainable and cost-effective workforce development opportunities, many did. Examples can be found at http://www.hwa.gov.au/our-work/current-programs and http://www.qrtn.com.au/projects. Failing to enable the continuation of innovative workforce measures that have demonstrably improved the health of patients, led to more cost-effective treatment, engendered more collaborative ways of working and other benefits to the community is an ineffective approach to addressing the increasing demands on the health system.

Who and why allied health?

Allied Health Professionals play an essential role ensuring Australians have access to the best health care available.

Allied Health Professionals can be considered, in very broad terms, as being health professionals *other than* medical, nursing or dental professionals. The health professions registered under the NRAS provides an alternative – a partial (and contested) list - Medical radiation professionals; Occupational therapists; Optometrists; Osteopaths, Pharmacists; Physiotherapists, Podiatrists and Psychologists (among others) but not including Speech Therapists, Dieticians, Exercise Physiologists, Social Workers among others.[6]

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[5] Ibid p55

[6] Allied Health Professions Australia (AHPA) describes 'Allied Health Professions" in the following terms: AHPA uses and builds on Professions Australia's definition of a profession with additional specifications: An allied health profession is one which has:

- a direct patient care role and may have application to broader public health outcomes
- a national professional organisation with a code of ethics/conduct and clearly defined membership requirements
- university health sciences courses (not medical, dental or nursing) at AFQ Level 7 or higher, accredited by their relevant national accreditation body
- clearly articulated national entry level competency standards and assessment procedures

Regardless, Allied Health Professionals are an increasingly important and capable group of health professionals with specialised skills, who tend to work collaboratively and play crucial roles in important areas of health care that contribute to preventative health care, early identification and treatment, rehabilitation and recovery and so on. They have, for example, crucial roles in preventing and addressing the impacts of chronic disease in areas such as diabetes, arthritis and cardiovascular disease[7].

Allied Health Professionals work across the breadth of the health sector; in public and private settings, in major public hospitals, small country hospitals, private hospitals, private practice, community health, mental health and aged care facilities, in remote communities, major cities and more.

Allied Health Professionals are educated to competently undertake a greater range of tasks and responsibilities than are often used[8], and often more effectively than traditional care models. Recent innovations in models of service delivery demonstrate improvements in timely access to services when the skills and expertise of the allied health workforce are optimised[9].

However, a number of barriers restrict changes to scope of practice to maximise the skills of the health workforce, including Allied Health Professionals. Barriers include legislative, administrative and funding policy, and local custom and practice[10]. It is necessary therefore to continue innovations and reforms to scope of practice to "…*maximize the efficiency and effectiveness of the available health workforce*."[11] These impediments to innovative, effective and cost-effective practice are dealt with further below.

Why Australia's tertiary education system should continue to focus on delivering innovative and creative (allied) health professionals

Developing an innovative and sustainable health workforce will best position Australia to address its **present and emerging health care demands – both domestically and internationally.**

The issues discussed above touch mainly on the importance of ensuring an appropriately skilled and accessible health workforce exists to meet growing domestic demand. However, Australia's international standing, among the top nations in terms of the quality of both its education and health sectors, means it is ideally placed to develop complementary strategies that enable innovation in

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· a defined core scope of practice
· robust and enforceable regulatory mechanisms

and has allied health professionals who:
are autonomous practitioners
practice in an evidence based paradigm using an internationally recognised body of knowledge to protect, restore and maintain optimal physical, sensory, psychological, cognitive, social and cultural function
may utilise or supervise assistants, technicians and support workers. http://www.ahpa.com.au/Home/DefinitionofAlliedHealth.aspx

[7] SARRAH Report 2015: The Impact of allied health professionals in improving outcomes and recuing costs in treating diabetes, osteoarthritis and stroke. http://sarrah.org.au/sites/default/files/docs/sarrah_report_on_the_economic_impact_of_allied_health_interventions_-_final_-_091015.pdf

[8] p4 Queensland Government, May 2014.Department of Health Ministerial Taskforce on health practitioner expanded scope of practice: final report https://www.health.qld.gov.au/ahwac/docs/min-taskforce/ministerial-taskforce-report.pdf]

[9] Ibid p3

[10] Ibid p9

[11] Op Cit Productivity Commission p303

meeting domestic health care needs while also further developing our impressive educational export achievements into regional and global markets.

Population growth, rapid economic development and changing patterns of disease globally, particularly in the Asia and Pacific region, suggest there are major potential opportunities to grow our on-shore and off-shore educational export markets[12]. Growth in Australia's educational exports has placed it among the top 3-4 export earners nationally (at around $17B per annum), and the primary services based export. However, despite this growth, and the rapid increase in domestic health student numbers, the number of international university students studying as health professions has remained largely unchanged over the past decade. The rapid growth in demand for health services in regional nations suggests there may be constraints on Australia as a supplier of health education services-particularly onshore.

The increasing prospects for the globalisation of health and the health workforce is reflected in the inclusion of service provisions within the trade agreements (TTP and ASEAN etc) Australia has negotiated recently. Australia's comparative strength in health research and translation also strengthens our potential to build on the creativity and innovative capacity of our workforce (including the highly skilled workforce we may be able to attract to Australia or collaborate with).

Research, translation and economic benefit - contributing to Australia's trade and export future

In recent correspondence with ACPDHS the Minister for Education and Training, Senator the Honorable Simon Birmingham, pointed to the Government's 2015 *Review of Research Policy and Funding Arrangements* which sought to support the development of Australia's national innovation system and capacity – by improving business and research collaboration, supporting economic growth and enhancing our competitiveness as a nation. ACPDHS members are engaged in constructive discussions with senior officials from the Australian Research Council and other relevant agencies tasked with promoting the translation of high quality research into more effective clinical practice. From an ACPDHS perspective, the Government's *Innovation and Science Agenda* offers the prospect of realizing not only greater profitability and commercial success for Australian business entities, but also the translation of research and innovative practice into improved health care and better health outcomes for people - that is more cost-effective, while improving the economic prospects of individuals affected and the nation, by reducing expenditures and increasing revenue capacity. It is important that health services be recognized for contributing to and impacting on the success of these broader policy priorities and agendas.

Minister Birmingham also advised *"I agree with you that Australia's international reputation as a leading provider of education services presents us with tremendous opportunities to leverage our expertise in health and education to meet the growing healthcare market in the Asia and Pacific regions. It is vitally important that we continue to build on our strong and emerging education and research partnerships to broaden our international engagement and further raise our international position."* Minister

[12] The Productivity Commission's Research Report into ***Barriers to Growth in Service Exports*** (November 2015) http://www.pc.gov.au/inquiries/completed/service-exports/report/service-exports.pdf found (Chapter 7 page 195) several barriers to growing educational exports, with recommendations to address these but few barriers to health exports, citing examples of success Australian health care providers had had in exporting services into major Asian markets. Nonetheless, there are barriers that impede growth in international students undertaking health professional education in Australia: referred to later in this submission.

Birmingham went on to note the beneficial implications of Australia's recent trade negotiations in opening up opportunities in existing and growth markets, including in health care and education.

Strong engagement and linkages with highly skilled and innovative people, enterprises and enabling systems internationally would generally be accepted as having a positive impact on domestic workforce capability and entrepreneurial opportunity.

Impediments and areas for improved performance

Earlier in this submission a question was raised as to why foreign students may be less inclined to enroll in Australian health professional university courses, despite our good international standing, ability to attract foreign students into other areas of study and the global demand for highly trained, capable health professionals.

The answer may, in part, reflect difficulties students face in accessing clinical placements as part of their education. Governments – albeit under pressure to find sufficient clinical placement and supervisory capacity to meet high domestic demand – have tended to restrict access to clinical places. The capacity to support clinical placements outside public (hospital) settings in Australia remains disproportionately low (at around 25 per cent of all places) despite the decades long trend toward health services increasingly being delivered in private hospitals, community and other primary health care settings. This constraint impedes potential growth, and contributes to reputational risk. Better coordination between portfolios, levels of government, universities and others is needed to:

- ensure the clinical education capacity of the nation is more closely aligned to Australia's current and emerging health service profile and needs, and ideally
- provide capacity to ensure Australia's health education export capacity and growth potential is not hindered by a lack of coherence between relevant portfolio approaches.

In correspondence with the Council, Minister Birmingham also noted that, "The training of our future health workforce is a shared responsibility between educators and employers and health service providers benefit by embedding student training into contemporary practice." The Minister went on to note that the Commonwealth Government, through the Health portfolio, invests over $1 billion per annum in programmes that build health workforce capacity.

While this is true (under Outcome 8 of the Health portfolio: Health Workforce Capacity), the Commonwealth has also very substantially reduced funding of health workforce capacity through recent Budgetary processes, including the Mid-Year Economic and Fiscal Outlook (MYEFO), released on 15 December 2015. MYEFO saw around $500M removed from the Outcome 8 over the Forward Estimates period. Minister for Health, the Hon Sussan Ley, MP, described the decisions in a media release *"Building a Health Workforce for Rural Australia"*[13], as being about better targeting. These reductions in funding will have direct, negative impacts on the extent to which allied and other future health professions will be able to access innovative clinical training opportunities in emerging areas of practice and demand, reducing the opportunities for students to experience, contribute to and promote, upon

[13] https://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2015-ley150.htm?OpenDocument&yr=2015&mth=12

graduation, innovative and flexible health care practices that are better able to deal with the emerging health care challenges Australia is facing. It is likely to have a negative impact on the health care outcomes for the population and reduce the prospects of embedding cost-effective and sustainable practices that also contain the growing costs of health associated with population ageing, the changing burden of diseases and community demand.

It is important to also note, that a large portion of the funding provided under Outcome 8 of the Department of Health is not directed toward systemic improvements in workforce capacity development or sustainability, but to payments to individual practitioners, who may or may not choose to practice in areas of relative need.

The nature of recent health workforce funding decisions overall – with some notable and positive exceptions – has been to reinforce existing limitations in the provision of timely, high quality and cost-effective health services when and where they are needed. This is unfortunate as several recent and positive Commonwealth heath workforce initiatives demonstrate the Government recognizes the value of coordinated, sustained investment in health workforce development in order to achieve better health outcomes, and strengthen structures required to address costly and persistent problems. Some cases in point include:

- Developing the medical training capacity and pathway in rural and regional areas – as a means of addressing the long-term problem of medical workforce shortages in rural Australia – from undergraduate through Medical Specialist training; and
- The establishment and expansion of the Rural Health Multidisciplinary Training Programme, bringing together Rural Clinical Schools (RCS - medicine only) and University Departments of Rural Health (UDRH – multidisciplinary).

It is important to note, however, that the large majority of the Commonwealth Health Workforce Capacity funding (over 75 per cent) goes to supporting medical practitioners – who make up less than 10 per cent of the health workforce. This is not an argument to reduce such support for rural medical education and training – that investment is justified by addressing persistent and expensive doctor shortages in rural Australia, which otherwise would exacerbate the costs to health systems, individuals and governments.

However, for the same reasons, investment to support other health professionals to establish and continue to practice in areas of need would also yield benefits. The absence of such supports also inhibits development of cost-effective and innovative care models that more fully and appropriately utilize the skills and capacity of other health professionals.

2. ACPDHS RESPONSE TO SPECIFIC TERMS OF REFERENCE

Terms of Reference 1: The extent to which students are graduating with the skills needed for the jobs of today and of the future

Health professional degrees tend to be relatively state of the art, and, because of the high placement component, are informed by current clinical practice. Therefore, students graduate – subject to ongoing access to appropriate clinical training exposure – with the skills needed in contemporary practice. Additionally, health sciences (and many universities more generally) emphasise the development of breadth and the transferability of skills that enable graduates to respond to changing workforce needs. With the addition of research exposure and expectations of critical enquiry and evidence-based teaching, graduates are equipped to respond to societal and other changes.

There are, however, limits or constraints that need to be considered

- Allied health courses are high content degrees in order to meet the requirements of external accreditation bodies, so often there is less opportunity to introduce additional content which may have a greater focus on future needs.
- The prescribed nature of degrees also make it difficult to combine them in double degree programs which could introduce new knowledge and skills, and possibly prepare graduates for broader scopes of practice and the future needs of the community .
- Innovation frequently comes from interactions at the margins of disciplines – so the structure and demands of health professional degrees often allows little time for intersection with non-health related disciplines, which potentially limits innovation and creativity in graduates of health professional degrees.
- Several accreditation bodies have strict, rigid and prescriptive requirements for both academic and clinical programs. Therefore, the opportunity to offer broad subjects that encourage skills in innovation, research and creativity is being lost. While many universities are attempting to incorporate these skills into other clinically focussed subjects, this would be far more achievable with more flexible criteria and requirements for course accreditation. In addition, the accreditation requirements are not necessarily appropriate for modern healthcare either in terms of the systems that students should or could be working in, or in terms of the changing health profile of the community.
- Responsiveness and innovation in clinical education (and placements): The structure, format and content of clinical placements often work against innovation.
    - The capacity to respond to innovations in traditional placement settings can be limited by service requirements, established service models or time pressures.
    - This then has negative flow on effects for the development of leadership skills in allied health graduates and their desire to lead change in the future.
    - They (Allied Health graduates) are also not exposed to new models of healthcare or new areas of practice (such as physical health in people with mental health disorders, or problems of multi-morbidity).
- Clinical placements are a critical component for a quality, safe and responsive health workforce. As mentioned previously, increased health program enrolments over the past 15 years (which continued with the uncapping of university places in 2010) increased competition for the limited clinical places and available supervisory capacity.

There is an imbalance between demand and supply: with the number of students enrolled in health programs and the available clinical placements (and funding capacity) required for course completion.

- Members are concerned about the level of Commonwealth Government funding for allied health programs being well below what is required to deliver these high content programs and to provide the clinical education needed. Previous Government reviews about the level of Commonwealth Supported Placement funding has identified this concern.
- Increased charging by clinical placement providers (that are not funded by Government or able to be sought from students) presents an impediment to grow student numbers to meet predicted future workforce needs.
- Some members have expressed concern about the quality of graduates if access to quality clinical placements remains limited.

Terms of Reference 2: Matters relating to laws and regulations that may act as a barrier to education providers being able to offer qualifications that meet the needs of the new economy and fastest growing sectors

Several areas of law and regulation at both state and national levels act as barriers to offering qualifications in health programs to meet the increasing health needs of our population and that are responsive to changing demand.

Health professional degrees are accredited by their professional bodies. The accreditation requirements produce safe practitioners, but may limit the opportunities of students to pursue more creative and innovative learning experiences, either at the university or when undertaking clinical placement.

The role of accreditation bodies in supporting innovation, and the approach that some accreditation bodies take currently in stifling innovation and creativity in the way that health students are educated.

Key areas for consideration include:

- Accreditation
  - Accreditation bodies frequently demand that students undertake very prescriptive practical experiences and are reluctant to recognize alternative experiences which may broaden the scope of health professional degrees and produce a graduate more aligned with future requirements in health care, and possibly more focused on creativity and innovation within future health care.
  - The relative absence of active measures and support for innovative cross-discipline or other reform promoted within the Australian Health Professions Regulatory Authority (AHPRA), which appears to rank such matters as being a low priority, despite being explicitly identified among the key objectives of the National Registration and Accreditation Scheme (NRAS) for health professions.
  - AHPRA is responsible for the administration of the NRAS; however directs around 5 per cent of its total Budget to Accreditation matters, providing little capacity for Accreditation Boards and others to promote workforce innovation and reform.
- Legislative barriers to scope of practice changes

- Many of the professions of allied health have been extending the scope of practice in order to provide more timely and responsive services to the patient or consumer of health services[14].
- Numerous legislative barriers have been encountered, as exemplified in the Queensland Government Department of Health Ministerial Taskforce on health practitioner expanded scope of practice: final report (pp36-37). Examples included: Radiation Safety Act 1999—Radiation Safety Regulation 2010; the Health Act 1937—Health (Drugs and Poisons) Regulation 1996; Mental Health Act 2000; and the Health Practitioner Regulation National Law Act 2010.

- Policy
  - Introduction of legislation to enable new programs such as the National Disability Insurance Scheme[15] Aged care reforms[16] and outcomes of reviews such as the Reform of Federation White Paper[17] and the review by the Primary Health Care Advisory Group[18] require responsiveness and innovation from the providers of health services and a commitment to developing the future health workforce to meet the specific service requirements.
  - However, changes in the sector due to reforms, such as the National Disability Insurance Scheme and Aged Care, are likely to have an effect on the availability of clinical placements, at least in the short terms as the sector adapts to the changes.
- Funding policy
  - Limited access to funding for allied health providers to funds to support and incentivize taking students over delivery of their own practice (see below In TOR 3).

Terms of Reference 3: Factors that discourage closer partnerships between industry; in particular small and medium enterprises, the research sector and education providers; including but not limited to: intellectual property; technology transfer; and rapid commercialisation.

Clinical qualifications should ideally promote innovation and build relationships between industry (*here in the form of health care providers*) and tertiary education because of the requirement of cross-institutional placements. It has been said at times, that there is a lack of engagement between education providers and industry, and similarly that industry leaders do not think current graduates meet their needs for innovative and creative thinkers.

More original strategies need to be developed and supported to enable better connections between industry and education providers on an ongoing basis in order to ensure development of the type of creative and innovative graduates that industry wants to employ in the future.

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[14] Op Cit: May 2014.Department of Health Ministerial Taskforce on health practitioner expanded scope of practice: final report

[15] National Disability Insurance Scheme http://www.ndis.gov.au/

[16] Australian Government Department of Social Services Aged Care Reform https://www.dss.gov.au/our-responsibilities/ageing-and-aged-care/aged-care-reform

[17] Australian Government Reform of the Federation White Paper https://federation.dpmc.gov.au/

[18] Australian Government Department of Health Primary Health Care Advisory Group http://www.health.gov.au/internet/main/publishing.nsf/content/primaryhealthcareadvisorygroup-1

Factors to be considered include:

- Barriers to developing partnerships, including the need and available resources to develop legal contracts around research and other partnerships.
- There are funding related issues that limit creativity, innovation and collaboration in tertiary-based education and subsequent allied health service delivery.
    - For example the use of telehealth interventions in allied health service delivery are not supported by current MBS funding, despite significant evidence of their cost-effectiveness, patient satisfaction and improved access to care.
        - This is discouraging to further telehealth implementation, as well as the further development of innovative, technology focussed interventions and services
    - This difficulty in implementing innovative care methods also acts as a disincentive for technology based industry and health care education to work together.
    - Within the current MBS funding structure private allied health practitioners are not paid for services provided by students.
        - This is in contrast to what is currently available to general medical practitioners, who are paid for the treatment and often, an additional incentive for student placements in their general practice.
        - This is a prohibitive barrier for many community based allied health care services to accept students into their practice, and thereby discourages a closer partnerships between university and health industry.
- Clinical placements
    - There are issues with clinical placements including placing students in smaller private organisations due to, for example, strict accreditation requirements and funding barriers.
    - It is uncommon for allied health students to undertake fieldwork placements with other industry partners, largely because of accreditation barriers - the accrediting, and consequently registration, bodies not recognising the value of such placements to graduates.

Terms of Reference 4: Relationships between tertiary education entrepreneurship programs and private incubator and accelerators.

There is scope to develop relationships between such public and private programs and organisations, including in the provision of health care, and in the education of future health professionals. For instance, it may be possible to draw on some of the more effective, innovative projects originally supported by Health Workforce Australia (or elsewhere) and seek to test the applicability (or potential to apply and adapt) in alternative settings.

Such approaches could enable innovative approaches to be tested, refined and applied with a view to assessing and improving performance against a range of possible assessment (outcome) approaches.

ACPHDS Members would welcome the opportunity to engage outcome-focused, evaluative and developmental activity of this kind.

Terms of Reference 5: Other related matters that the Committee considers relevant.
The Inquiry's Terms of Reference provide ample scope to identify, investigate and recommend possible reform that will lead to Australia's future workforce having the skills and ability to compete in a rapidly evolving, knowledge-based and internationalised environment. Our prospects as individuals and as a nation are not guaranteed. We cannot afford to be complacent or to miss opportunities for well-directed, coherent and reliable policy settings.

The specific Terms of Reference discussed above sensibly focus on key aspects of our educational and business operating systems that will enable or hinder development of a more agile, capable, innovative and entrepreneurial workforce and economic environment.

There may be scope – under *Item 5 of the Terms of Reference* - for the Committee to identify some of the broader structural issues that, if addressed, would promote an operating environment where a creative and innovative labour force strategy could have most impact. These issues might include, for example:

- Clarity in the roles and responsibilities of the spheres of Government – including the areas of policy identified as priorities in the Reform of the Federation process, notably Health and Education.
    - It is reality that government share responsibilities in these complex areas; between themselves and also with private and not-for-profit service providers, and with individuals. Too often mutual interests and collaborative partnerships – core elements underpinning the evolution of functioning health, education and effective governmental systems – have been eroded by short-term priorities and cost-shifting.
    - This is an important competitive factor – as among the likely reactions of a highly creative and innovative labour force, exposed to a competitive and global environment, is to go to where their contribution is enabled, not hindered.
- Greater certainty in key aspects of national policy – such as taxation and investment policy; investment in research, infrastructure, social and economic support structures, which underpin and enable (cross-sectoral and other) partnerships to develop, mature and yield returns when there is sufficient expectation of a stable operating environment to enable this to occur.
- Cultural issues and structural drivers that encourage adversarial behaviour contribute to environments that are neither cost-efficient or promote creative and innovative practice.
    - Unfortunately these manifest throughout the system – for example where Commonwealth-state relations are hostile or combative; it exacerbates pressures to cost-shift or contain responsibilities at the service delivery end.
    - For example, while Australia's health and education systems developed symbiotically over decades, often around mutual interest and strong local relationships, these strengths can be misunderstood, underestimated or eroded by policy settings that reflect and reinforce segmentation, an over-concentration on risk management (leading to risk aversion and cost shifting) and an inadequate recognition of the importance of positive interaction between areas of policy in delivering positive outcomes for people.
    - This can develop or reinforce working cultures at the frontline of clinical service delivery that may be unwelcoming of innovation and change. Even where

innovation, creativity and new models of care may be accepted and promoted at the policy and upper managerial levels of service delivery entities and hospitals, those on the ground who recruit staff, manage tight budgets and are required to work to KPIs (which may distort behaviour negatively) may not support or act on this thinking. This is a significant issue that needs to be addressed if any of the above proposals are to be successfully implemented. Adoption of a longer term perspective is required with the government playing a key role to balance the shorter term perspectives required by funding and KPI reporting requirements within both health and education institutions.

If the Committee would like to discuss this submission or any other matters that may arise in the course of the Inquiry, ACPDHS Members would be happy to contribute. If you have any questions please contact ACPDHS' Executive Officer, Robyn Adams on 07 4781 5806 (or email acpdhs@jcu.edu.au).