Health Sciences Australia

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

Submission to the Review of Australian Higher Education by the Australian Council of Pro Vice-Chancellors and Deans of Health Sciences

The Australian Council of Pro-Vice-Chancellors and Deans of Health Sciences (ACPDHS) is the peak representative body for those Australian universities that provide undergraduate education in 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. We welcome the opportunity to provide input into the Review of Australian Higher Education.

Meeting labour market and industry needs

With the ageing of the Australian population and the growth of chronic disease, the allied health professions will be critical to providing adequate and appropriate health care to the Australian population. However, the capacity of Australian universities to train the next generation of allied health professionals is severely constrained by existing funding structures that result in institutions struggling to meet the accreditation requirements of the various professional accrediting bodies because the amount of funding is insufficient to meet:

- costs associated with teaching the relevant basic sciences. All of the allied health professions have a considerable requirement for graduates to have a comprehensive understanding of the basic sciences, including anatomy and physiology ;
- costs associated with small group teaching particularly with respect to the acquisition of clinical skills required to ensure a safe level of clinical practice;
- costs of equipping, maintaining and running profession specific clinical skills laboratories;
- costs associated with the placement of students in clinical facilities. Many facilities are now charging universities a per capita amount for the placement of students; and
- costs associated with recruiting and retaining clinical academic staff in an environment where State Health Department and private employers offer salaries that are much higher than comparative university salaries.

The current funding models constrain the ability of universities to respond to the need for an increase in graduates in most of the health sciences, especially in those highly specialised disciplines where costs are high but the absolute number of graduates needed is relatively low, e.g. podiatry and orthotics. Funding from the Department of Employment, Education and Workplace Relations (DEEWR) based on EFTSL and the Clusters does not deliver enough money to universities to run these programs. Given the increasing tendency for State Health Departments to charge universities for clinical placement, even in the high volume professions, universities are reluctant

to increase enrolments as clinical placement costs are that high that the funding received is inadequate to cover them.

National workforce

National workforce approaches are useful for making resources available to address major deficiencies. However at a national level, information is aggregated to become an average, and the average will rarely be true at a regional level. Within Australia, workforce requirements at a regional level are diverse, and so programs to address workforce issues need to be based at the regional level. Whilst a national effort is required to direct significant resources to addressing workforce demand, planning and implementation needs to be done at a local level.

Opportunities to participate in higher education

New approaches are needed to support students from disadvantaged backgrounds into tertiary education. In regional areas, costs associated with tertiary education are compounded by students having to live away from home. Existing student support measures such as Austudy and ABSTUDY do not cover living expenses, especially where local economies are booming because of the mining industry.

Experience has shown that small programs need funding models that are not based on EFTSL. A threshold amount of funds are required to provide the infrastructure (human and capital) to allow access for disadvantaged groups, after which a per capita funding model can be used. For example, James Cook University runs a small program delivering the Bachelor of Nursing Sciences on Thursday Island which is supported by a permanent lecturer and part-time staff. The presence of this program is helping to instil in the community the notion that university qualifications are attainable, through creating local role models. Importantly, these types of initiatives need to be seen as a long term investment in community development, and funded accordingly.

Indigenous representation in the allied health disciplines is trailing that in Medicine and Nursing. Part of this can be explained by the lack of allied health professionals working in disadvantaged areas, including Indigenous communities. Experience from New Zealand suggests that significant staffing is required to promote recruitment and retention of Indigenous students in the health professional degrees.

Resourcing the system

The current funding models do not support the cost of educating students in the allied health disciplines. Under current arrangements, the DEEWR provides $10,106 per EFTSL for allied health students compared to $18,227 for medical students. The cost structures for these courses are very similar as previously mentioned. The critical issues are:

- ensuring that funding for the allied health disciplines reflects the true cost of delivering university based training;
- increasing the pipeline to reflect real retention rates (92%-100%);
- targeted and adequate funding for clinical placement;
- developing a new model for clinical training; and

- ensuring that funding levels are sufficient to allow the development of research, evaluation and evidence based practice in the allied health domains.

We believe that there needs to be a new construct for clinical teaching in all of the health professions. The vision is for a "Teaching Health System" that would see teaching and research embedded within health departments and facilities (of all sizes) as a critical and core activity. The acceptance of teaching and research as core activities of the health system would allow for innovation in clinical practice to develop and be supported; the current health system that of necessity, is totally service delivery focussed, has resulted in little clinical innovation. Innovation in clinical delivery should be seen as important as innovation in the basic medical and health sciences.

New funding mechanisms would be needed to facilitate the development of a "Teaching Health System" The creation of vertically and horizontally integrated clinical schools involving all of the health professions would support the clinical training of students 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.

Funding from the Department of Health and Ageing for Rural Clinical Schools and University Departments of Rural Health has transformed the availability of clinical teaching facilities in non-metropolitan Australia. This model could be transferrable to Indigenous communities and disadvantaged metropolitan areas.

Professor Ian Wronski

Chair

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