CONSULTATION: EMPLOYMENT WHITE PAPER TERMS OF REFERENCE

30 November 2022

Summary

Universities are key to addressing critical healthcare skills shortages. The Australian Council of Deans of Health Sciences institutions supply allied health graduates for the care economy and considers national healthcare workforce planning is urgent. Sustainable, innovative policy solutions are also needed to increase the supply of supervised clinical placements for students to complete their degrees: traditional clinical training models in market-based service delivery are adhoc.

Introduction

1. The **Australian Council of Deans of Health Sciences (ACDHS)** welcomes the opportunity to provide a high-level response to the Terms of Reference for the development of the Employment White Paper (the White Paper). ACDHS is the peak representative organisation for Australian universities engaged in education and research in healthcare sciences. As the educators of allied health professionals, ACDHS sits at the nexus between health care and education sectors. As a collective we are the largest provider of allied health education in Australia, teaching over 83,000 students at any one time. Allied health professionals comprise almost a third of the country's healthcare workforce and deliver over 200 million health services annually[1]. More information is available at https://acdhs.edu.au/
2. ACDHS members provide the pool of qualified allied health workers equipped to work in a range of settings, most notably in the healthcare sector, and also in education and justice. Policy settings in health, education and home affairs, and other labour market dynamics, serve to shape the ultimate workforce and its sustainability.
3. It is from this unique perspective that ACDHS provides the following comments against the following specific items under Scope and Themes:

   2.1 Building a sustainable care economy in the context of an ageing population and other drivers of demand for care services.

   5.3 Skills, education and training, upskilling and reskilling, including in transitioning sectors and regions.

4. Universities are key to addressing the skills shortages currently facing Australia, with the crisis in the healthcare workforce already evident. ACDHS considers that national workforce planning for the healthcare sector is now urgent, having languished for almost a decade. The development of the Employment White Paper is an important opportunity to mobilise a range of organisations and sectors around the conviction that a strong healthcare workforce is a critical investment contributing not only to improving the well-being of the population, but also to economic prosperity. This process must include public and private sector providers, civil society

[1] Allied Health Professions Australia at https://ahpa.com.au/what-is-allied-health/ Accessed on 3 November 2022

representatives, regulatory bodies, professional associations, trade unions and education institutions and students and their families.

TOR 2. Future of Work and labour market implications of structural change with a focus on:

2.1 Building a sustainable care economy in the context of an ageing population and other drivers of demand for care services

5. ACDHS member institutions supply graduates for the care economy. We recognise that the care economy is a complex ecosystem with components that interact in many different ways. ACDHS has detailed knowledge and understanding of the elements that relate to the supply of allied health professionals as part of the formal paid labour force. Paid care work in the care economy is highly feminised and this is also true for the allied health professions. Across the board allied health comprises a majority female workforce. There is, however, some variation between disciplines, ranging from dietitians at 95 per cent female, to physiotherapists (64 per cent), and pharmacists (55 per cent).[2]
6. Many of the current and future challenges to the sustainability of the care economy are those that face the paid healthcare workforce. There is increasing prevalence of chronic diseases with increasing complexity as people age. At the same time more people prefer to age at home so more sophisticated services need to be provided in the community setting.
7. Rapid innovation in health technologies and the capacity to quickly integrate them into health systems was well demonstrated during the COVID-19 pandemic. As noted in the recent independent review of the COVID -19 response in Australia *Fault Lines*[3] "years' worth of digital transformation occurred within weeks or months". The report also notes the little or no surge capacity in health systems. It is vital that we build on the recent experience with COVID-19 and natural disasters by preserving and developing the planning and response capacity as a core strategic approach. Climate change is facilitating the spread of known and novel pandemic prone communicable diseases and increasing the frequency of extreme weather events. The Government's commitment of funds to an Australian Centre for Disease Control and a National Health Sustainability and Climate Unit[4] is welcomed.
8. Long COVID has emerged as yet another burden on the care economy. While it is currently poorly understood, signs are that it is having a disproportionate impact on the healthcare workforce. Evidence to the House of Representatives Inquiry into Long COVID has already identified that Australia's healthcare workers appear to be particularly at risk of long-COVID. [5]
9. Allied health professionals working across the care economy have responded flexibly to COVID-19 and natural disasters. Allied health services build community and individual resilience to disasters through preventive and restorative interventions to address physical and psychological impacts and to provide post disaster recovery.
10. COVID-19 provided the impetus for universities to develop new approaches to education and support for clinical placements for students (e.g. simulations to provide students with skills related to telehealth). ACDHS has showcased innovations and successful models of curriculum

[2] centhttps://www.aihw.gov.au/reports/workforce/health-workforce
[3] Shergold P, Broadbent J, Marshall I, Vargheses P. Fault Lines. An Independent Review into Australia's Response to COVID-19. 20 October 2022. https://www.paulramsayfoundation.org.au/news-resources/fault-lines-an-independent-review-into-australias-response-to-covid-19
[4] https://www.health.gov.au/resources/publications/budget-october-2022-23-budget-overview
[5] Professor L Irving. 12 October 222 Public Hearing. Standing Committee on health, Aged Care and Sport, Parliament of Australia, Impact of long COVID and repeated COVID infections.

design using telehealth[6] including student led telehealth clinics. The telehealth experience also provides important insights for students into cybersecurity, privacy, and confidentiality issues.

11. Outmoded models of care will need to be overhauled to address these challenges to the care economy. This is an issue across healthcare:
    a. Australia's Primary Health Care 10-year Plan 2022-2032[7] notes that funding models for allied health professionals, nurse practitioners, nurses, midwives and others need to be better developed to promote access and support the delivery of effective, appropriate care in viable business models.
    b. Aged Care Reform is underway at pace, with the implementation of the recommendations of the Royal Commission into Quality and Safety of Aged Care. Access to allied health is an acknowledged core component of care to maximise independence and quality of life and reduce or delay institutionalisation, but new service delivery and funding models for allied health are yet to be found.
    c. The Independent Review of the National Disability Insurance Scheme (NDIS) must address availability and access to allied health professional services according to need, and the interface with the health system.

12. The current General Practitioner (GP) workforce shortage in Australia has drawn high profile attention. [8] Overseas models such as the first contact practitioner[9] aim to assist GPs to manage their workload more efficiently. Such models could be utilised in Australia in areas such as:
    a. The proposed Medicare Urgent Care Clinics. There is evidence that a first contact physiotherapist model in hospital emergency departments in Australia can reduce waiting and treatment times for patients with musculoskeletal problems.[10] Direct triage to advanced physiotherapy for people with musculoskeletal problems in the new Urgent Care Clinics would free up a considerable amount of GP time to be used to respond to people with other conditions requiring GP consultation.
    b. Community management of people with long COVID. Allied health led community rehabilitation has been a feature of models overseas. [11,12] Support for allied health led community-based rehabilitation services through increasing the number of sessions claimable under the Medicare Benefits Schedule (MBS) and/or grant funding to Primary Health Networks could reduce pressure on hospital based long COVID clinics and GPs.

[6] See https://acdhs.edu.au/rapid-fire-showcase/
[7] Future focussed primary health care: Australia's Primary Health Care 10 Year Plan 2022-32. Commonwealth Department of Health 2022
[8] For example https://www.smh.com.au/healthcare/health-minister-to-focus-on-terrifying-trend-of-gp-shortfall-20220730-p5b5vc.html
[9] https://www.england.nhs.uk/gp/expanding-our-workforce/first-contact-physiotherapists/ accessed on 31 October 2022
[10] For example: Bird S, Thompson,K .Primary contact physiotherapy services reduce waiting and treatment times for patients presenting with musculoskeletal conditions in Australian Emergency Departments: an observational study. *Journal of Physiotherapy*. Vol 62, Issue 4 October 2016 pp 209-214.
[11]Parkin A, Davison J, Tarrant R, et al. A Multidisciplinary NHS COVID-19 Service to Manage Post-COVID-19 Syndrome in the Community. *Journal of Primary Care & Community Health*. 2021;12.
[12] Pohar Manhas K, O'Connnel P, Krysa J, Henderson I, etal, Development of a Novel Care Rehabilitation Pathway for Post-Covid Conditions (Long Covid) in a Provincial Health System in Alberta, Canada, *Physical Therapy*, Vol 102, Issue 9 September 2022.

TOR 5. Labour force participation, labour supply and improving employment opportunities

5.3 Skills, education and training, upskilling and reskilling including in transitioning sectors and regions

13. The recently released National Skills Commission 2022 Skills Priority List[13] confirms the central role of universities in addressing the current and increasing skills shortages, with health professionals driving the rapid increase in professional occupation shortages. These are particularly apparent in services for vulnerable groups such as people living in aged care facilities, with disability, and living in rural and remote locations.

14. ACDHS members note that there are a number of constraints to increasing the supply of qualified allied health professionals. Constraints on growth in numbers of allied health graduates due to limits on enrolment numbers imposed by course accrediting bodies and limited availability of clinical placements for students so that they can meet requirements to graduate are key impediments. Moreover, it has been common for allied health to be overlooked in favour of nursing and medical graduates when it comes to health workforce policy solutions (e.g. HELP fee relief announcement to incentivise medical and nurse practitioner graduates to work in rural and remote areas).[14]

15. Almost all allied health disciplines require a clinical practicum component as part of the entry-level education to achieve registration to practice. There are several obstacles to universities securing placements for students. While there is considerable variability between universities in the way clinical placements are organised, administrative requirements are increasing and becoming more costly and onerous. Traditionally the public sector has provided student placements, but as the care economy moves towards market-based approaches, there is increasing demand from the private sector, where there is less capacity to provide student placements with the required level of supervision.

16. There are also challenges relating to negative attitudes from the supervisory workforce balanced against the recognised need from institutions about the importance of placements to the future workforce. There is a considerable body of research to support the value of clinical placements to the workplace and in influencing graduates' careers of choice. A systematic review of the evidence quantifying student impact on allied health patient activity, clinician time and productivity supports the productive value of students in the workplace.[15]

17. A number of successful industry partnerships have been developed by universities, with Government support to establish more clinical placements in underserved areas such as aged care and rural and regional locations. Unfortunately these models are characterised by short-term pilot or trial interventions and without the assurance of sustainable, longer-term funding models, will fail to become embedded into systems.[16]

[13] 2022 Skills Priority List Key Findings Report 6 October 2022. Accessed on 7 October 2022 at: https://www.nationalskillscommission.gov.au/sites/default/files/2022-10/2022%20SPL%20Key%20Findings%20Report%20-%206%20October%202022_0.pdf

[14] https://ministers.education.gov.au/clare/help-debt-wiped-doctors-and-nurse-practitioners-work-rural-and-remote-australia

[15] Bourne E. Short K, McAllister L. and Nagarajan S (2019) The quantitative impact of placement on allied health time use and productivity in health care facilities: a systematic review with meta-analysis. *Focus on Health Professional Education* Vol 20, No 2.

[16] See for example Loffler, H etal (2018) Student participation at Helping Hand Aged Care: taking clinical placement to the next level. *Journal of Nursing Research*. 2018; 239(2-3) 290-305.

18. ACDHS recommends that new ways to grow student clinical placements should be explored, such as: allowing supervised student delivered services to be claimed on the MBS; and introducing incentives for private practicing allied health professionals to have students on placement similar to those provided to general practices for medical students.

19. We understand that the development of an allied health workforce plan is under active consideration by Government. It will require a different approach from medical and nursing workforce planning due to the range of disciplines and the mix of registered and non-registered allied health professions. It will also require an approach inclusive of education, disability and aged care sectors in addition to health.

20. There are a number of pressing healthcare workforce issues requiring attention through national workforce planning. Australia has fallen behind in national health workforce research and planning since the abolition of Health Workforce Australia in 2014. We urgently need an evidence based, state of the art national healthcare workforce strategy that is supported with adequate funding. When developing workforce plans it is crucial that the constraints of an ageing academic workforce in delivering these courses are also addressed. Attracting people from a range of backgrounds into academic careers and equipping them with the teaching and research skills required is an essential underpinning to a sustainable supply of healthcare workers.

21. ACDHS recommends that urgent attention be given to national healthcare workforce planning, informed by robust data and including an integrated approach to professions and sectors. Such planning must also include provision for the academic workforce delivering education and training. The proposed development of an allied health workforce plan should be undertaken with this broader context in mind.

22. The emergence of a focus on microcredentials holds the promise of rapidly addressing skills shortfalls. Although short courses and other educational experiences that would fall within the definition of microcredentials have been in existence for many years (e.g. first aid training) the brand has gained prominence in recent years. Many Australian universities have been delivering microcredential courses, although not necessarily labelled as such. For example, during the first years of the COVID-19 pandemic, many Australian universities rapidly developed and implemented healthcare courses to deliver more skilled workers, particularly in the area of aged care.[17]

23. The Australian Government has a National Microcredential Framework [18], developed in response to a gap identified while developing the National Microcredentials Marketplace announced in 2020.[19] The area is moving quickly, with pilot funding recently announced to support offshore and higher education microcredentials. Employment considerations following completion of microcredential/s and remuneration are also likely to inform success, and outcomes are likely to be different depending on the sector. The collection of evaluative information and data as part of the evaluation of this pilot will make an important contribution to address the current lack of data and analysis about the benefits of microcredentials.[20]

24. Microcredentials provide access to lifelong learning and can provide pathways to formal qualification. It is important that the development of microcredential curriculum be led by those

[17] See for example University of South Australia short course in aged care at https://www.unisa.edu.au/unisanews/2020/edition5/feature/
[18] National Microcredentials Framework. Department of Education, Skills and Employment. Australian Government. November 2021 https://www.education.gov.au/higher-education-publications/resources/national-microcredentials-framework
[19] https://ministers.dese.gov.au/tehan/marketplace-online-microcredentials
[20] Brown & Mhichil (2021) and Brown etal (2021) referenced in Desmarchelier R, Cary L, Toward Just and equitable micro-credentials: and Australian perspective. *Int J Educ Technol High Educ* 2022 19(1):25

with teaching and learning expertise rather than business or industry partners.[21] Equity in access and courses that respond to learner needs are also important. For students, employment, price, financial assistance and return on investment are important, together with readily accessible information about what is on offer, quality assurance and how micro-credentials can be integrated into the formal basic training and further education/professional development.

If you have any questions about this response then please do not hesitate to contact ACDHS at secretariat@acdhs.edu.au.

[21] Desmarchelier R, Cary L, Toward Just and equitable micro-credentials: and Australian perspective. *Int J Educ Technol High Educ* 2022 19(1):25