Australian Healthcare Reform Alliance

Australia's Health Workforce - Response of the Australian Health Care Reform Alliance to the Productivity Commission Position Paper

Preamble:
The Australian Health Care Reform Alliance (AHCRA) welcome's the interest of CoAG, the Australian Health Ministers Advisory Council and the Productivity Commission in the health workforce, which is an acknowledgement that there are serious issues to be addressed and improvements that can be made.

The objective of the AHCRA in raising issues in relation to the health workforce is to improve the provision of health care to the Australian community: safe and efficient care from a safe and sufficient workforce.

AHCRA strongly supports self sufficiency in the health workforce as well as developing extra capacity over time to support other countries in the region in which we live.

It is the strong view of the AHCRA that a whole of government approach is essential if genuine improvements are to be achieved: federal and state and territory governments working cooperatively together.

It is also the strong view of the AHCRA that recommendations for change to the way the health workforce is educated, regulated or works, or implementation of those recommendations can only be achieved if structural changes are made by government to the way health care[11] is funded and provided. Improvements for the health workforce will not be achieved if they occur in isolation from the context in which they work.

Engagement of the community who are the recipients of care and well as the clinicians who provide the care is essential if maximum benefit is to be obtained.

The AHCRA recognises that, in the long term, structural improvements in the way the health workforce is educated; in the way educational programs for health workers are accredited; in the way the health workforce is regulated; in the various roles of health workers; and in the way the health workforce relates to each other in the provision of health care; are necessary. However, in the short to medium term, the AHCRA considers that efficiencies can and must be achieved within existing structures.

An urgent response from government is required to meet the immediate needs of the health workforce: the allocation of additional funded places in the higher and vocational education sectors and the introduction of strategies for entry, retention and re-entry to retain health workers already in the workforce.

[11] The term 'health care' in this paper is used in its broadest sense, and is inclusive of: promoting health and preventing ill health, acute health care, rehabilitation, care for people with disability, care for young people, maternity care, care for families, mental health care, care for people with alcohol and other drug issues, aged care, and care for people who are dying; in all settings: acute hospitals, people's homes, residential facilities, workplaces, schools etc; wherever people live: cities, outer metropolitan areas, rural areas, remote areas.

Australian Healthcare Reform Alliance

AHCRA recommendations:

1. **Innovation**

1.1 The AHCRA supports 'in principle' Draft Proposal 4.1 of the Productivity Commission's Discussion Paper on the health workforce:

The Australian Health Ministers' Conference should establish an advisory health workforce improvement agency to evaluate and facilitate major health workforce innovation possibilities on a national, systematic and timetabled basis.

- *Membership of the board should consist of an appropriate balance of people with the necessary health, education and finance knowledge and experience.*

1.2 The support of AHCRA is based on the following understandings:

- Safety and quality should be the main driver (as well as the development of a flexible and effect health workforce).
- Innovation must be driven by evidence. Cost savings are all too often based on short term gains rather than long term efficiencies.
- Governance of such an agency is critical.
- The level of government the agency is accountable to is also critical.
- Local innovative practices with national applicability need to be identified and national uptake facilitated.
- The agency must be adequately resourced to conduct its investigations, trial innovations and make recommendations for reform.
- Consideration should be given to broadening the scope of such an agency (see AHCRA Recommendation 5).

2. **Workforce numbers**

2.1 The AHCRA strongly supports Draft Proposals 9.1 and 9.2 of the Productivity Commission's Discussion Paper on the health workforce.
Current institutional structures for numerical workforce planning should be rationalised, in particular through the abolition of the Australian Medical Workforce Advisory Committee and the Australian Health Workforce Advisory Committee. A single secretariat should undertake this function and report to the Australian Health Ministers' Advisory Council.

Numerical workforce projections undertaken by the secretariat should be directed at advising governments of the implications for education and training of meeting differing levels of health services demand. To that end, those projections should:

- *be based on a range of relevant demand and supply scenarios;*
- *concentrate on undergraduate entry for the major health workforce groups, namely medicine, nursing, dentistry and the larger allied professions, while recognising that projections for smaller groups may be required from time to time; and*
- *be updated regularly, consistent with education and training planning cycles.*

2.2 Integration is required between recommendations for workforce improvement, education for the health workforce and workforce numbers – ideally these functions should reside within the one agency.
2.3 There is an urgent need to establish an effective process for allocating and funding university based education for the health workforce.
2.4 Once recommendations are made they must be funded and implemented.
2.5 Recommendations should not be limited to undergraduate entry level but also address the needs of the specialist workforce.
2.6 High level linkages are needed between health departments and departments of science, education and training.
2.7 Should have a specific brief to address rural and remote workforce shortages as well as the workforce supporting Indigenous communities.
2.8 Ideally would consider workforce requirements for the provision of community, aged care, mental health and disability services also.
2.9 Must be required to collaborate with consumers and health professionals.

3. Clinical training

3.1 The AHRCA strongly supports Draft Proposal 5.3 of the Productivity Commission's Discussion Paper on the health workforce:
To help ensure that clinical training for the future health workforce is sustainable over the longer term, the Australian Health Ministers' Conference should focus policy effort on enhancing the transparency and contestability of institutional and funding frameworks, including through:

- *improving information in relation to the demand for clinical training, where it is being provided, how much it costs to provide, and how it is being funded;*
- *examining the role of greater use of explicit payments to those providing infrastructure support or training services, within the context of a system that will continue to rely on considerable pro bono provision of those services;*
- *better linking training subsidies to the wider public benefits of having a well trained health workforce; and*
- *addressing any regulatory impediments to competition in the delivery of clinical training services.*

3.2 This is a huge area of concern.
3.3 The health workforce should be designated a priority area under the Commonwealth Grants Scheme and funded accordingly commencing 2006.
3.4 Funding not just policy is required.
3.5 Funding for all education for the health workforce – both theoretical and clinical – should be equitable across the professions, that is, at the same level as medicine.
3.6 Funding should be provided to health facilities to employ staff specifically to support students and vocational trainees and facilitate their clinical training.
3.7 Investment is urgently required into more interactive laboratory learning, clinical simulation and new models of clinical education.

3.8 Facilities require support so that they can coordinate all clinical training occurring at their facility.

3.9 Incentives should be provided to facilitate access to a broad range of clinical placements, for example in the private sector, the community, non-government sector and aged care sectors. For example the work of the Medical Specialist Training Steering Committee, which is planning for extension of medical specialist training into the private and community sectors, should be encouraged and used as a model for other professional groups.

3.10 There also needs to be an assessment of how clinical training is structured within courses eg. what is the optimum for learning and what is the costs to deliver in real terms.

3.11 Clinical education issues for students (undergraduate, postgraduate and vocational trainees) at rural universities and for students with clinical placements need to be urgently addressed. These students often experience serious economic hardship as they are often required to pay rent in two places and they frequently cannot find supplementary work (see position statement of NRHA www.ruralhealth.org.au).

4. Accreditation

4.1 The AHCRA supports 'in principle' Draft Proposal 6.1 of the Productivity Commission's Discussion Paper on the health workforce:

The Australian Health Ministers' Conference should establish a single national accreditation agency for university-based and postgraduate health workforce education and training.

- *It would develop uniform national standards upon which professional registration would be based.*
- *Its implementation should be in a considered and staged manner.*

A possible extension to VET should be assessed at a later time in the light of experience with the national agency.

4.2 The support of AHCRA is based on the following understandings:

- The national accreditation agency would act as an overarching governance body for accreditation services.
- The national accreditation agency would oversee but not duplicate the work of those organisations already accrediting or willing and able to accredit to the national standards.
- The national accreditation agency may provide accreditation services for those organisations not willing or able to accredit to the national standards.
- Any national standards developed should build on and extend the national standards already developed by some professional groups.
- Clinical input into accreditation and professional ownership of accreditation is critical.

5. Registration

5.1 The AHCRA supports the concept of national registration.
Registration boards should focus their activities on registration in accordance with the uniform national standards developed by the national accreditation agency and on enforcing professional standards and related matters.

5.2 The support of AHCRA is based on the understanding of an overarching national registration governance body with discreet professional boards or panels to manage professional registration.

5.3 Any national standards developed should build on and extend the national standards already developed by some professional groups.

6. MBS

6.1 The AHCRA strongly supports Draft Proposal 8.1 of the Productivity Commission's Discussion Paper on the health workforce:
The Australian Government should establish an independent standing review body to advise the Minister for Health and Ageing on the coverage of the Medicare Benefits Schedule (MBS) and some related matters. It should subsume the functions of the Medical Services Advisory Committee, the Medicare Benefits Consultative Committee and related committees. Specifically, the review body should evaluate the benefits and costs, including the budgetary implications for government, of proposals for changes to:

- *the range of services (type and by provider) covered under the MBS;*
- *referral arrangements for diagnostic and specialist services already subsidized under the MBS; and*
- *prescribing rights under the Pharmaceutical Benefits Scheme.*

It should report publicly on its recommendations to the Minister and the reasoning behind them.

6.2 Transparent review and evaluation of access to Medicare and the MBS is strongly supported, both in relation to innovative funding models and access to rebates for services delivered by a wider range of providers, with an appropriate scope of practice and who met appropriate standards of practice.

6.3 Rebates for delegated services should be set at a reasonable rate eg. the rebate for nurses and other health practitioners in general practice is too low and does not compensate the practice for using alternative staff.

6.4 All other rebates should remain constant, even when the service is as a result of a referral.

6.5 The concept that access to the MBS is always through the general practitioner is not supported, that is, where the review body recommends a rebate for a specified service, the rebate should be available on first contact.

The Health Reform Imperative: Our major problems escaped unscathed from the COAG process.
Where will we find the political leadership to take us on the reform journey?

John Dwyer

Introduction

Australians are only too well aware that their health care system is increasingly unreliable, indeed dysfunctional, surely an intolerable situation for a wealthy country with a huge surplus. Public hospitals have major problems because of ever-increasing demand, under-funding, and shortages of appropriately skilled health professionals. The essential continuum of care that should link primary, community, and hospital services is made all but impossible because of the jurisdictional inefficiencies associated with the great divide between Canberra and the states. Planned surgery is rationed, general practitioners must raise their fees to survive, and specialists' fees make it increasingly difficult for a large number of Australians to benefit from their care. Personal finances are increasingly a major determinant of health outcomes. This is not good enough for a wealthy country like Australia, particularly when the major barrier to progress is political intransigence, rather than lack of policies to address these issues.

What follows is a discussion of four major areas of reform required to facilitate improvements in all problematic areas of our health system. They are the problems created by the federal-state divide, a failure to address workforce issues and the related restructuring of primary care and hospital reforms.

2. Bridging the Federal-State Divide

Australian consumers, of course, are only too well aware of the constant bickering between the state and federal governments over who is responsible for the problems in the health care system. Under the Australian Constitution, the federal government can purchase health care for its citizens, but not provide it directly. This they do through a variety of arrangements, such as the Medical Benefits and Pharmaceutical Benefits schemes. The federal government contributes tax dollars to the states to help them with their health care responsibility, namely the running of public hospitals. The Prime Minister has acknowledged that, if policy makers were to start from scratch to design a new Australian health care system, they would not do it this way again. The federal Health Minister, Tony Abbott, has described the current arrangements as a 'dog's breakfast of a system'.

No individual reform is more important than developing a mechanism by which the country can have a single source of funding for the planning and implementation of the health care system needed by contemporary Australia. Fundamentally, such reforms are crucial and will require considerable political leadership to achieve them. They must involve the pooling of all federal and state funds for redistribution by one planning authority that acts in a patient-focused manner to ensure that health care is targeted, integrated, fair, and cost-effective.

The pooling mechanisms could be played out in a number of scenarios but only one seems viable.

This scenario would see pooled funds made available to a third party; for example, an **Australian Health Care Corporation** that would be owned by Australians, but not by either state or federal governments. The Corporation would have a board with very heavy consumer involvement and report to a governing body of state and federal political leaders. This latter model has many attractions, including the abolition of current inefficiencies associated with health care provision across state borders. In reality,

current political tensions make it necessary for those who advocate such a model to accept that Australia must immediately embark on a journey toward a single source of funding, starting with individual states and the Commonwealth agreeing to pool funds used for programs for which they share responsibilities. Such trials could be regarded as experiments, with lessons learnt continuously improving the model and perhaps attracting other states to embrace a similar approach. Australians must not let this essential reform remain in the political 'too hard basket'.

2. *Addressing Workforce Shortages*

The nation has a major shortfall in the number of skilled health professionals needed to prevent illness and deliver health care to Australia's communities. So often now, governments find themselves in the media spotlight, as headlines detail the lack of beds available in public hospitals. Governments typically react by providing additional monies to correct the situation, only to find there are no nurses available to open hospital beds. The average nurse in Australia is 47 years old! Remunerations and conditions must be made attractive to those who are drawn to this vocation, and Australia needs at least 1,800 more places for nurses in the country's universities.

There are insufficient numbers of doctors due to the increasing casual nature of the medical workforce; misdistribution of the workforce; and increasing reports of professional dissatisfaction, which might deter young people from a medical career. Allied health professionals are also in short supply and this is particularly true in the public sector because remuneration for such professionals is now very much more attractive in the private sector.

The recent productivity Commission's report on the health workforce contains several sensible suggestions none of which were acted upon at the recent COAG meeting! Disappointingly however, the report failed to recommend that Australia should become self sufficient in terms of training the professionals it needs and did not bite the bullet on the number of HECS funded additional places we need in our universities for students of the health professions.

3. *Remodeling Primary Care in Australia*

Two much-needed reforms will require the remodeling of primary care. The first demands that much more emphasis be placed on preventing illness. The second necessitates the restructuring of primary health care so that doctors can care for many patients in a community setting who are currently being sent to hospitals.

In the delivery of primary health care, the Australian system is becoming increasingly less fair. In many poorer socioeconomic areas, doctors have little choice but to bulk-bill. When pressures force them to attempt to ask for co-payment, we know that a number of patients will stay away from the doctor's surgery. The situation exists where, in some areas, doctors have to make their income through the volume of services they provide, whereas elsewhere, where the average person can readily afford a co-payment, doctors can provide a better quality service. This means that, increasingly, those Australians whose lifestyles are putting them at risk for the development of major illnesses and who need the most quality time with their doctors often receive the least.

.Australia needs to explore alternative models of remunerating general practitioners so that these difficulties can be overcome. To do so, the country must experiment with programs that see a move away from the exclusively 'fee-for-service' payments that currently characterise the primary care system. This involves exploring, as other countries have done and are doing, the appropriateness in contemporary Australia of offering general practitioners up-front payments—'contracts' to care for patients with chronic and complex diseases, with such remuneration making it possible for them to

look after patients at home rather than sending them to hospital. This is the ultimate solution for addressing the hospital crisis.

Doctors need to be part of primary health care teams where health care professionals, such as specialist nurses and other allied health professionals, are available to provide many of the services currently provided by doctors. This means extending Medicare payments to health professionals other than doctors (one of the sensible recommendations in the Productivity Commission's report). The primary health care team would focus on personal needs of the patient and pay a considerable attention to individual health plans to help people prevent illness.

Only part of a general practitioner's work needs to be remunerated in this way, with a number of standard services continuing to be available through a 'fee-for-service' mechanism. In New Zealand, such a system exists and, without any coercion, 80% of general practitioners have embraced such a model of care. The major stumbling block here is that the model requires federal and state governments to pool funds to allow the appropriate business plans to be developed.

4. Hospital reforms

Particularly in recent years, there has been insufficient political honesty about problems within the hospital system. Many consumers feel that no matter which public hospital they attend, they will find a broad range of services available, including those for the management of emergencies, and that all these services will be of similar quality. Given the workforce situation, this is certainly not true and, indeed, is never likely to be true. Nothing is more important in Australia, in terms of improving quality and safety, than exploring with the public the reality that role delineation for individual hospitals will ensure that the services they do offer, although not the full range, are of the highest quality. Hospitals should be networked so they create, in a given region, 'a string of pearls,' with each hospital offering programs of excellence where the workforce skill mix is available to do the job properly. Certainly, no matter where an Australian enters the hospital system, they should be triaged and assisted in moving to a facility that does have the capacity to care adequately for their current problem.

Even if Australia had the appropriate number of health professionals, the opening of additional public hospital beds so critically needed at the moment is not the ultimate answer. The primary care remodeling discussed above will provide the best solution for the clearly unsustainable pressure on the country's hospitals.

Current data proves beyond doubt that the almost $3 billion tax dollars used each year to support private health insurance does not achieve the goal of relieving pressure on the public hospital system. Private hospitals provide a range of very different services to those that place pressure on public hospitals. What is needed is a genuine partnership between private and public hospitals, with considerably more of the private health insurance dollar going directly to hospitals rather than to third party payers. With appropriate leadership, policy makers can do far more to promote synergy and collegiality between private and public sector hospitals.

The Way Forward

At the Health Care Summit, delegates agreed unanimously that the federal government should immediately establish an Australian Health Care Reform Commission. The Commission would be composed of leading policy bureaucrats from state and federal departments of health, experts in change management, and clinical and consumer leaders. The job of the Commission would not be to generate policies, but to work on implementation strategies By its very nature, this would be a collaborative effort between state and federal governments, the bureaucracy, clinicians, and consumers.

Without the best brains available coming to work every day to work diligently on the reform agenda, it is hard to imagine progress being made with these urgently needed reforms. Of course, the first step involves a degree of political leadership and courage to make this happen. That courage should be boosted by consistent polling, which makes it clear that there is no domestic issue as important to the Australian community as restructuring and improving the health care system to provide Australians with the care they want, very much need, and can afford.

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COAG ON HEALTH - THE REPORT CARD

John Dwyer can't for the life of him understand why our leaders were so pleased with themselves on Friday

As I write, (late afternoon) administrators in hospitals around Australia are scurrying around phoning agencies to offer exorbitant hourly rates in an attempt to find locum doctors and nurses to cover their institute tonight! Many chosen will have inadequate experience for the tasks at hand. Nowhere is the crisis more keenly felt than in Queensland where they must be incredibly relieved that, on Friday at the COAG meeting, Mr Beattie got the go ahead to have a Private Hospital help him train 60 full fee paying students who will be ready for his hospitals in six years! No wonder he was so excited.

The COAG working party, charged with exploring initiatives that would allow our leaders to improve our struggling health system received consistent advice on how this could be done from consulted clinicians, consumers and colleges. Start, they were urged, by seriously addressing structural reform to rid us of the wretched jurisdictional separation of responsibilities that prevents State and Federal health programs being integrated. This produces massive cost ineffectiveness (duplication costs two billion dollars annually), cost shifting and inequity of access to needed services. Experts provided mechanisms that would allow one set of brains to administer one pot of pooled dollars to overcome this mess. Structural reform it was argued should be a pre-requisite for tackling the huge problems we face in improving Indigenous and mental health, providing adequate care for the disabled and addressing numerous areas of inequity.

Equally urgent, the working party was told, was the need to swing our "hospital centric" health system around to one that emphasises the maintenance of "wellness" and early diagnosis to minimise the development of chronic disease. To do this will require a restructuring of the way we deliver primary care in Australia. Wellness is associated with happiness, productivity, a less costly health system and reduced demand for hospital beds, obviously an urgent priority. Champion the establishment of Integrated Primary Health centres where teams of health professionals use their skill optimally to keep us well was the cry. As the Productivity Commission recommended, extend MBS payments to other than doctors in such teams so that doctors can be freed up to do what only they can do including caring for patients in the community they must currently send to hospital. Combine this approach with an in depth community consultation with Australians who need to understand and embrace this change in our health care culture. Canada, the UK, France and many other countries have done so.

What about our workforce crisis? Please at COAG declare a policy of work force "self sufficiency" wherein we will train sufficient Australians to care for our needs. We need 900 more HECS funded places for doctors, 1800 for nurses and many more for Allied health professionals. Please don't rely on places for "full fee" paying students. Of course the suggested approach will take years to succeed hence the need for new models of care now to best use our available workforce.

Well after all that consultation and advice how well did our leaders perform on Friday as champions of a raft of urgently needed reforms? Poorly, indeed it is hard to understand why they were so pleased with themselves.

While the structural reforms discussed above would make it far more likely that the additional dollars being made available over the next few months to strengthen mental health services would be used to maximum efficiency, so dire is the current situation that of course the additional funding promised is welcome. The announcement of increased funding for primary care while also appreciated would have been received more enthusiastically if it had been pinned to a firmer declaration about the need for prevention and early diagnosis and commitment to the models of care that could achieve this goal. It seems that the States, particularly NSW and Victoria, are more committed than the Commonwealth to this approach. The major primary care initiative, a Medicare item to cover the expenses of a " check up " for Australians was proposed by the College of General Practitioners and is important but to then have COAG focus on doing so at age 45 suggest a failure to appreciate our current knowledge that preventative strategies require lifestyle and genetic issues to be tackled as early in life as possible. Frustratingly many sensible suggestions from the productivity Commission that could help make this possible have been shelved for future discussion. Indeed you would be forgiven for thinking that Mr Abbott's satisfaction as he published news on Friday of increased (patchy) "bulk billing" rates across Australia suggests that he equates good primary care with being bulk billed rather than the quality of the clinical encounter. What does it profit a man to be bulk billed but not achieve the desired outcomes from the consultation? In many areas where socio-economically disadvantaged Australians are most frequently bulk-billed health outcomes are poorest!

Other frustrations? The lack of attention to equity issues, particularly as they affect Australians living in remote and rural communities and on going safety and quality problems with nothing like sufficient support for the accelerated use of IT in improving health care. Finally our call for a post COAG implementation task force to implement agreed reforms but more particularly to work immediately on the next raft of reforms needed for continuous improvement, in concert with clinicians and consumers, leaves one with little confidence in the viability of the reform agenda. Into the election season must we reformists go?

Professor John Dwyer AO; Chair Australian Health Care Reform Alliance

Australian Healthcare Reform Alliance

ACHRA VISION

A health system that assists individuals to stay healthy and delivers compassionate and quality health care to all, when and where required.

ACHRA PRINCIPLES

ACCESS

- Health care is a right and should be available on the basis of need not the ability to pay.
- All should have access, in a timely manner, to services that maintain and support health and offer quality health care to those in need.
- Revenue from taxation should be used to fund health care services that provide equity of access and outcomes.

PRIMARY HEALTH CARE

- Modern health care systems should be designed to maximise the utilisation of health promotion and preventive strategies and those that allow early diagnosis and treatment to minimise the development of chronic disease.
- Health care systems should provide support so that individuals can maximise their own health.

COMMUNITY ENGAGEMENT

- Health care systems must be built on a partnership between consumers, health professionals and health policy makers.
- Changes to the health care system in Australia must be discussed with the Australian community to ensure they are informed, empowered and ready to embrace change.

AUSTRALIAN HEALTHCARE REFORM ALLIANCE (AHCRA)

Audiological Society of Australia, Australian College of Midwives, Australian Consumers' Association, Australian Council on Intellectual Disability Australian Council of Social Service, Australian Healthcare Association, Australian Health Promotion Association, Australian Nursing Federation, Australian Physiotherapy Association, Australian Salaried Medical Officers Federation, Catholic Health Australia, Centre for Clinical Governance Research, Combined Pensioners and Superannuants Association, Country Women's Association of Australia, Doctors' Reform Society, Effective Healthcare Australia, Health Consumers' Association, Health Issues Centre, Health Consumers' Network, Health Professions Council of Australia, Maternity Coalition, National Aboriginal Community Controlled Health Organisation, National Public Hospitals Clinicians' Taskforce, National Rural Health Alliance, Services for Australian Rural and Remote Allied Health, NSW Council on Intellectual Disability, NSW Nurses' Association, Public Health Association of Australia, Public Hospital and Medicare Alliance (Qld), Royal Australian College of General Practitioners, Royal Australasian College of Physicians, Rural Doctors Association, South Australian Salaried Medical Officers Association, Victorian Medicare Action Group

Australian Healthcare Reform Alliance

EQUITABLE OUTCOMES

- Inequity and injustice in the delivery of health care is undermining Australia as a nation and must be reversed.
- The poor health status of Australia's Indigenous community must be addressed urgently with an increase in culturally appropriate resources.
- An equitable health care system will ensure that adequate and targeted resources are made available to all with special needs.
- There are many social determinants (from poverty to the state of the environment) that can impact on the health of an individual or community. Investment to address negative determinants must be built into Australia's health care planning.

WORKFORCE

- Australia must have a policy that extends beyond 'self sufficiency' to see us not only capable of training the health professionals needed to care for our community but also able to contribute to the health of our region of the world.
- Health workforce planning should result in the development of professionals who can provide quality services in a culturally sensitive manner to cater for the diversity that characterises modern Australia.

EFFECIENCY

- Health care reform must remove the jurisdictional inefficiencies associated with the divided health care responsibilities of our State and Federal governments.
- Health care, as much as possible, should be based on the best available evidence and delivered by the most appropriately skilled health professional.

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