HEALTH WORKFORCE AUSTRALIA BILL 2009

THE INQUIRY

1.1 On 14 May 2009 the Senate, on the recommendation of the Selection of Bills Committee (Report No.5 of 2009), referred the provisions of the Health Workforce Australia Bill 2009 to the Community Affairs Committee for inquiry and report by 15 June 2009.

1.2 The Committee received 23 submissions relating to the Bill and these are listed at Appendix 1. The Committee considered the Bill at a public hearing in Canberra on 11 June 2009. Details of the public hearing are referred to in Appendix 2. The submissions and Hansard transcript of evidence may be accessed through the Committee's website at http://www.aph.gov.au/senate_ca.

BACKGROUND

1.3 In January 2006 the Productivity Commission released a report entitled *Australia's Health Workforce*. The report noted the complexity of Australia's health workforce arrangements and the involvement of numerous bodies at all levels in health workforce education and training and concluded that a more sustainable and responsive health workforce for Australia was needed. One of the recommendations was that more effective governance arrangements for institutional and regulatory structures for the health workforce should be established nationally.

1.4 On 29 November 2008, COAG agreed to a package of reform to the health and hospital system. One component of the subsequent National Partnership Agreement on Health and Hospital reflected the earlier Productivity Commission's recommendations and involved the creation of 'a National Health Workforce Agency to establish more effective, streamlined and integrated clinical training arrangements and to support workforce reform initiatives. Its responsibilities will include funding, planning and coordinating clinical training across all health disciplines; supporting health workforce research and planning; funding simulation training; and progressing new workforce models and reforms.'

1.5 The National Health Workforce Taskforce (NHWT) was established as part of the COAG package to develop strategies to meet the National Health Workforce Strategic Framework. The NHWT has undertaken a considerable level of consultation, including comment being sought on two discussion papers: *Health Education and Training, Clinical Training – governance and organisation* and *Clinical placements across Australia: capturing data and understanding demand and capacity*. Most of those who provided submissions indicated that they had contributed to consultation in various forums, including the formal consultative process conducted by the NHWT and in providing feedback on the discussion papers. The authority to be established by this Bill will then subsume the current activities and responsibilities of the NHWT.

THE BILL

1.6 The Health Workforce Australia Bill 2009 (the Bill) establishes Health Workforce Australia (HWA) as a statutory authority under the Commonwealth Authorities and Companies Act 1997. HWA will be responsible for implementing a majority of the health workforce initiatives agreed to by COAG in November 2008.

1.7 The Bill specifies the functions, governance and structure of Health Workforce Australia, enables health ministers to provide directions to HWA and requires HWA to report to health ministers. Health Workforce Australia will be responsible for:

- funding, planning and coordinating undergraduate clinical training across all health disciplines;
- supporting clinical training supervision;
- supporting health workforce research and planning, including through a national workforce planning statistical resource;
- funding simulation training; and
- providing advice to health ministers on relevant national workforce issues.

1.8 The Bill provides that the HWA has such other functions as may be conferred upon it by regulations. The Minister may also make a legislative instrument specifying the kinds of students who are eligible to receive payments for undertaking clinical training and the kinds of clinical training that would be eligible. Such a legislative instrument may specify kinds of clinical training by reference to specified courses in which clinical training is provided or specified persons providing clinical training.

1.9 The Bill provides a legislative basis for HWA's operations and governance arrangements that reflect the shared funding and policy interest of all jurisdictions. HWA will be governed by a Board comprising a nominee from each state and territory and an independent chair and may also include up to three other members selected by health ministers. A chief executive officer will be responsible for the day-to-day administration of Health Workforce Australia, and expert committees and consultants will be engaged to assist with functions as required.

1.10 Health Workforce Australia is to commence management of undergraduate clinical training from 1 January next year. The bill is required to establish Health Workforce Australia by July 2009 to ensure it is operational within the time frames agreed to in the COAG national partnership agreement.[1]

1.11 The Explanatory Memorandum notes that the Commonwealth will provide $125 million over four years for the establishment and operation of HWA. A further $1.2 billion in combined Commonwealth and States and Territory funding will be

1 Description of Bill from Minister's second reading speech and Explanatory Memorandum.

administered through HWA over four years for the majority of initiatives under the COAG health workforce package.

ISSUES

1.12 Comments on the establishment of Health Workforce Australia and its potential to ensure high quality and a sufficient number of clinical training places for the rapidly increasing number of medical students, and students in other health professions were generally favourable, ranging from strongly supported to warmly welcomed, though the Australian Doctors' Fund maintained that HWA would 'for the first time allow for the direct intervention of an unelected bureaucracy into Australian healthcare standards'.[2] However, the common view was that the national focus was welcomed as a mechanism to engage the multiple jurisdictions, protect against unilateral departures from a consistent approach, and lead to better planning with the ultimate result of better access to and the provision of more appropriate and improved health care for the public.

1.13 While generally supportive, many submissions indicated that it was difficult to provide detailed comment on the Bill. It is essentially a structural Bill, technical in nature and basically providing the legislative framework required to establish the HWA and form the basis of its ongoing operations. Many considered that a number of key elements were not described, or not satisfactorily described, in the Bill. Most concerns focussed on the functions, powers and responsibilities of the HWA. As the AMA, one of a number of groups that a made a similar comment, stated:

> these [functions] are broad in nature and provide very little real insight into the activities of the HWA or its impact on health workforce education and training. Much of what the HWA will be able to do is yet to be revealed as a legislative instrument(s) will need to be put in place to support the operation of the Bill once it becomes law.[3]

1.14 The Committee Chair drew attention during the hearing to the longstanding concern of the committee[4] about legislation that is referred to the committee without the supporting regulations and then expecting senators to make decisions based on unknowns. As noted in the above comments one of the key issues numerous witnesses raised about the legislation was the lack of detail on certain aspects which would be included in regulations.

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2 *Submission* 20, p.2 (Australian Doctors' Fund).

3 *Submission* 3, p.3 (AMA).

4 See comments in Reports by the Community Affairs Committee on the Private Health Insurance Bill 2006 and 6 related Bills, paras 1.75-80, tabled on 28 February 2007 and the National Health Amendment (Pharmaceutical and Other Benefits – Cost Recovery) Bill 2008, paras 1.14-18, tabled on 25 August 2008.

Funding, planning and coordinating clinical training

Funding

1.15 The Medical Deans noted that there are no specific requirements on how the HWA actually enters into the provision of this financial support, commenting that it is 'essential that the Bill require the Agency to consult and cooperate with both education and health providers on the provision of financial support and, importantly enter into agreements with such providers'.[5]

1.16 The explicit funding for clinical placements will be important in enabling students of all socio-economic backgrounds to participate in high quality and varied clinical training. Undertaking a clinical placement by a student is not a cost free exercise, especially if undertaken outside their usual place of study. The Optometrists Association Australia noted that at the moment, there are limited clinical placement scholarships for 'allied' health professions in rural and remote Australia. Currently a range of 'allied' health professions compete for a limited number of clinical placement scholarships funded by the Australian Government and there is a case to increase capacity in this scholarship program ahead of more explicit funding by the new Health Workforce Australia Agency.

1.17 In order to expand clinical placements in rural and regional Australia, the Optometrists argued that adequate funding is required to allow students to participate (to cover costs of living in rural and regional Australia), and build capacity of practitioners and local hospitals to host clinical placements. There also needs to be sufficient attention to linking students to local communities where they undertake their clinical training, to induct them into rural life so that links are made outside the normal working day.[6]

1.18 Catholic Health Australia noted that one of the operational proposals that is being considered is that regions be established to oversee the operation or allocation of clinical placements to government hospitals, to non-government hospitals, and to interrelate with the university and the training system. It was expected that this would provide the opportunity for rural, regional and underserved areas to be properly represented. Mr Martin Laverty, CEO of Catholic Health Australia emphasised the importance of the non-government sector and indicated that their facilities were well placed to provide assistance with clinical placements:

> Our country hospitals, our aged-care providers, are most interested in creating and providing opportunities for nurse clinical placements and medical clinical placements within country areas. That will only be properly put in place if the balance of the allocation of clinical placements between government and non-government service providers is properly managed and the voice of aged care is very firmly represented at the board

5 *Submission* 5, p.1 (Medical Deans).

6 *Submission* 15, p.2 (Optometrists Association Australia).

> table… This is an opportunity for a circuit-breaker, to say that there is a strong network of hospitals and aged care run by the non-government sector in Australia, which are in a position to access the opportunity that these new clinical placements provide, and the only way we will ensure that is if the governance arrangements of the establishment of Health Workforce Australia give proper regard to aged care and country and regional needs.[7]

1.19 Coverage under the Bill as allied health professionals and issues with the cost of funding clinical training were raised by the Osteopaths who advised that:

> Currently there is severe financial pressure on Osteopathic faculties/schools and programs in Australian universities, arising from the high cost of clinical ("hands-on") training. Such training is not subsidised, as in many other health and allied health professions, through access to public health facilities. [It is provided on-campus].[8]

Accreditation and clinical training

1.20 The AMA provided useful background to the current system[9], highlighting that Australia has a world-renowned system of medical education and training. A robust and independent accreditation framework, overseen by the Australian Medical Council (AMC)[10] underpins this system. Explicit guidelines require that the accreditation of medical education (including the component of medical education that takes place during clinical training placements) should ensure that quality assessment is independent of government, the medical schools and the profession, and that the accrediting body (in this case the AMC) should be authorised to set standards in respect of medical education and training, including clinical training.

1.21 Constant emphasis was made that the role of accrediting medical education and training must continue to undertaken by the AMC and the HWA must not seek to intrude into, to fetter or to influence the AMC's accreditation functions in any way.

1.22 Within the current accreditation framework substantial diversity exists. This encourages medical schools to develop courses that meet student and community needs within a framework of social responsibility, innovation and academic excellence. Diversity allows medical schools to build on their particular advantages and it is seen as one of the strengths of medical education and training in Australia.

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7 *Committee Hansard* 11.6.09,pp.21-22 (Mr Martin Laverty, Catholic Health Australia).

8 *Submission* 18, p.2 (Australian Osteopathic Council) and *Submission* 2, p.3 (Australian Osteopathic Association).

9 *Submission* 3, pp1-2 (AMA).

10 The AMC noted in its submission that since 1985 the AMC has been responsible for setting standards for medical education and training, assessing medical courses against these standards, and accrediting courses that meet AMC standards. The AMC has no direct role in the allocation or management of clinical placements. *Submission* 9, p.1 (AMC).

1.23 Such diversity and flexibility in current arrangements are regarded as fundamental. Many argued that the concept of reducing pre-professional clinical training activities to 'one size fits all' and eliminating the current divergent range of approaches to medical student clinical training must be resisted.[11]

1.24 Clinical placements provide essential clinical and professional learning opportunities to students by enabling them to gain experience in treating patients and to mix with peers. Currently, the role of identifying appropriate clinical placements is in the hands of universities, postgraduate medical education councils, and medical colleges because they are in the best position to ensure that clinical placements are of value and properly complement the education and training programs that they deliver at undergraduate, prevocational and vocational levels respectively.

1.25 Submissions acknowledged that the universities and health care providers have collaborated very effectively in providing clinical education for medical students. The parties have broad experience and knowledge and in many places hard-won goodwill and support resulting from many years of negotiation. What they do not have is adequate logistic and financial support. Their submissions emphasised the concern that it would be counter-productive if this effective system was dismantled. Universities Australia summed up the arguments put by many:

> If the HWA acts as a facilitator to provide funding, administrative and higher-end strategic planning support for universities and health care providers, it will assist in solving these problems [inadequate logistics and financial support] now and prevent them becoming exacerbated over coming years as increasing numbers of health students enter the system.
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> If, on the other hand, the HWA is established to be directly involved in operational aspects of clinical education, with direct involvement in the negotiation for and provision of clinical education places between universities and health care providers, Universities Australia believes that it will not substantially assist in alleviating current problems and, indeed, may add to them through imposing a new level of bureaucracy that is not responsive to local needs, or to changes in curricula and practice, and which may erode the good relations that have built up between individual universities and health care providers over decades.[12]

1.26 The message was clear: while the HWA should focus on leadership, best practice and innovation in clinical education and training, and be involved in the management of clinical placement through a planning and coordination role, there is no role for the HWA in the central allocation of clinical training places.

1.27 Although a limited brokerage role was considered by some to be appropriate, it was regarded as important that clinical training continues to be managed at the local

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11 Eg *Submission* 6, p.2 (CPMC).

12 *Submission* 1,p.2 (Universities Australia). Also *Submissions* 5, p.2 (Medical Deans); 8, p.1 (ACPDHS); 11, p.5 (RCNA); 12, p.2 (AMSA);

level to maximise the benefit available from longstanding relationships established between health services and education providers. As Professor Ian Wronski said: 'It is regional communities of interest that really drive successful clinical placement programs and it is based on trust and relationships'.[13]

1.28 The Department advised that it is anticipated that HWA will work with a number of regional or local entities to support clinical training:

> Subject to further agreement and consultation with stakeholders, regional entities would broker and oversee relationships and collaborations between education and clinical training providers with benchmarking by HWA.
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> Regional entities are expected to match supply and demand for placements and distribute them appropriately, including student support activities where necessary. They would have a role in ensuring that performance indicators are met. The entities would monitor service provider clinical placement quality and safety. Regional entities will be directly accountable to HWA for the local management of placements, ensuring that outcomes around maximising capacity and efficiency are met. It is expected that most of the regional entities would be partnerships with existing bodies such as Divisions of General Practice, relevant universities and local health services. This new role for these entities would be funded through HWA.[14]

1.29 There were also concerns that the HWA could move to impose uniform clinical placement requirements within a discipline. The timing, placement length and learning outcomes vary across and within professions. The role and expertise of the professions in determining these requirements and maintaining that position was emphasised by many submitters.

1.30 The Royal College of Nursing Australia drew attention to the particular significance of the supervisory arrangements between education and health service providers. The College noted that currently there are significant shortages of appropriately prepared clinical facilitators who are essential for optimal student clinical learning experiences.[15] The vital link between investing in continuing professional development and increasing the capacity to offer quality clinical placements may only be maintained if the number of nurses or health professionals prepared to contribute to collegial teaching and mentoring students are increased as the number of students who would benefit from these new arrangements are similarly increased in number.

1.31 Professors White and Hensley spoke from their perspectives of the difficulties faced by universities in finding clinical placements that has required collaboration

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13 *Committee Hansard* 11.6.09, p.12 (Professor Wronski).

14 *Submission* 14, p.2 (DoHA).

15 *Submission* 11, p.4 (RCNA).

with each other as well as area health services and the development required in terms of the recruitment of clinical teachers, their training and the review of curricula.[16]

Standards

1.32 The Bill does not provide a clear definition of clinical training and nor does it specify the types of courses considered eligible for funding by the HWA. Such crucial aspects of the Bill will be determined by the Minister for Health and Ageing through regulation. The possible negative effect the HWA could have upon standards for health education and training was raised by a number of submitters. The AMA argued:

> It is not hard to envisage that, with a budget under its administration in excess of $1.2b, the HWA will be able to significantly impact on the standards of medical education in Australia. There is an obvious potential for the HWA, through funding arrangements, to impose de facto standards for clinical training that are inconsistent with independently accredited arrangements.[17]

1.33 The Australian Nursing and Midwifery Council (ANMC) also commented on the impact of these aspects being determined by the Minister:

> There is no apparent requirement to include consultation with the National Boards of the health professions, Accrediting Bodies or Professional Bodies. It is difficult to see how this would not impact on the accreditation functions of the Professional Boards and Accrediting Bodies of the health professions who are responsible for determining the standards and criteria for accreditation of educational courses leading to professional registration and practice. Given the capacity for this to impact the overall standards of educational preparation of health professionals and ultimately of the standard of care to the Australian community the ANMC is concerned that there is no provision within the Bill to ensure a consultation process with these bodies.[18]

1.34 The Department clarified the situation relating to setting standards:

> HWA will not set standards around the actual clinical training to be undertaken. Matters regarding training content, length of placements, assessment and so forth are the responsibility of the accreditation body for that profession and the universities. For example, universities offering courses in medicine will still need to be accredited by the Australian Medical Council (AMC) and will be responsible for ensuring that clinical placements satisfy the AMC's guidelines. Post graduate medical education is out of the scope of HWA.[19]

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16 *Committee Hansard* 11.6.09, pp.10-11 (Professors White and Hensley).

17 *Submission* 3, p.3 (AMA). See also *Submission* 15, p.4 (Optometrists Association Australia).

18 *Submission* 17, pp. 1-2 (ANMC).

19 *Submission* 14, p.3 (DoHA).

Workforce planning

1.35 The Medical Deans were concerned that there is no mention of workforce planning, though it had been identified as a key function of the HWA in documentation relating to the HWA's establishment. The Deans stressed that workforce planning is an essential component of the health reform agenda if Australia is to successfully manage the development of its health workforce for the future and especially for meeting the burgeoning needs of outer-metropolitan, regional and rural areas to ensure all Australians have access to quality health care. The Medical Deans believed that 'the omission of the key function of planning in the legislation is serious and will severely limit the Agency's value to health workforce reform'.[20]

1.36 The Australian Medical Council (AMC) also noted that while the explanatory notes made reference to a planning function this had not been included in the list of functions in section 5 of the Bill. The AMC commented that as the HWA is a health workforce authority, so it is meant to cross over a number of areas related to health workforce planning and development, not just clinical placement and, as such, the AMC 'would like a little bit more clarification on the relationships with existing or proposed bodies which have similar mandates'.[21]

1.37 The SA Health & Community Services Skills Board considered that it was critical that the roles of existing bodies should be taken into account and stated that:

> The large number of stakeholders involved at all levels of health workforce planning and strategy makes this a complex environment and is an ongoing issue that requires continuing facilitation. It is important that the creation of the HWA does not further complicate matters by replicating existing arrangements but is instead able to draw together the stakeholders in a manner that is productive and progresses the reform process.[22]

1.38 In relation to workforce planning, the Department advised that:

> The establishment of HWA will also allow for a national approach to workforce planning. Historically, data on the health workforce has been sporadic and unreliable, often relying on voluntary surveys. HWA will work with the National Registration and Accreditation Scheme (scheduled to commence in July 2010), Medicare Australia and other sources to build a statistical database holding detailed de-identified information on Australia's health workforce.
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> The availability of quality data will assist HWA in the analysis of current workforce distribution, quantify shortages and provide for a tool to support policy development and workforce planning.[23]

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20 *Submission* 5, p.2 (Medical Deans).

21 *Committee Hansard* 11.6.09, p.25 (Ms Drew Menzies-McVey, AMC) and *Submission* 9, p.2.

22 *Submission* 23, p.1 (SAHCSSB).

23 *Submission* 14, p.3 (DoHA).

Possible future expansion

1.39 It was argued by some that the Bill enabled future expansion to occur. While the current focus of the Bill is on undergraduate or pre-professional entry clinical training, it was possible that at some subsequent time the HWA's activities could be extended to encompass also medical specialist vocational training. The AMA described this as extension 'by stealth' and was concerned that should the role of the HWA be so expanded 'then its capacity to interfere with medical workforce training will be strengthened even further'.[24]

1.40 Should such an expansion eventuate, some groups, such as the Committee of Presidents of Medical Colleges, argued that adequate consultation and cooperation with the Specialist Medical Colleges and the profession generally would be essential to ensure that any measures introduced did not impinge negatively on the existing clinical training processes.[25]

Simulation training

1.41 The expanded use of simulation training was supported by a number of submitters. The Committee of Presidents of Medical Colleges (CPMC) welcomed the focus on simulated clinical educational activities which it considered are 'currently somewhat underutilised in medical education'. The CPMC outlined the operation of simulation training, adding that the HWA needed to consider how best to ensure that rural and urban trainees have access to similar opportunities:

> Simulation usually targets the development of specific skills and it will be of value to consider in which areas of training simulation provides the most benefit. At present, simulated learning opportunities in the field of technical competence generally provide basic support and tend to be limited to the early phases of the learning process. However, several disciplines are more advanced in their use of high fidelity simulation, which involves large capital investment and high ongoing support costs.[26]

1.42 The Australian and New Zealand College of Anaesthetists (ANZCA) does offer such an advanced course and argued that there was a need for the development of a more coordinated national approach to simulation training with consistent standards. The ANZCA referred to the simulation course offered to its trainees and suggested that the course could be readily modified for broader use.[27]

1.43 However, submitters did note that while simulation is an excellent adjunct to in-situ clinical learning, it cannot on its own be a substitute for the many elements

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24 *Submission* 3, p.5 (AMA).

25 *Submission* 6, p.1 (Committee of Presidents of Medical Colleges). Also *Submission* 4, p.1 (RCPA).

26 *Submission* 6, p.2 (Committee of Presidents of Medical Colleges).

27 *Submission* 16, p.5 (ANZCA).

required for adequate medical training and in particular, the necessity for exposure to the clinical environment.[28]

1.44 The Department noted that the COAG health workforce package has provided funding for greater use of simulated learning environments (SLEs) to support clinical training. The department explained the role envisaged for HWA:

> HWA will identify the most appropriate settings for SLEs in consultation with the states and territories and stakeholders. This will include determining the size and location of training centres, with priority being given to rural and regional settings. HWA will also fund the establishment of mobile SLE units which will support training and professional development in areas which traditionally have limited access to facilities. This will help improve access to clinical training for an increasing number of health students in coming years.[29]

Research

1.45 The HWA will also be given a research function and the power to collect, analyse and publish data that will inform the evaluation and development of policies in relation to the health workforce. Professor Jill White from Universities Australia was strongly supportive of the research function:

> One of the arms of this new body is in relation to innovations research and I know that our council—and, I would believe, the others—believe that it is as important an arm as the clinical funding arm. Being able to engage in research into new and innovative models of care as well as clinical education models, models that would give greater primary health care access, new maternity service models, is really important. They are all models that link into both care delivery and better educational models for clinical education, so I think that the innovations research arm is absolutely fundamental to Health Workforce Australia.[30]

1.46 Although this data collection and research role was strongly supported, a note of caution was made that the HWA's role would not overlap or usurp the work performed by the Australian Institute of Health and Welfare (AIHW). Catholic Health Australia was one group who expressed this need for caution:

> Whilst Health Workforce Australia needs to take on a policy, a research function, I would hope very much that that does not necessarily mean that we are somehow rearranging the responsibilities that the Institute has at the moment, and that it can retain the independence and the premier position that it has as the provider of reliable and independent data on health workforce and other issues affecting the Australian community.[31]

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28 *Submission* 11, p.3 (Royal College of Nursing Australia) and *Submission* 6, p.2 (CPMC).

29 *Submission* 14, p.3 (DoHA).

30 *Committee Hansard* 11.6.09, p.7 (Professor White, Universities Australia).

31 *Committee Hansard* 11.6.09, p.21 (Mr Martin Laverty, Catholic Health Australia).

1.47 The Department explained how it was expected that the data collection and use would be undertaken.

> The National Registration and Accreditation Scheme will be developing a very good set of workforce data, which is updated on a regular basis, for all the registered professions for the first time ever. We are currently discussing with the AIHW about the data from the National Registration and Accreditation Scheme being sent to the AIHW and deidentified. The AIHW would then basically be the holder of that data, because they have legislative provisions in place around secrecy and privacy, which are very stringent and well respected within the sector. They would then produce a series of reports, similar to those that they already produce…
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> The other thing they will do is send that deidentified data to Health Workforce Australia, who will then be able to use it for planning for demand and supply purposes, which is not a role that the AIHW currently has. So the AIHW will be in the middle of the train of data, will be the custodian of that data, and will continue to provide to stakeholders and to governments the standard reports that they do now.[32]

Representation on the Board and stakeholder input

1.48 There was much criticism the proposed governance structure did not reflect the interests of the broad range of stakeholders, with considerable concern expressed over the composition of the Board being heavily weighted to State and Territory representation[33] without representatives from the health professions or education sector specifically included. There needed to be a more equitable balance of representation from the educational institutions, the health professions, the primary health care sector, the private health care industry and the broader community sector. Groups from each of these sectors were strong advocates of their cause in having dedicated places on the Board.[34]

1.49 The importance for such a balance of representation was described by Professor Ian Wronski:

> What people bring is a perspective of the world from their own profession that is very useful in understanding how to take a system forward, and so we need some balance of disciplinary dimension to the sort of decision making that HWA is going to make…What is important to be established through the board process is the representation of views of the world from across the health professions, as well as from universities and from the disciplinary areas that are important in making these sorts of decisions. Also, if we are going to expand clinical placements, the great untapped

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32 *Committee Hansard* 11.6.09, p.46 (Ms Natasha Cole, DoHA).

33 The Department advised that it was understood that the state/territory representation would be by the health CEOs in each jurisdiction (*Committee Hansard* 11.6.09, p.42).

34 *Submissions* 1, p.2 (Universities Australia); 5, p.2 (Medical Deans); 8, p.2 (ACPDHS); 9, p.3 (AMC); 13, p.1 (AGPN); 15, pp.4-5 (Optometrists Association Australia); 17, p.2 (ANMC).

> areas are the private sectors and the NGO sectors, and yet they seem to have been excluded, so I think there is some rethinking to do about that.[35]

1.50 The Bill does provide for the establishment of committees to provide advice or assistance to the HWA in the performance of its functions. However, the membership of such a committee may be by Board members, non-members or a combination of both. The Optometrists Association Australia picked up on this aspect commenting that:

> If profession-specific issues are being examined by the Health Workforce Agency, we would expect that any committee established to advise the new agency would include appropriate representatives from the relevant profession, including relevant registration and accreditation boards.[36]

1.51 The Department considered that the establishment of expert committees 'will be crucial in ensuring HWA can provide quality advice to the Board and Health Ministers'. The Department emphasised that the committees will draw upon relevant health, education and other experts as required and that they will also provide an opportunity for stakeholders to be fully engaged in the policy development and workforce planning tasks required to ensure an effective and sustainable health workforce in the longer term.[37]

1.52 While the work of the committees was regarded as important, it was representation on the Board that was more keenly desired. Professor White commented:

> Committees are an absolutely necessary part of doing the business, but they are not a substitute for having the appropriate voices at the key table. I would not see them as a substitute; I would see them as an important adjunct to the work of the board. But it is fundamental that medicine, nursing and midwifery, and allied health are represented at that board level; and the vice-chancellors, I would believe, as well.[38]

1.53 It was broadly argued that there is no guarantee that the medical profession or the other health professions, nor the education sector, will have any meaningful input into the work of the HWA. Stakeholder input is regarded as essential to inform its activities in relation to all of its functions including the funding of clinical training, workforce planning and health workforce reforms.

1.54 In the absence of strong stakeholder input, concern was expressed that the proposed governance structure means that there is a very real danger that the HWA will be dominated by the considerations of state/territory health departments that are

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35 *Committee Hansard* 11.6.09, p.5 (Professor Wronski, ACPDHS).

36 *Submission* 15, p.5 (Optometrists Association Australia).

37 *Submission* 14, p.4 (DoHA).

38 *Committee Hansard* 11.6.09, p.10 (Professor White, Universities Australia).

focused on service delivery in public hospitals. Training is likely to become a secondary consideration. As the AMA stressed:

> The HWA needs to be open and transparent in all areas of its activity. Stakeholder involvement will be fundamental to its success or otherwise.[39]

1.55 The Department explained the different functions of the Board and committees and the approach taken to their memberships:

> The governance board is exactly that, it is a governance board, so it is there to be a management board for the agency, to ensure that the agency carries out its functions appropriately. There is always the issue, as you would know, that everybody would like to be a part of this, but really we need to have a board that is workable, and trying to have everybody represented on the board is just not going to work. As I say, it has a different purpose, and that is to make sure that the agency runs effectively.
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> Allowed for in the legislation are a number of expert committees that will look at particular aspects of the work of the agency, and we would see that as providing an avenue for more representation from organisations to put their views into the workings of the agency through a committee structure rather than through the board structure…
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> We thought that the appropriate way to get input from key stakeholders was through the expert committee structure rather than on the board itself… there are many stakeholders that want to be involved in this, and we welcome that involvement, but actually trying to find positions on the board for everybody would mean that we would have an unworkable and unwieldy board structure. We think the way to do this is as expressed in the legislation - through expert committees.[40]

1.56 The Department also advised that the provision that enables committees to be established was intended to be flexible enough so that there would be 'some standing committees on the issues that are particularly relevant to the agency, for example you might have a standing committee on the clinical training subsidy'.[41]

1.57 To have some standing committees would provide greater certainty as to their importance and assurance to the stakeholders who become members of any standing committees. Universities Australia's recommendation that a Clinical Education Advisory Committee be established to report to the Board on health and education issues and comprise experts that would enable a balanced representation of stakeholder groups[42], could be an example of a committee that would fit the standing committee concept as envisaged by the Department.

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39 *Submission* 3, p.7 (AMA).

40 *Committee Hansard* 11.6.09, pp.42, 44 (Ms Kerry Flanagan, DoHA).

41 *Committee Hansard* 11.6.09, p.43 (Ms Natasha Cole, DoHA).

42 *Submission* 1, additional information dated 13 June 2009, p.1 (Universities Australia).

CONCLUSION

1.58 The evolution of these reforms within the health workforce system has been undertaken over a number of years. Generally the form and direction that is being taken that would deliver significant national benefit is supported by stakeholders across the system.

1.59 The Committee notes that all major submitters to this inquiry have been involved in the discussion and other processes in the development of this legislation, primarily through the National Health Workforce Taskforce. However many still expressed some concerns relating to the Bill, especially the composition of the Board and committees that would ensure that the views of a broad cross-section of stakeholders are heard; and the possibility for the HWA to interfere with independently accredited education and training standards.

1.60 The Committee further notes that the Department advised in their submission and oral evidence that further consultations are being undertaken by both Departmental officers and the Taskforce.

> A number of operational parameters such as eligible courses, the delivery model and level of funding per student are still under discussion with stakeholders to ensure the most effective solution for clinical training.[43]

1.61 The Committee considers that if these consultations are undertaken with a genuine desire to resolve the remaining concerns, that are primarily related to implementation issues and filling-in detail that is likely to be provided by the Regulations, then the timetable envisaged for the introduction of this reform through the passage of this Bill should not be delayed.

Recommendation

1.62 The Committee recommends that the Health Workforce Australia Bill 2009 be passed.

Senator Claire Moore
Chair

June 2009

43 *Submission* 14, p.2 (DoHA). Also *Committee Hansard* 11.6.09, p.48 (Ms Flanagan).