SUBMISSION TO THE INQUIRY INTO HEALTH WORKFORCE AUSTRALIA BILL 2009

Overview

The AMC is an active contributor to discussions concerning the work of the National Health Workforce Taskforce (NHWT) and its initiatives related to health workforce reform. The AMC has commented on the papers and participated in the consultation forums on clinical placements, and on the governance and organisation of clinical training in Australia. Since the March 2008 COAG Intergovernmental Agreement (IGA) for a National Registration and Accreditation Scheme for the Health Professions, the AMC has also contributed to the discussions on the development of the new national registration and accreditation scheme (NRAS).

The AMC is an independent national standards and assessment body for medical education and training. The purpose of the AMC is to ensure that standards of education, training and assessment of the medical profession promote and protect the health of the Australian community. 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 roles include the accreditation of medical school education courses in Australian and New Zealand universities, and the accreditation of vocational training programs in medical specialty colleges. The AMC has also worked closely with state and territory medical boards on the development of nationally consistent approaches to the registration of medical practitioners. The AMC has recently been assigned the accreditation functions for the Medical Board of Australia under the NRAS. The AMC has no direct role in the allocation or management of clinical placements. The AMC submission is made from the perspective of an accrediting body.

The government's health reform agenda is ambitious and there are a number of initiatives underway or that are being proposed which will make significant changes to Australia's health care system. What remains unclear in the draft legislation to establish Health Workforce Australia (HWA) is the relationship and the degree of interconnectedness between each of these initiatives and existing structures with similar or related functions in health and education. While the AMC recognises that the intent of the Bill is to provide the framework for the establishment of HWA, the AMC is concerned about the principles which would guide the operations of HWA given the nature of the functions included in the Bill.

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This submission comments on the proposed functions and scope of powers of the new authority as outlined in Sections 5 and 6 of the Bill. The areas of concern for the AMC relate principally to:

- the broad scope of the proposed functions and the powers of Health Workforce Australia (HWA)
- the relationship with stakeholders in medicine and education with roles in clinical education and training.

Guiding principles for HWA

The AMC understands that the NHWT has been assigned the responsibility for establishing the new Authority and that once established, HWA will replace the current NHWT and take responsibility for its work in workforce planning and research, education and training, and innovation and reform. The draft legislation does not include any transitional provisions for this change from the existing NHWT structures to the new Authority. The AMC has concerns that to date, there have only been limited stakeholder consultations on governance and data collection in clinical placements arrangements. The AMC understands that a separate NHWT paper on the funding arrangements and responsibilities for clinical training is being developed but notes that it has yet to be released for comment.

The new Authority will need to identify those initiatives which are currently working well and might be replicated elsewhere, as well as those areas which are in need of improvement, including in stakeholder engagement. Effective stakeholder engagement of the medical profession and the education providers at both the undergraduate and the post-graduate (vocational) levels at the earliest stage of the HWA's existence would contribute to a better alignment between the Authority and the education and the health sectors, thus helping to avoid the problems encountered in the early days of the Postgraduate Medical Education and Training Board (in the United Kingdom) and the challenges in managing the tensions between the supply of and demand for the number of trainee placements, as is the case with the New Zealand Clinical Training Agency where the funding for training is delinked from costings for service provision. While the explanatory notes state that the new Authority will result in more efficient, streamlined and cost efficient arrangements for clinical training, the AMC would underline that this cannot be at the expense of good practice in clinical education and training.

The drafting of Section 5 would grant a broad range of functions to the new Authority but does not provide a mechanism for engagement with the range of stakeholders whose roles relate directly to the work of HWA. The draft bill also does not state how, or if, the new Authority will be working with other bodies with similar mandates such as Skills Australia, the Tertiary Education Quality and Standards Agency, the proposed NSW Institute for Clinical Education and Training, Clinical Education and Training Queensland, the Medical Training Review Panel, the proposed National Clinical Education and Training Agency, and the new National Boards under the national registration and accreditation scheme. This is of real concern as the intent behind the establishment of HWA is to create a body which operates across the health and education sectors and across jurisdictions. The explanatory notes also make reference to a planning function but this is not captured in the list of functions in Section 5.

We note that submissions to the work of the National Health and Hospitals Reform Commission and to the NHWT have drawn attention to the challenges in establishing a central authority responsible for clinical training and education. These submissions underlined the importance of the input of the professional workforce, the undergraduate medical deans, and the postgraduate medical colleges in the functions of a central authority responsible for clinical training and education in order to ensure that the high standards of medical practice in Australia are upheld. Professional engagement would give the bureaucracy an appreciation for the diversity of needs, complexity of curricula, different costing models, the range of clinical settings for each profession, the range of opportunities for innovation, and the range of opportunities provided by the diversity of clinical training models.

As an accreditation body, the AMC is primarily concerned with the ability of education providers to demonstrate the quality and effectiveness of their programs including their clinical training arrangements. The AMC has considerable reservations about a central body utilising data to restructure or realign the clinical placements activities conducted by individual medical schools. This is because local negotiation, taking account of historic affiliations as well as different needs of the various medical schools, is likely to lead to a more satisfactory outcome. While the data available for the new central Authority is likely to be very valuable in giving an overview of the supply of and demand for places, and hence assist with appropriate matching of these, a centrally imposed solution is likely to be less acceptable than one worked out locally. It is also less capable of responding to local developments and services demands which affect the availability of clinicians to act as student supervisors.

The proposed governance structure does not reflect the interests of the broad range of stakeholders in health and education, as the composition of the Board does not specifically state that representatives from the health professions or from the education sector will be included. In the Bill's current formulation, the jurisdictions are represented on the HWA Board but the health professions are not. As HWA will be working nationally, the role of the Chair will be key in bringing together the jurisdictions. The Chair will need to have relevant experience and background. The role of the Chair will also be critical to ensuring that the jurisdictions are able to discuss issues from a national perspective.

The creation of a central body responsible for clinical training has the potential to create additional layers of bureaucracy, which in turn will lead to a system that is less responsive to changing circumstances in the health and education sectors. The creation of a central body should therefore aim to retain the expertise in the systems that support the education and training of health professionals entering the health system, and the expertise in the development of standards in education, training and continuing professional development. Loss of that expertise and experience could compromise the capacity of the new Authority to engage the health professions and to develop effective policies on clinical training.

The functions of the new Authority should not impair the culture of innovation and continuous quality improvement which currently exists in medical education and training. The process of innovation works best when diversity is valued and when higher education providers have the latitude to trial and evaluate new methods and implement them based on the evidence of their success. This bottom-up process builds on a broad approach to identifying areas for innovation and on appropriate

support and buy-in within the institution and within the profession (key elements to sustainable reform), and thus, better reflects the strengths and capacity of the institution rather than the priorities of a central Authority, which may be influenced by short term workforce considerations.

Functions

The AMC notes the following issues relating to the proposed functions of HWA:

- Section 5(1)(a): it is not possible to comment on the financing arrangements or models for clinical training as the NHWT has yet to release a discussion paper on this issue.

- It is also not clear whether Section 5(1)(a) and (b) relate to specific levels of clinical training. The explanatory notes refer to 'pre-professional education', a term which is not commonly used. It is not clearly defined in the explanatory notes and could generate confusion, leading to a number of different interpretations across the health professions. By contrast the NHWT paper 'Clinical training – data management system' refers to clinical placements at the professional entry level.

- Section 5(1)(b) should be deleted as it does not reflect the clear consensus amongst stakeholders that 'it was clear that the role of the Authority would not be to allocate students to clinical placements as this required local skills and knowledge that could not be encompassed within an information system alone without becoming overly burdensome. Likewise, it was not desirable for the Authority to deem capacity as this did not respect long standing relationship and pre-existing legal agreements.'[1]

- Section 5(1)(d) is not clear on what is meant by 'development of the health workforce'. The current construction could be taken to mean professional development initiatives, expanding the number of funded positions, development of a supply of professional health workers to meet workforce demand, and so on.

On terminology, the use of 'clinical training' should be replaced with 'clinical education and training'. The latter is applicable across all of the health professions, and gives a more accurate reflection of what is actually taking place when students undertake part of their education in a clinical setting. From the AMC's perspective, the NHWT definition of clinical training is too narrow. The AMC has provided an extended definition in its response to the NHWT discussion document 'Clinical training – Governance and organisation'.

The explanatory notes state that the Authority's responsibilities will relate to 'all health disciplines' but it is not clear from the language of the Bill whether this scope of responsibility will extend beyond the current ten registered health professions and those professions which are likely to be included at a later date under the national registration and accreditation scheme. There are other providers of healthcare which also require practical placements with patients during the education and training

[1] National Health Workforce Taskforce. Clinical training – Data management system, April 2009. available on www.nhwt.gov.au

phases, such as speech pathologists, audiologists, occupational therapists, and prosthetists.

Alternative roles for Health Workforce Australia

The following are suggested as tasks for the new Authority that could be supported to improve clinical education and training:

- **Encourage a health service culture which values clinical training and education and the benefits it brings**: while clinical training is a cost to the health care system, it is also a benefit. There is a potential positive impact on patients when care is provided in an environment where education is valued. The benefits which late stage students bring to health services also need to be acknowledged, as it is in other jurisdictions such as the UK and New Zealand. High standards of patient service depend on the medical staff and other health care practitioners who deliver that care having an active involvement in continuous quality improvement, evaluation of outcomes, maintenance of professional standards and advancement of knowledge. There is no better guarantee of quality of, or maintenance of, standards than staff involvement in teaching.

- **Support research into models for effective and sustainable clinical teaching**: educational research into models of clinical education and teaching is generally undertaken without funding, and so is generally constrained to concentrate on short-term, easily measurable or self-reported attributes and outcomes. Funding is required if there is to be long-term work on the quality and effectiveness of clinical education.

- **Support infrastructure development**: based on its accreditation experience, the AMC considers that for clinical education in medicine, the limiting factors for developing more clinical placements relate to infrastructure availability. Providers need more support for physical and human infrastructure to support teaching within health service settings, plus explicit recognition of the capacity restraints in the all-important ambulatory and community settings of primary care practice. This includes teaching and learning facilities in hospitals and GP practices, spaces for student(s) to sit; teaching/tutorial rooms on wards and near theatres, etc. There are also issues relating to the availability of supervisors; VMOs may abound, but they attend public and private hospitals episodically and cannot provide the continuity of education and supervision that is needed. Registrars could fulfil this role but do not necessarily have job descriptions that facilitate this activity. Central databases could then be used to monitor the effectiveness of these allocations, and to maintain accountability for their use.

- **Monitor performance against plan from the jurisdictions/agencies that carry out training:** funding should go with the trainees to fund time for supervision, infrastructure and simulation facilities. It would be valuable to have the Authority monitor and hold accountable the jurisdictions from whom they have clawed back funds, to ensure that they do not do less in helping train their own workforce than they are doing at the moment.

In summary, the AMC welcomes this opportunity to comment on the establishment of Health Workforce Australia. The AMC is concerned that the draft legislation does not provide for stakeholder and professional engagement and only describes the proposed functions of HWA in very broad terms. It is therefore not clear what linkages will be forged between HWA and other bodies (both existing and proposed) with similar mandates, nor is it clear how HWA will lead to more effective governance arrangements around health workforce training, planning and policy developments across the jurisdictions and the health and education sectors. The current formulation of the proposed functions of HWA says little of the complex arrangements which will be necessary for its effective functioning. The AMC remains firmly of the view that a case has not been made for a central allocation, tendering or brokering that would apply to a wide range of health professions. Facilitative, positive options for the Authority's involvement in clinical education governance and organisation need to be explored.

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