Submission to Senate Community Affairs Committee
Health Workforce Australia Bill 2009

Authorised by
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About the Australian Dental Association

The Australian Dental Association Inc. (ADA) is the peak professional body representing over 10,000 registered dentists engaged in clinical practice. ADA members work in both the public and private sectors. The ADA represents the vast majority of dental care providers.

The primary objectives of the ADA are:

- To encourage the improvement of the oral and general health of the public,
- to advance, and promote the ethics, art and science of dentistry, and
- to support members of the Association enhancing their ability to provide high quality professional oral health care.

There are Branches in all States and Territories other than the ACT, with individual dentists belonging to both their home Branch and the national body. Further information on the activities of the ADA and its Branches can be found at www.ada.org.au.

The ADA thanks the Senate Community Affairs Committee for the opportunity to address issues in the Health Workforce Australia Bill that are of relevance to the ADA.

Background

Currently, review and reform of health and the health professions is receiving considerable attention from the Federal Government. Whilst this focus on health delivery is welcomed, the preponderance of reform agendas, many of which overlap leaves the impression of a number of agendas progressing without a coordinated plan for implementation arising from this activity.

The similarity in the objectives of the National Registration and Accreditation Scheme and the AHMC/AHMAC Health Workforce Committee Structure (one body of which is the Health Workforce Australia (HWA) - established by the Health Workforce Australia Bill) reflects this.

The major initiatives currently taking place in relation to health workforce are briefly the following:

1. The National Registration and Accreditation Scheme (NRAIP). The Senate Affairs Committee is already aware of the significance of this issue as it is noted that a separate Senate Community Affairs Committee is evaluating that scheme. The ADA has made a submission to the Committee expressing its concerns in several areas. In the NRAIP, it is proposed that there will an inter relationship of the Ministerial Council, Australian Health Workforce Advisory Council, National Agency, Agency Management Committee, National Committees, nine national (Health specific) boards and State/Territory Offices.

This is a very substantial investment of resources directed to the improvement in the safety and quality of health care. What is being created here is still, to a large extent, in developmental phase. Bill B under the Scheme is yet to be published, so much of the details as to the mechanism remains imprecise and is therefore still able to be refined.

2. The Australian Commission for Safety and Quality in Health Care (ACSQHC) is embarking upon a program that will require health practices, including dental practices, to be accredited. In this regard the ADA has, through the creation of an internal Committee and the development of a Memorandum of Understanding with the AGPAL/QIP Group, commenced the implementation of the creation of a set of standards against which dental practices will be accredited. An accreditation body will then evaluate practices against those standards.

3. The National Health and Hospitals Reform Commission has filed an interim report and is expected to file a further report within the next few weeks. The interim recommendations of this Commission could if adopted, re-define the way health care delivery is provided in Australia. Adoption of some of the recommendations could well impact adversely upon the progress that has been made in relation to the reforms proposed under the actions taken in response to changes set out in 1 and 2 above.

Overview

In brief, the reform agendas in place potentially are creating a preponderance of change and whilst reform per se is not opposed, the ADA has concerns that the outcomes or proposed outcomes of some of the reform proposals are not being given time to settle and allow identification of the ramifications on the delivery of health services in Australia.

The creation of the HWA adds yet another dimension to the reform process. The ADA will in this submission suggest that while the HWA will provide a very useful role in supporting health workforce research and planning through statistical research, the provision of a responsibility for:

> *"Implementing a national strategy for workforce reform that will demonstrate, pilot, evaluate and implement new workforce models to improve the effectiveness and efficiency of service delivery, within a framework of safety and quality"*[1]

is superfluous to needs at this time. This additional level of a reform process outside those established in the NRAIP process is both uneconomic, and creates the potential for a fractured reform process due to duplication.

[1] Health Workforce News-Issue 3 May 2009. Page2.

Health Workforce Australia.

It is difficult to see with any precision exactly what roles and functions HWA will have.

The Explanatory Memorandum to the Health Workforce Australia Bill 2009, states that the HWA be created as there is:

"a need for more effective governance arrangements around health workforce training, planning and policy development that can work across and with jurisdictions and the health and education sectors. The creation of a new single body that can operate across both the health and education sectors and jurisdictional responsibilities in health is critical to devising national solutions that effectively integrate workforce planning and policy." [2]

This sentiment is then repeated throughout the Second Reading Speech for the Bill where there is frequent reference to the need for an authority to improve on the "very poor national data on the health workforce"[3] available.

The ADA would support the need for the creation of such a body as the gathering of national workforce data, including training places, is something that the ADA has been advocating for some time. Collecting and processing accurate workforce data has to be the first step in the consideration of any development process. Until accurate data is available there can be no justification for any modification of existing policy.

Examination of the makeup of the proposed HWA Board – being nominees from each State and Territory would seem to be appropriate. It is noted that these Board members need have no specific health background and as the HWA will be an authority performing collection and collation of workforce data that would seem appropriate.

The Explanatory Memorandum then goes on the state:

"Its (HWA) responsibilities will include funding, planning and coordinating pre-professional entry clinical training across all health disciplines; supporting health workforce research and planning, including through a national workforce planning statistical resource, and funding simulation training. The Authority will also ensure best value for money for the workforce initiatives, a more rapid and substantive workforce planning and policy development environment and will provide advice to Health Ministers on relevant workforce issues."[4]

The provision of these roles to this body seems to extend the ambit of HWA and its membership well beyond what has been envisaged in the original quote provided above. The ADA questions the necessity for these powers to be provided to such an authority that will be concerned with "*effective governance arrangements around health workforce training, planning and policy development".*

It is the ADA's view that the HWA as constituted is an inappropriate body to perform these very wide-ranging tasks and that these tasks would more properly be the purview of a more specialised body and perhaps one of the existing bodies with a similar brief, set up under the NRAIP.

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[2] The Parliament of the Commonwealth of Australia-House of Representatives-Health Workforce Bill 2009-Explanatory Memorandum, Page 1.

[3] Hansard-Second Reading Speech- Page 2

[4] The Parliament of the Commonwealth of Australia. House of Representatives: Health Workforce Bill 2009-Explanatory Memorandum, Page 1.

The ADA does not consider the HWA as constructed will have the expertise to advise on issues of clinical training as it is not a body qualified to deal with these issues. This is clearly the role of the national registration and accreditation authorities created under the NRAIP. Such functions in fact require a degree of independence from government. It has been for this reason that the ADA has continually advocated for a separation of the roles of practitioner registration and qualification accreditation under the NRAIP scheme.

The Health Practitioner Regulation (Administrative Arrangements) National Law Bill 2008 was created to assist in the continued development of a flexible workforce to enable innovation in education and service delivery.[5] The similarity between this role and that of the HWA is remarkable. There is clearly a potential for duplication of effort here and one which should be avoided and the role provided to the structure best able to deliver on this.

The function of the Australian Health Workforce Advisory Council (AHWAC) includes provision of independent advice to the Ministerial Council about the following:

a) *"Any matter relating to the Scheme that is referred to it by the Ministerial Council.*
b) *At the request of the Ministerial Council, any matter relating to the Scheme on which the Ministerial Council has been unable to reach a decision.*
c) *Any other matter relating to the Scheme that it considers appropriate."*

Having regard to the other authorities created pursuant to the NRAIP[6], it is clear that AHWAC set up under NRAIP will be dealing with issues such as the development of health professions' standards and training, oversight of overseas trained health practitioners' assessment and the provision of advice to the Ministerial Council on delivery of health services within Australia. It, through its utilisation of the national boards and their expert Committees, would clearly be better served to address the non statistical gathering functions that are proposed to be part of the HWA role.

A cursory review of the respective functions of the two bodies (HWA and AHWAC) demonstrates a clear overlap of roles and interests. There is no necessity for this duplication, as it will only have the potential to lead to conflicting solutions being advanced in seeking improved health delivery and waste scarce public funds. Creation of a body that will collect and process workforce data is a valuable service and one that would be suitable for a body such as that proposed to be created under the Health Workforce Australia Bill. It is the ADA's point that this organisation does not have the expertise to be able to provide advice on workforce reform, as advice on workforce reform should come from those expert in the workforce themselves.

As the NRAIP process has a representation of registered and qualified health providers, it is the ADA's view that any streamlining of health training arrangements and workforce reform initiatives would be more authoritative and valuable coming from registered health workforce practitioners with input from community members as this group would know best how that reform could occur in such a way as to maintain and improve safety and quality in service delivery.

[5] Consultation paper on Issues Supplementary to the Intergovernmental Agreement on a National Registration and Accreditation Scheme for the health professions to be included in the first bill.
[6] See "Background" page 1 of this paper.

It is recognised that within the HWA legislation there is the capacity for the formation of "Expert Committee and Consultants". Again this power or authority exists under the NRAIP model. Again the propensity for duplication, development of contrasting views and conflict exists. The ADA reiterates that duplication is costly and unnecessary and the role should fall to that structure best equipped to recommend solutions and that would be the NRAIP process due to the health expertise present within that structure.

As mentioned at the outset, reform of health delivery and in particular the collection and processing of workforce data, is a worthwhile initiative but it must not be implemented for reform's sake. There should be a demonstrable need established and the reform proposal not be implemented if it will in any way compromise on the quality and safety of health care delivery. If shortages in workforce numbers are indicated through the statistical gathering of the HWA, then this has to be seen as a shortfall in workforce planning and addressed by creation of additional suitably trained workforce. The creation of that workforce should not come at a cost of reduction in quality and safety of delivery. Modification of workforce practice may not necessarily be the best solution and investment in training and infrastructure may be the more sustainable long term solution. Decisions on these questions must be with a body skilled in health delivery and the HWA as constituted is clearly not such a body.

Conclusion

The ADA recommends:

1. The HWA's function is restricted to that of a body responsible for effective governance arrangements around health workforce by obtaining and collating health workforce data. This will provide the evidence base on which more suitably qualified bodies can then make recommendations in the event reform is needed.

2. Roles associated with education and training be the purview of the NRAIP process.

3. Planning, coordinating and determining the needs for clinical training across health disciplines should be roles which the National Health Boards and Accreditation Agencies determine pursuant to the NRAIP.

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