



## **Response to the Productivity Commission Position Paper**

### ***Australia's Health Workforce – September 2005***

November 2005

#### **Contact for further information**

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## Introduction

### About SHPA

The Society of Hospital Pharmacists of Australia (SHPA) is the professional body that represents pharmacists and pharmacy technicians working in hospitals and many related parts of the health system. Members are drawn from a diverse range of pharmacy and health practice settings including public and private hospitals, community pharmacy, academia, research, industry, government, consultant pharmacy and a range of quality use of medicines projects, clinical governance and medicines management programs.

The SHPA vision is "Excellence in medicines management through leading edge pharmacy practice and research".

### About hospital pharmacy

Pharmacists in hospitals are actively involved in all aspects of medicines use, without the need for referrals.

#### **Safe and effective medicine use is the core business of hospital pharmacists.**

Hospital pharmacists, as part of the health care team:

- work closely with patients to help them get the most from their medicines;
- work on hospital wards alongside doctors and nurses as part of the health care team;
- work in specialist areas e.g. emergency department, pre-admission clinics, intensive care, cancer treatment, paediatrics, renal, psychiatry, drug information services (and as providers of national medicine "Help Lines" for health professionals and consumers);
- visit patients in their homes to provide information and support after discharge from hospital;
- dispense medicines and make special medicines, including specialized formulations for non-sterile and sterile products (cytotoxics, injections, parenteral nutrition formulae for adults and neonates, eye drops, clinical trial drugs, special situations, novel problems);
- participate in clinical trials of new medicines and research to improve medicine use;
- manage or supervise other staff; and
- manage multi-million dollar budgets for medicines.

### About this response

As in its original submission, SHPA will **focus on pharmacist issues in the hospital sector**, both public and private, acknowledging that in future these services may be delivered via different "**virtual hospital**" models with more community based care.

However, it must be understood that future services will require a similar health professional skill set to that found in hospitals today and that it should leverage the current network of community pharmacies.

SHPA supports the larger goal of a healthy and dynamic pharmacy sector. As part of the global workforce, Australia needs to be able to educate and train sufficient pharmacists for current and future roles and to maintain workforce participation throughout life to maximise the payback from this investment.

## Response to the Productivity Commission Position Paper “Australia's Health Workforce” September 2005

SHPA recognises the significant effort made by the Productivity Commission in drawing together the Position Paper on health workforce issues, and supports much of the Paper.

However, the Paper is pitched at a high level and it is a major concern that the follow-up actions may be limited to high level bureaucratic committees that may, as now, lack the funding streams to implement necessary actions.

**SHPA's responses to specific draft proposals in the position paper are set out from page 6.**

However, as a preliminary, SHPA wishes to raise the following concerns about the Position Paper that relate to “silences” on certain key topics and noticeable absence of recommendations.

Much of this SHPA comment is available in more detail in the original SHPA Submission to the Productivity Commission.

### **1. No recommendation about the need for integrated actions.**

Most actions on the health workforce are connected to other actions and/or outcomes. Solutions to the health workforce issues do require the goodwill, collaborative resolve and **integrated actions** of governments at all levels, professional bodies, the higher education sector, regulatory authorities and health professionals themselves. There is a need for this to be explicitly recognised.

In addition, workforce initiatives for certain practice settings should not be considered in isolation e.g. pharmacy is a dynamic workforce and the sectors are not mutually exclusive. Similarly, actions implemented to, say, support pre-registration training for pharmacists can also be designed to lead to service innovations and new paradigms of care, especially in rural and remote areas.

Whilst the Position Paper is pitched at a high level, it should also be stated that “one size may not fit all”, and even within an overarching framework, different initiatives may be better suited to certain professions.

### **2. No recommendations for better coordination between the two levels of government that fund health services, to potentially ameliorate problems arising from fragmentation of roles and responsibilities between the many funders of health care.**

The SHPA submission noted that the complexity of the health funding system is an **overarching constraint** in moving to remedy the workforce situation. Whilst the Position Paper has devoted much attention to new inter-professional role changes, at present within the same profession, pharmacists are actually prevented from providing extended pharmacy services, by the operation and business rules of existing government funding systems.

With the hospital pharmacy workforce numbers being relatively small, there is huge opportunity to take up some workforce recommendations on a **nationally** consistent basis. This, in itself would be a ‘quick win’ productivity gain, as currently SHPA must work jurisdiction by jurisdiction, leveraging various projects to move ahead.

### **3. No recommendation about State/Territory governments as providers of public sector health care**

Governments themselves are also major providers of health care. In an environment of health workforce shortage, the relative inflexibility of the public sector can result in the worst shortages occurring in the public sector. It would be helpful to recommend that “incentives” proposed for rural health could equally be applied to the public sector, in areas of need, on a national basis.

SHPA proposes that a trial of reimbursement of HECS debt should be applied to the public hospital pharmacy sector as an “incentive” for recruitment to the public sector. Such actions, as incentives, are attractive in that they can be applied (or discontinued) with relatively short lead times.

The Productivity Commission seems to have only considered HECS fees (page 67) as part of education and training. **SHPA is proposing reimbursement of HECS debt as a recruitment/short term retention tactic and seeks to have this included in the final Paper.**

Given the high proportion of females in many health professions, it is also important to provide family friendly employment conditions, such as the provision of child care at all public hospitals, to increase "attractiveness to participate" at all stages of life.

#### **4. No recommendations to improve recruitment and retention**

The Position Paper is extremely limited on recruitment and retention issues. SHPA has devoted much time to research on this area and suggests that any new health workforce improvement agency should consider these issues as a necessary stream of activity, as well as innovation etc.

Research from hospital pharmacy indicates that the most important factors in the retention of, and job satisfaction for Victorian hospital pharmacists in both metropolitan and rural areas were:

- the availability of sufficient and suitably qualified staff;
- hospital management's support for the practice of hospital pharmacy;
- professional development opportunities; and
- access to organised continuing education.

**Hospital pharmacists in rural areas indicated that the availability of locum and relieving pharmacists was a crucial retention issue for them.**

Career paths are also an issue if the only way to achieve better remuneration and career prospects, is to move out of clinical areas to management or the pharmaceutical industry. Re-entry courses should be funded and conducted most efficiently on a national basis. Consideration should be given to these being conducted in hospitals as a way of recruiting pharmacists into hospital pharmacy practice.

#### **5. No recommendations about the reduction of "red tape" associated with government as a funder**

The silence about reduction of government red tape in operation of the MBS and PBS was deafening.....

If CoAG wants improved outputs from the health workforce then acceptable changes in red tape that also maintain accountability, must be achieved. In particular, the introduction of arrangements such as the use of the PBS in public hospitals, must integrate with the patterns of care delivery as a matter of priority to minimise waste of resources due to a funding system with a labour intensive approach.

#### **6. In summary**

The pharmacy profession already makes a large contribution to the safety and quality of healthcare and a similar, largely voluntary contribution to professional standards, codes of ethics, professional continuing education and development, tertiary training course accreditation, clinical training of undergraduates and postgraduates and this should be recognised.

**Consumer services related to medicines use, medication safety and reducing adverse events require a full complement of pharmacists and pharmacy support staff in our hospitals.**

Solutions to the health workforce issues require the goodwill, collaborative resolve and integrated actions of governments at all levels, professional bodies, the higher education sector, regulatory authorities and health professionals themselves.

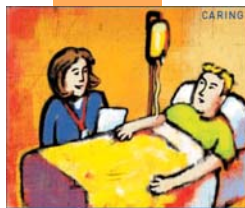
SHPA is committed to achieving this objective.

The solutions that are developed must be integrated, holistic and flexible with achievable lead times/resources as detailed in the example, on the following page. Modest funds are needed to implement these actions.

To attract  
**NEW**  
pharmacy  
graduates



career path



Pharmacist



To make  
hospital  
pharmacy  
attractive  
career long

## Overview of recruitment and retention strategies for hospital pharmacy

Refer to 2004 SHPA Report for related background research underpinning these recommendations ([www.shpa.org.au/pdf/whatsnew/nhwsf\\_response.pdf](http://www.shpa.org.au/pdf/whatsnew/nhwsf_response.pdf))

WHAT	HOW	Opportunity for national collaboration?
<p><b>Create new pre-registration training places in hospitals</b> (using sequestered funding for up to 50% of pharmacy graduates) ★</p>	<p><b>START NOW AND INCREASE IN INCREMENTS</b> to have more places in all jurisdictions until there are places for up to 50% of graduates (also need funding for one clinical supervisor for 10 pre-reg places), then monitor outcomes and review</p>	<p><b>YES</b> <i>SHPA has experience and can assist with national coordination / implementation to avoid duplication in each jurisdiction and so that this can start ASAP</i></p>
<p><b>Market hospital pharmacy</b> actively to all 3,000 current pharmacy undergraduates ★</p>	<p><b>QUICK WIN</b> Support SHPA's aim to conduct regular talks at all pharmacy schools as part of the "Hospital Pharmacy – a world of possibilities" campaign</p>	<p><b>YES</b> <i>This program has started with seed funding from SHPA – but needs a funded national annual promotion campaign</i></p>
<p><b>Incentives for newly qualified pharmacists</b> (2-5 years post graduation) to work in public hospitals ★</p>	<p><b>QUICK WIN</b> Pro-rata yearly refund of HECS debt for pharmacists who work in public hospitals</p>	<p><b>YES</b> <i>Suitable to be developed and administered as a national scheme</i></p>
<p><b>Advertise job opportunities on the SHPA national job register</b>, which is 'marketed' to all pharmacy students and pharmacists as a 'one-stop shop' ★</p>	<p><b>QUICK WIN</b> Easy to put in place to support the current workforce Also good for <b>CAREER LONG</b> recruitment</p>	<p><b>YES</b> <i>SHPA national job register for hospital pharmacy could be funded for all public hospitals on a national basis</i></p>
<p><b>Appropriate award structure and adequate remuneration</b> for hospital pharmacy to be "competitive" with other sectors</p>	<p><b>UPDATE ASAP</b> Restructure awards in next EBAs. Learn from changes in South Australia to improve both recruitment and retention for <b>CAREER LONG</b> applicability</p>	<p><b>NO</b> <i>This must be undertaken in each jurisdiction unless a federal award for hospital pharmacy could be created (which would be welcome)</i></p>
<p><b>Create formal re-entry programs for hospital pharmacy practice</b> to entice 5,000 non-working pharmacists or those who have not worked in hospitals</p>	<p><b>START IMMEDIATELY</b> Needs to be developed, so work needs to start now (but can leverage off some existing courses) and be applicable <b>CAREER LONG</b></p>	<p><b>YES</b> <i>SHPA could develop a national deliverable package to avoid each jurisdiction "re-inventing wheels"</i></p>
<p><b>Maintain an adequate workforce</b> to provide hospital pharmacy services, which includes using the skills of qualified pharmacy technicians who are better trained ★</p>	<p><b>ONGOING</b> Continue salary packaging and the recruiting of overseas pharmacists (holiday visa, permanent) <b>START IMMEDIATELY</b> Promote and facilitate improved training of the <b>pharmacy technician workforce</b> using the new national competencies <b>QUICK WIN</b> <b>Fund LOCUM relief for rural hospital pharmacy services</b> under the existing national rural and remote workforce development program, which currently only applies to community pharmacy</p>	<p><b>YES</b> <i>These are all suitable for national collaboration, development and implementation</i></p>
<p><b>Create family friendly and flexible working conditions</b> with professionally rewarding roles for part-time staff</p>	<p><b>ONGOING</b> Actively encourage improved and flexible working conditions to retain staff Collaborate and share good news stories via SHPA website as <i>working lives</i> series, to be promoted widely building on the "Hospital Pharmacy – a world of possibilities" campaign</p>	<p><b>YES</b> <i>The NHS in the UK has created a working lives series. SHPA could develop and maintain this nationally</i></p>

## **SHPA response to the draft proposals in the Position Paper**

### **DRAFT PROPOSAL 3.1**

In its upcoming assessment of ways to improve the level of integration within the health care system, the Council of Australian Governments (CoAG) should consider endorsing the National Health Workforce Strategic Framework (NHWSF), subject to broadening of the self sufficiency principle, in order to enhance cohesion between the various areas and levels of government involved in health workforce policy.

#### **SHPA response:**

**SHPA supports the National Health Workforce Strategic Framework.**

**SHPA has responded in detail on its content to AHWOC and Health Ministers with recommendations for the national action plan of recruitment and retention strategies for the hospital pharmacy workforce.**

**However, whilst being received well by Ministers and AHWOC, no assistance on implementation of the suggestions has been forthcoming.**

**There is much opportunity to demonstrate increased political will and leadership in its implementation and this could be strengthened in the draft proposal.**

[http://www.shpa.org.au/pdf/whatsnew/ahwoc\\_recomm.pdf](http://www.shpa.org.au/pdf/whatsnew/ahwoc_recomm.pdf)

[http://www.shpa.org.au/pdf/whatsnew/nhwsf\\_response.pdf](http://www.shpa.org.au/pdf/whatsnew/nhwsf_response.pdf)

### **DRAFT PROPOSAL 3.2**

CoAG, through its Senior Officials, should commission regular reviews of progress in implementing the NHWSF. Such reviews should be independent, transparent and their results made publicly available.

#### **SHPA response:**

**Supported.**

**However, such reviews whether undertaken by CoAG or another agency will only be valuable if actions have been taking place.**

**To date, no funding support has been forthcoming from government on a national basis, despite the overwhelming efficiency of such an approach.**

Workforce issues for hospital pharmacists have been evident for several years. Staffing vacancy rates are considered to be the **most important** issue impairing the ability of hospital pharmacists to improve outcomes for patients in hospitals. Services related to medicines use for consumers, medication safety and reducing adverse events require a full complement of pharmacists in our hospitals.

### **DRAFT PROPOSAL 4.1**

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.

#### **SHPA response:**

**The SHPA believes that this proposed agency must also be resourced to fund initiatives.**

**SHPA cautions that care must be taken to avoid more government "silos" via the creation of new agencies.**

**SHPA supports consideration of the suggestion of the Health Professions Council of Australia (HPCA) that the proposed agency could be amalgamated with the proposed Workforce Education and Training Council, suggested in proposal 5.2, and should also take over the numerical workforce planning discussed in proposals 9.1 and 9.2. This single national body might be called the Health Workforce and Education Improvement Agency (HWEIA).**

SHPA agrees that such a body could be responsible for mapping supply and demand, monitoring progress towards implementing the National Health Workforce Strategic Framework, and facilitating workforce and educational innovation. SHPA agrees that although advisory, the HWEIA must have the authority to direct the Department of Education, Science and Training (DEST) with respect to allocation of health professional placements (mix and distribution), and to monitor the adequacy of funding for health professional education. Its governing body should include high level Departmental officials plus representatives of the health professions, consumers and the universities – a true partnership of government, providers and consumers.

**SHPA supports an integrated approach to minimise the government “silo” effect.**

**The Productivity Commission Position Paper has failed to adequately recognise the pro-active work that has already been undertaken to date, by organisations such as SHPA.**

It is essential that Government realise that overcoming the health workforce problems will only be successful if all stakeholders can work together with integrated effort.

A “top-down” approach from Government that fails to recognise and assist the current significant investment by key stakeholders would at best be “re-inventing wheels”, and at worse, be doomed to fail.

SHPA has already been working pro-actively with others (e.g. DHS Victoria funded staff) and independently using its own scarce internal resources, to participate in and undertake research in order to better understand the current hospital pharmacist workforce issues.

- The focus has been on gathering the necessary evidence to formulate strategies for the improved recruitment and retention of pharmacists in our public hospitals.
- SHPA considers that there is now enough evidence to move from “studying the problem” to implementing strategic solutions as part of a nationwide action plan.
- The number of hospital pharmacists is small relative to doctors and nurses, so the financial resources to achieve these actions are modest, especially if undertaken on a national basis, which makes good sense for many recommendations.

SHPA supports innovation in health service delivery, and in particular for medicines and pharmacy services. SHPA recognises that in future, more acute care will be delivered from a community base or in the home. When the word hospital was used in its submission, SHPA stated that it should be construed to mean a “**virtual hospital**” to encompass various future acute care practice settings, where consumers may need more complex care from their health professionals, including hospitalisation.

Hospital pharmacy managers are continually investigating avenues to improve patient safety, minimise medication incidents, reduce labour-intensive distribution functions and facilitate accountability of medication use. This includes increasing the number of pharmacy support staff and extending the role of pharmacy support staff into new areas.

With in-depth knowledge and **focus on pharmacist issues in the hospital sector**, both public and private, SHPA acknowledges that in future these services may be delivered via different “**virtual hospital**” models.

Political will is needed to fund evidenced based pharmacy services across the barriers represented by the current Australian Government and State/Territory funding silos.

**DRAFT PROPOSAL 5.1**

The Australian Government should consider transferring primary responsibility for allocating the quantum of funding available for university-based education and training of health workers from the Department of Education, Science and Training to the Department of Health and Ageing. That allocation function would encompass the mix of places across individual health care courses and the distribution of those places across universities. In undertaking the allocation function, the Department of Health and Ageing would be formally required to:

- consider the needs of all university-based health workforce areas; and
- consult with vice chancellors, the Department of Education, Science and Training, other relevant Australian Government agencies, the States and Territories and key non-government stakeholders.

**SHPA response:**

**Not supported – due to the risk associated with creating another bureaucratic silo.**

**SHPA would prefer that:**

- **Key advice should be forthcoming from DoHA on the needs of the health workforce for action by DEST. Such advice may come via the new proposed advisory body.**
- **DEST must ensure that universities do allocate places as needed to support identified needs. It should not be possible to discontinue courses in Podiatry and Nursing, nor should other courses be allowed to be instigated (duplicated) without consideration of efficiencies.**

**DRAFT PROPOSAL 5.2**

The Australian Health Ministers' Conference should establish an advisory health workforce education and training council to provide independent and transparent assessments of:

- opportunities to improve health workforce education and training approaches (including for vocational and clinical training); and
- their implications for courses and curricula, accreditation requirements and the like.

**SHPA response:**

**This function could be amalgamated with the proposed advisory agency in 4.1.**

**DRAFT PROPOSAL 5.3**

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.

**SHPA response:**

**This is supported, as long as the proposal is well thought through and implemented as part of an integrated workforce strategy.**

**For pharmacy training, it must be understood that there is a post graduation pre-registration intern year as well as undergraduate clinical training. Both areas need to be supported.**

**The number of undergraduates has increased substantially in the past 2-3 years. This puts a strain on undergraduate clinical training and pre-registration training.**



**Shortages of pharmacists are most acute in the public hospital sector and are projected to continue.**

**Increasing the number of pre-registration training places in Australia's public hospitals (aim for 50% of graduates) needs to be understood as being fundamental to both short and long term recruitment efforts, not only training. Therefore, it must be considered and funded in that context.**

**Research shows that:**

- 75% of newly qualified pharmacists who have worked as a pharmacist in hospital undertook their pre-registration training in hospital, a positive experience during this pre-registration year is important factor in their decision to work in hospital after their qualification.
- In 2002, 79% of Victoria's 80 pre-registration pharmacists were retained in the hospital workforce upon registration.
- Australia could encourage more pre-registration training to be undertaken in hospitals, which has the potential to be a recruitment tactic for pharmacists to the hospital system. Taking on extra pre-registration training places has also been reported as part of the plan for NHS hospitals in the UK.
- Schemes such as support for medical students on rural placement also need to be expanded to include new models of pre-registration training for pharmacists.

**There is a need to nationally fund 50-100 pre-registration pharmacist training positions in rural hospitals under a new paradigm that encourages pharmacists to be competent and confident to work in all practice settings to support rural communities.**

The pharmacists of the future should be trained and skilled to take on a variety of roles across the continuum of care, in particular **for rural communities**. Hospital based training produces pharmacists who are used to working in health care teams and who can easily support residential aged care homes, nursing homes and home based (more) acute services.

#### **DRAFT PROPOSAL 6.1**

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.

#### **SHPA response:**

**Not supported at this point, except to assess and accredit the competency of health professionals who are undertaking new or extended roles e.g. To extend prescribing rights, all health professionals should have to demonstrate their competence, as an undergraduate or postgraduate.**

[http://www.shpa.org.au/pdf/positionstatement/prescribing\\_jun05.pdf](http://www.shpa.org.au/pdf/positionstatement/prescribing_jun05.pdf).

**In order to ensure safety and quality, professions need to own and set their standards and to ensure appropriate and detailed oversight of the accreditation process. The Council of Pharmacy Regulatory Authorities currently undertakes this on a national basis for all pharmacy courses.**

**SHPA recommends that the first step is to ensure that there is a single national approach to accreditation of courses for all professions and then to consider the need for an additional accreditation agency layer.**

SHPA rejects any notion that profession-based accreditation impedes workplace innovation and job redesign. Professional accreditation underpins safety and quality as well as represents professional specialisation, which in turn underpins the development of expertise, innovation and the evolution of new roles within the health setting.

**DRAFT PROPOSAL 6.2**

The new national accreditation agency should develop a national approach to the assessment of overseas trained health professionals. This should cover assessment processes, recognition of overseas training courses, and the criteria for practise in different work settings.

**SHPA response:**

**The SHPA supports development of a national approach, but to protect consumers the health professions need to continue to assess overseas applicants. The Australian Pharmacy Examining Council already undertakes this for pharmacy on a national basis.**

**DRAFT PROPOSAL 7.1**

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.

**SHPA response:**

**SHPA supports a national approach to registration (and regulation) of health professionals and considers that this is best achieved in the first instance by requiring a single national registration framework for profession specific groups.**

**For pharmacy, the Council of Pharmacy Regulatory Authorities should take this on a national basis and abolish the state/territory duplication. SHPA suggests that the national registration process be used to efficiently gather longitudinal pharmacist workforce participation data on an ongoing basis.**

**DRAFT PROPOSAL 7.2**

States and Territories should collectively take steps to improve the operation of mutual recognition in relation to the health workforce. In particular, they should implement fee waivers for mobile practitioners and streamline processes for short term provision of services across jurisdictional borders.

**SHPA response:**

**Strongly supported see 7.1 – strengthen to abolish the state/territory duplication for pharmacy.**

**DRAFT PROPOSAL 7.3**

Under the auspices of the Australian Health Ministers' Conference, jurisdictions should enact changes to registration acts in order to provide a formal regulatory framework for task delegation, under which the delegating practitioner retains responsibility for clinical outcomes and the health and safety of the patient.

**SHPA response:**

**Strongly supported see 7.1.**

**Pharmacists already use support staff and efforts are being made to improve the competencies of hospital pharmacy technicians/assistants on a national basis, as the current workforce has essentially been trained "on the job".**

[http://www.shpa.org.au/pdf/positionstatement/tech\\_ps\\_aug03.pdf](http://www.shpa.org.au/pdf/positionstatement/tech_ps_aug03.pdf)

**Further efforts on uniform national regulation could be welcome developments (with 7.1, 7.2).**

**DRAFT PROPOSAL 8.1**

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.

**SHPA response:**

**Supported. Such payments should be made directly to the pharmacists (or other health professional) providing the service.**

Also refer to Response to 6.1.

**Health professionals who are undertaking new or extended roles e.g. to extend prescribing rights, all health professionals should have to demonstrate their competence (as an undergraduate or postgraduate).**

[http://www.shpa.org.au/pdf/positionstatement/prescribing\\_jun05.pdf](http://www.shpa.org.au/pdf/positionstatement/prescribing_jun05.pdf).

**DRAFT PROPOSAL 8.2**

For a service covered by the MBS, there should also be a rebate payable where provision of the service is delegated by the practitioner to another suitably qualified health professional. In such cases:

- the service would be billed in the name of the delegating practitioner; and
- rebates for delegated services would be set at a lower rate, but still sufficiently high to provide an incentive for delegation in appropriate circumstances.

This change should be introduced progressively and its impacts reviewed after three years.

**SHPA response:**

**This proposal does not appear relevant for pharmacy services - no further comment.**

**DRAFT PROPOSAL 9.1**

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.

**SHPA response:**

**SHPA supports the integration of health workforce related activities into one national workforce body that should report directly to AHMC.**

**DRAFT PROPOSAL 9.2**

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.

**SHPA response:**

**SHPA supports the integration of health workforce related activities into one national workforce body that should report directly to AHMC. (Also refer 7.1).**

**DRAFT PROPOSAL 10.1**

The Australian Health Ministers' Conference should ensure that all broad institutional health workforce frameworks make explicit provision to consider the particular workforce requirements of rural and remote areas.

**SHPA response:**

**Supported, with the proviso that the notion be expanded to all areas of workforce shortage. These may be in rural or remote areas, but also non-metropolitan and even metropolitan for some functions (e.g. shortage of oncology pharmacists in major public hospitals). Support may be needed to up skill the existing workforce and to use more information and communication technology to support novel service delivery and/or professional support.**

**DRAFT PROPOSAL 10.2**

The brief for the health workforce improvement agency (see draft proposal 4.1) should include a requirement for that agency to:

- assess the implications for health outcomes in rural and remote areas of generally applicable changes to job design; and
- as appropriate, consider major job redesign opportunities specific to rural and remote areas.

**SHPA response:**

**Supported, as for 10.1.**

**DRAFT PROPOSAL 10.3**

The Australian Health Ministers' Conference should initiate a cross program evaluation exercise designed to ascertain which approaches, or mix of approaches, are likely to be most cost-effective in improving the sustainability, quality and accessibility of health workforce services in rural and remote Australia, including:

- the provision of financial incentives through the MBS rebate structure versus practice grants; and
- 'incentive-driven' approaches involving financial support for education and training or service delivery versus 'coercive' mechanisms such as requirements for particular health workers to practise in rural and remote areas.

There should also be an assessment of the effectiveness, over the longer term, of regionally-based education and training, relative to other policy initiatives.

**SHPA response:**

**10.1, 10.2, 10.3 – SHPA supports measures to improve access to rural health services.**

**Innovative arrangements developed to provide improved rural services should be evaluated and may also prove useful and applicable in other areas of shortage e.g. reimbursement of HECS debt if working in rural areas or public hospitals with recognised workforce shortages. (Also see response to 5.3).**

**DRAFT PROPOSAL 11.1**

The Australian Health Ministers' Conference should ensure that all broad institutional health workforce frameworks make explicit provision to consider the particular workforce requirements of groups with special needs, including: Indigenous Australians; people with mental health illnesses; people with disabilities; and those requiring aged care.

**SHPA response:**

**SHPA supports the notion of Divisions of Primary Care, rather than Divisions of General Practice.**

**These should be integrated with other services across the continuum of care including pre-admission/post-discharge care from hospitals, as well as the network of community pharmacies.**