

Response to the Productivity Commission's Position Paper
Australia's Health Workforce

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Introduction

This is a private submission, written from the perspective of my experience as a former Chief Executive of the Royal Australasian College of Surgeons and as a consultant to the Consortium of Universities for Professional Health Education. The latter is a consortium of university medical schools – the University of Melbourne, the University of Sydney, the University of Queensland, the University of Newcastle, the Australian National University – which is exploring alternative training pathways and the most effective ways through which medical schools can play a role in the training of the health workforce. A document describing the work of the Consortium is attached.

The Commission's Position Paper has developed some crucial recommendations for the improvement of the health workforce and should be commended for being prepared to raise issues which have tended to be beyond debate in the past.

However, while the Commission has recognised the need to take a holistic approach rather than compartmentalising the several policy areas and decision making processes, I believe that the Commission could have gone further to tie the various strands of this difficult problem together so that we have a continuum of inter-related policies that are consistent and effective. I have explored these issues in this response.

Health Workforce Improvement Agency – Draft Proposal 4.1

The concept of having an overseeing body to promote workforce improvement is an excellent one, but the Draft Proposal envisages an advisory body which would need to liaise with several others, with no capacity to implement decisions. It also has overlapping functions with other proposed bodies. For example, one of the tasks of the Agency would be to concentrate on opportunities for job substitution and re-design, yet the responsibility for determining accreditation and training is located in other agencies. This Agency would also examine issues relating to the most efficient use of workforce, which might better be examined by the new entity responsible for numerical workforce projections.

On the other hand, it would be an excellent body to define the continuum of competencies that are required to deliver effective and efficient health services and to assess the border overlaps where jobs could most effectively be delegated. I would envisage a set of definitions from technical assistants through to medical specialists with sufficient detail to enable the agency to make recommendations on how best to meet a workforce shortage through relevant job re-design, the use of multidisciplinary teams or

inter-professional activity. In association with detailed studies of “patient journeys” in key disease categories this would provide a powerful tool for deciding the most appropriate delineation of clinical and diagnostic responsibilities at all levels of the health workforce. The more effective use of clinical teams would also be of benefit to improving patient outcomes.

My concern is that the system be simplified so that there is clarity about where decisions can be made and which body is responsible for implementing them. Having an Agency with the information to make better decisions and improve the workforce but ultimately with no power to influence the take-up of its recommendations would be a missed opportunity. If the Agency is to remain as a stand-alone one, it would be preferable to give it wider powers to influence the decisions of other agencies. Alternatively, it might be more effective to have all the agencies proposed by the Commission under a single co-ordinating Authority which can rely on several expert departments to provide it with the advice required to make accreditation, registration or health workforce decisions.

Funding – Draft Proposal 5.1

The proposed transfer of funding allocations from the Department of Education, Science and Training to the Department of Health and Ageing (pp. 66-73 and Draft Proposal 5.1) does not resolve the question of providing adequate clinical places for both medical and specialist trainees, because this is a function of the States. A Commonwealth decision to increase numbers in medical schools or in the specialties must be part of an agreement with the States that they will fund the relevant clinical places in the hospitals where the trainees will be taught. This in turn will need to be accompanied by earmarked funding to hospitals to prevent an agreement at a jurisdictional level being nullified by the actions of an independent hospital board facing a budget shortfall.

In the case of specialist trainees, the salaries of trainees are known, so it might be better to allocate a sum, which includes the cost of the salary and on-costs in addition to a training supplement, for each trainee to the training provider. The hospitals could then bid for trainee posts knowing that they would receive income which they could use to compensate trainers as well as gaining a service delivery function.

The proposed arrangement would also not address the general question of clinical places for medical schools. The creation of a new medical school will not achieve an increase in graduates without a concomitant increase in clinical places. Without that increase the effect will be to reduce the overall number of places per trainee, with a flow-on effect on existing medical school numbers and clinical places. If that leads to existing schools losing clinical places they will be forced to reduce their intake levels by the number of places allocated to the new school.

Health Workforce Education and Training Council – Draft Proposal 5.2

The Commission is right to focus on the lack of co-ordination in the continuum of education and training and also to identify this lack of co-ordination as inhibiting

workforce change. The compartmentalisation of the training system leads to rigidities which impede both the speed of training and the development of alternative pathways, including the creation of a “skills escalator”.

The arguments against any major change to the system, based on the fear of a reduction in standards and quality, are not well founded. There are training systems in Canada and the United States which deliver a high quality workforce through a far more liberal training environment which is nevertheless more consistently and effectively regulated by government. The regulation of medical training in the United Kingdom, through the new Postgraduate Medical Education Training Board (PMETB) is also a good example of a system which will be better regulated while delivering faster pathways to graduation and the possibility of alternative pathways if they can be shown to meet defined criteria and competencies. In each of these countries the training time has been reduced by at least two years by comparison with Australia. While it is too early to assess the impact on the professions in the UK, the Canadian and American systems have been demonstrating their effectiveness for over a century.

While the Commission has discussed the promotion of more responsive education and training arrangements, it has nevertheless accepted that the training of specialists will continue to be conducted through the Colleges. While this will no doubt continue to be the case, there is an argument for opening up this training area to include the medical schools. In any case there is a need for greater regulation of this sector. This should be aimed at creating a more professional approach to the development of curriculum and the delivery of teaching and learning than can be achieved through organisations which are dependent on volunteers who may not necessarily have the educational experience required in a changing training environment. Not to do so would perpetuate a system which is determined entirely by the profession, with no regulation over the quality of the programs or their length. The unilateral addition of a year to a training course has a significant flow-on effect on the public costs of health care and the delivery of medical services, yet there is no external body to determine whether the additional training is justified. This is in contrast to the medical schools which are required to justify their course contents and length of courses or to the UK system where the Postgraduate Medical Education Training Board must approve all curricula and competency statements so that it can judge whether a training program is capable of achieving its stated objectives.

The Commission should reconsider the involvement of medical schools in the training of specialists, through a parallel stream of training, so that new training pathways can be tested. These could include enabling students to begin their specialisation studies while undertaking their initial qualification thus reducing the length of the specialist training programs. Reducing the length of the training program would not directly affect the standard of clinical services or the quality of the graduates. Australia has a longer training program than the US and Canada (and now the UK), yet the standard of health care in those countries cannot be regarded as inferior to Australia's. The significant factor is that those completing the training program have the competencies required for effective and safe practice. These will emerge from a rigorous and comprehensive

training program whose quality is regulated and assessed on a regular basis through re-certification systems. Quality controls should be developed for whatever training system is in place and be applied rigorously to all training institutions.

The importance of developing an effective competency-based education and training system is that it is becoming widespread as a model internationally and will address several other issues in the Commission's Position Paper – it will be easier to establish which tasks can be delegated to non-medical staff and their value (pp. xlvii-lix and Draft Proposals 7.3, 8.1, 8.2 and 10.2); it will provide a basis on which medical and non-medical staff can be assessed for periodical re-certification; it would create a more open system so that the influence of particular professional interests can be mitigated (“custom and practice blockers” p. 70). A final advantage is that it would provide a fair and sustainable basis upon which international medical graduates can be assessed because they would be required to demonstrate that they have the same competencies that are expected of locally trained doctors.

A more coherent training environment will also enable workforce planning to be based on training which is appropriate to the shortages identified, and could also provide fast-track training courses by recruiting trainees from other fields of study or cognate professional areas. The concept of the “skills escalator” is one that would be fostered under this arrangement (pp. 62-63).

Explicit Clinical Training Regime – Draft Proposal 5.3

The Commission argues correctly (pp. xl-xlii, 77-87 and Draft Proposal 5.3) that there is currently no means by which the real costs of providing clinical training can be calculated, thus making it difficult for new providers of training programs. It is clear from an examination of the contractual arrangements for medical staff in many teaching hospitals that the level of *pro bono* training is not as high as might be claimed, because many have a contractual obligation to teach and supervise trainees. There is also the additional question of the value of trainees' contributions to the service delivery functions of the hospitals and the consequent impact of those contributions to the effective workloads of their training supervisors.

Nevertheless, it is also clear that there is a level of *pro bono* training which might be placed at risk if additional payments to training staff were to become the norm without a concomitant increase in the budget for the hospitals concerned.

There is an implication in the material in Box 5.7 on p. 85 that clinical training is the preserve of the Colleges. In fact, while College training tends to be focused on clinical training, the same issues apply to control over clinical training places to both medical schools and the Colleges. The number of clinical training places is determined by State governments and the hospitals themselves. The Commission's proposal that funding should be both more explicit and follow the trainee is an important one, but it must be backed up with adequate funding and the funding must be earmarked.

The further arguments cited in Box 5.7 that systems involving universities in specialist clinical training has not been widely successful are not supported by the evidence in the US and Canada and many European countries. To allow these comments to stand unchallenged in the report is to give them a level of credibility which they do not merit. Doing so will also provide comfort to those who would argue against any change in the current training environment.

National Accreditation Agency – Draft Proposals 6.1 and 6.2

The establishment of a national accreditation agency (Draft Proposals 6.1 and 6.2) is a significant improvement to the current system. There is an urgent need to define the competencies of the several areas of the health workforce and from this definition to develop rigorous training programs that are capable of producing graduates with the necessary competencies. The development of this new system will enable new entrants into the training market to assess what they need to do to succeed and it will develop a system of regulation that is effective.

However, as mentioned earlier in this submission, there is a need to ensure that the work conducted at the accreditation stage is continued throughout the professional life of the practitioner by ensuring that competencies are maintained and tested on a regular basis. Australia now spends some \$400 million per year on the hospitalisation of patients as a result of medication errors in public hospitals alone. The total costs of medication errors, including private hospitals and those that do not lead to hospitalisation but nevertheless require corrective medication and medical attendance are closer to \$1 billion per annum, so an examination of the competencies of prescribing professionals in this area alone would lead to significant savings and better quality care.

The Commission discusses the development of an integrated reform program (p. xxxii), and Figure 5 on p. xxxiv describes a flow chart of what might occur. In the discussion on p. xxxii, there is no mention of continuing professional education and in Table 5 (p. xxxiv) and Figure 4.1 (p. 43) there is no link between continuing professional education and a system of regular re-certification. Without such a link the CPD activities will not be taken seriously, nor will they be based on the maintenance of competencies which should be integral to continuing practice.

The proposed National Accreditation Agency's role should therefore be extended to include the regulation of a system of periodical re-certification and registration of members of the health workforce, including the capacity to determine that limits should be placed on the breadth of practice of any individual practitioner.

The proposed health workforce improvement agency (p. xxxv and pp. 24-53 and Draft Proposal 4.1) could also have a role in these processes by ensuring that CPD programs are properly regulated.

Registration and National Standards – Draft Proposals 7.1, 7.2 and 7.3

The combination of a national accreditation agency and the development of national registration will provide a firm basis for improvement of the health workforce, but as I have mentioned earlier, this will not be complete unless there is a system of regular re-certification and re-registration based on a rigorous and consistent continuing professional development regime which applies to all sections of the health workforce. Once again, if there were a combination of competency based training, and a system of re-certification based on the maintenance of those competencies, we would also have a better and more open system of assessment of international medical qualifications and the capacity to practice.

Health Workforce Planning – Draft Proposals 9.1 and 9.2

These proposals will facilitate the development of some good information on the health workforce, provided that sufficient resources are devoted to the task. That the proposed new Secretariat will concentrate on the health workforce as a whole rather than on the medical workforce is also to be welcomed because of the inter-relationships that have been discussed in the Commission's report and my own comments in this submission. The broader scope of the workforce projections is also to be applauded, provided that the Secretariat works closely with the proposed Health Workforce Improvement Agency.

But the issue of adequate funding is crucial and the Commission is right to propose three- or five-year funding. The Australian Medical Workforce Advisory Committee's work has been compromised because lack of funding has prevented it from exploring all of the factors that might influence the workforce, including the impact of feminisation, changing attitudes to working hours, and the impact of safe working hours. The Committee's work was also influenced by the fact that it was heavily dependent on the voluntary work of the professions which it was studying. There needs to be capacity in the proposed new Secretariat for independent and objective analysis through the use of several modelling systems and external researchers with expertise.

Conclusion

I have attempted in this submission to respond to the Commission's request that responses address the individual draft proposals. Nevertheless, I hope that you will accept a concluding comment on the structure that will emerge from the combination of the Commission's proposals. My concern is that several of the agencies proposed have overlapping responsibilities but there is no evident mechanism for determining which will have ultimate authority. Yet the Accreditation and Registration bodies will both require research of the type to be conducted by the Improvement and Workforce agencies. While this research will often be time critical, they will have no control over timing and may therefore develop their own research arms. The central message in the Commission's report is that health workforce problems can only be addressed adequately if there is a co-ordinated approach. Perhaps this leads to a co-ordinating function for an Authority that will be responsible for education and training, accreditation, registration, research and planning.

I would be happy to meet with members of the Commission to elaborate on any of the issues I have raised in this response.

Professor Vin Massaro
Managing Director

11 November 2005

ATTACHMENT 1

CONSORTIUM OF UNIVERSITIES FOR PROFESSIONAL HEALTH EDUCATION

BACKGROUND

In response to the discussion surrounding health workforce issues, a subgroup of the Committee of Deans of Australian Medical Schools has identified a common interest in exploring the development and possible delivery of medical and health education opportunities. This group is known as the **Consortium of Universities for Professional Health Education** with representatives from the medical/health faculties of five Australian universities with specific specialist medical training interests and expertise.

THE CONSORTIUM

The member universities of the Consortium and their representatives are:

University	Representative
The Australian National University	Mr Robert Wells Director, Policy and Planning (Health)
Faculty of Medicine, Dentistry and Health Sciences, The University of Melbourne	Professor James Angus Dean
Faculty of Health, The University of Newcastle	Professor John Marley Dean
Faculty of Health Sciences, The University of Queensland	Professor Peter Brooks Executive Dean and Chair of the Consortium
Faculty of Medicine, The University of Sydney	Professor Andrew Coats

THE PROJECT

The Consortium is interested in diversifying its range of course offerings and working in partnership with specialist medical colleges and relevant health and medical agencies.

Four initial **Programs** have been identified:

- a common basic sciences course for trainees entering specialist vocational medical training;
- a professional development program for career medical officers;
- a training program for radiographers; and
- a training program for pathology technicians.

The Consortium is seeking advice on the feasibility of developing and delivering each of these programs including consideration of the regulatory framework, definition of relationships with other organisations, particularly the relevant specialist medical colleges and identification of possible funding sources.

The outcome of this project will be the production of a report outlining the feasibility of and planning for the development and delivery of the four programs. The report will inform the Consortium on the best way forward and provide indicative strategies and timeframes for future stages of the project.

The **Project Terms of Reference** are:

- to facilitate the establishment and functioning of the Consortium
- to provide advice to the Consortium on -
 - the status of existing education and training opportunities related to the following programs, and future plans of those already in the marketplace –
 - a common on-line basic sciences course for trainees entering specialist vocational medical training,
 - a professional development programme for career medical officers,
 - a training programme for radiographers, and
 - a training programme for pathology technicians;
 - potential demand for each of the programs;
 - attitudes of existing providers and the potential for future partnerships;
 - the status of the current regulatory framework impacting on the development and delivery of the programs, and any foreshadowed changes; and
 - identification of sources of funding for each of the initiatives, and facilitation of their successful attainment, and
- to consider policy questions around the role of universities in vocational medical training.

THE CONSULTANTS

The Consortium has engaged Massaro Consulting Pty Ltd (Professor Vin Massaro and Mrs Lorraine Perry) to undertake the project. The Company specialises in strategic policy, management and planning advice to higher education institutions and governments and has a special interest in medical education. Vin and Lorraine have had lengthy careers in university management and administration as well as spending several years at the Royal Australasian College of Surgeons – Vin as Chief Executive and Lorraine as Director of Academic Services.

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