

# RESPONSE TO PRODUCTIVITY COMMISSION'S POSITION PAPER "AUSTRALIA'S HEALTH WORKFORCE"

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## SUMMARY

The Productivity Commission (hereafter PC) is to be congratulated on making a determined effort to consider how future health workforce needs may be assessed, and how these needs may be optimally met. The Position Paper (hereafter PP) contains some proposals that the Australian Psychological Society (APS) would support. But there are also some proposals that we could not support, and hope that they will not be included in the Report that the PC will craft following this stakeholder commentary phase. With regard to broader issues, this paper initially analyses what it sees as the limited and inappropriate “blueprint” approach and also rejects the implicit support for de-professionalisation conveyed in the PP.

### Supported proposals

1 Medicare broadened to include appropriate Allied Health services. This needs to consider both MBS items for services and specific PBS items for specific professions and services. This proposal is supported not just because of its obvious advantages to practising health psychologists, but primarily because it serves to meet three well-established and crucial outcome indicators of health services provision. These are:

- fairer **access** of the community to appropriate services;
- increased **effectiveness** as is demonstrated in a wealth of clinical research demonstrating treatment effectiveness for a wide range of psychological interventions in both mental health and physical health arenas;
- improved **efficiency** in the provision of services as it has been clearly demonstrated that psychological interventions in many health domains are not just effective but *cost effective* as well.

2 There are a number of specific attempts to create standard approaches to health professional training, accreditation and funding. In general the notion of more standardised approaches to a number of these aspects is strongly endorsed by the APS and we have been supporting such practices for many years. We would support the modification of regulatory processes to streamline inter-jurisdictional movements by professionals and reduce the costs thereof. What is not supported are some of the mechanisms and stated aims set out in these proposals and these will be argued below in greater detail.

### Unsupported Proposals

1 **National Accreditation Agency** Proposal 6.1 recommends the establishment of a national accreditation agency to facilitate the development of national standards upon which professional registration would be based. The complexities surrounding the accreditation of tertiary professional education and training courses are far reaching. Where professions, such as psychology, actually complete this accreditation around Australia, it is not only enormous in its scope but extremely resourced demanding in its process. It is also currently dependent on the voluntary services of academic psychologists somewhat similar to the hospital accreditation process familiar to those in the health professions. Unless the accreditation of specific disciplines and professions was retained within that specific discipline, it is unlikely that this sort of voluntary contribution would be continued. It would also be exceptionally difficult for personnel outside of the professional discipline being assessed to be sufficiently conversant to make an accurate or reliable assessment of another profession’s course of training. We therefore oppose this aspect of the proposal as totally unrealistic and impractical.

What would be acceptable is the development of broad uniform national standards with which the assessment and accreditation of tertiary professional training courses would need to comply. The

internal processes and outcomes would need to be managed by the specific profession within that broad framework.

We oppose a model of workforce analysis and planning that assumes (wrongly) ready predictability of national health workforce needs, pursues even greater centralised governmental control over courses of training, treats the universities as “degree factories”, and reduces the autonomy and the involvement of the professions and the universities in determining the nature of professional qualifications and associated basic and advanced professional education and training.

2 ***A national registration process.*** A similar argument would be had with Proposal 7.1. The concept of national registration of professions is eminently sensible. The APS has been promoting such a concept for psychology for many years. But if this proposal suggests that there can be one national registration structure across all health professions, then, like Proposal 6.2, it is both impractical and unrealistic. There would still need to be profession-by-profession regulation structures heavily involving members of the profession within that regulatory process. Most regulatory and disciplinary processes conducted by the State Registration Boards involve efforts around detailed and complex aspects of professional practice rather than broad, generalised ethical or professional concerns.

3 ***Generic health positions.*** There is underlying notion hinted at in the Draft Proposals but given quite explicit voice in the Fact Sheet One (A summary of the commission's draft proposals) that sees specialisation and professional boundaries as a major handicap to workforce flexibility and the improvement of the health workforce. The underlying reasoning and philosophical principles best reflected in Fact Sheet One seem very doctrinaire and ideological in nature. There is an explicit suggestion that professional specialisation is in itself a hindrance to development. This is a position with very little logical support. Without the development of specialisation, much of the progress in health assessment, treatment and management would not have occurred. It is inevitable, and beyond the human psyche to resist, that with the growth of knowledge, specialisation occurs. It is also to the great benefit of a community that specialist expertise and services are available.

It may well be argued, that there needs to be a broadening of the health workforce to include a range of service providers but not at the expense of specialists and experts who can provide appropriate training, supervision and high-level expertise for the more complex and taxing cases. Discussions about the developments within the health workforce certainly need to occur, but these developments should not be allowed to undermine or obliterate the great wealth of specialised knowledge and skills within the professions.

4 ***The splitting of funding between DoHA and DEST.*** The reasoning behind this division of the funding between Departments seems superficially attractive and sensible. However, for the profession of psychology and its undergraduate and postgraduate training courses around Australia it would create a nightmare. A considerable proportion of psychology education is not for the health profession. The undergraduate training courses on which professional training is built as postgraduate courses involves the academic discipline of psychology and a range of cognitive, social and biological components of human behaviour taught within a scientific framework. These undergraduate courses provide a universal basis for progression to specialisation in psychology which can cover such diverse topics as organisational structures, performance enhancement in sport, educational achievement and paranoid psychosis. Postgraduate courses that equip professionals for their chosen specialty are in many cases unrelated to the health domain.

So this raises a significant anomaly in cost splitting. Would undergraduate courses be continued to be funded by DEST because they teach a scientific discipline? Would only those postgraduate courses which directly relate to health be funded by DoHA? Or would all postgraduate courses in psychology be funded by DoHA, including those in organisational, sports, educational and forensic psychology? In terms of university courses, funding, regulatory mechanisms, and the education of

the profession as a whole, Psychology must continue to be, and be seen as, a basic and an applied scientific discipline, which certainly finds professional application in health arenas, but also does so beyond those health arenas.

5 ***Inclusion of or movements towards the VET sector.*** Any proposal to shift professional training to VET level and its lower entry standards would be very strongly opposed. (This does not mean that we oppose the inclusion of carers and consumers of mental health services in plans for the recruitment, education and training of the future mental health workforce, but such inclusion must be collaboratively well planned.)

6 ***General concern over centralised bureaucratic processes.*** Such suggested bodies (Proposals 4.1, 5.2 and 6.1) are likely to be remote from the issues, lacking in the requisite in-depth expertise to cover all the health professions, accountable only to government (with no accountability to the public, the professions, the universities and the other educational communities), costly to operate, inflexible, slow, and very likely ineffectual but highly dysfunctional in their decisions. They are likely to inflict even more regulation and disempowerment (and associated expense and other costs) on the professions through a “centralisation of power” process, under the rubric of “national coordination” and “national accreditation”.

## **Two Essential Proposals**

1 ***Funding.*** We note that many submissions to the Commission appear (from the quotes in the PP and our own reading of them) to have complained about the very serious ill effects of inadequate Federal and State Government funding (as did the APS’s two earlier submissions to the Commission). Yet on this specific matter the PP (even though it goes into some detail in explaining the funding framework for health services and noting the crucial role of adequacy of funding) in effect takes the very disappointing line that the educational and health service delivery cloth will have to be cut according to the existing level of funding.

*We strongly urge the Commission to stress to the Federal Government the grave ill-effects of underfunding, and the great importance of improving direct Government funding of universities and the health services. This is especially so for the mental health services which are undoubtedly in crisis because of poor funding (and other but secondary reasons), as the Mental Health Council of Australia (MHCA) has stressed in its report "Not for Service".*

*Further economies will not solve, indeed will exacerbate, the problems. To argue that enhanced workforce productivity is the only currently available or politically acceptable solution (as the PP essentially concludes) is to condemn sufferers of mental health problems, and the mental health service delivery systems, to continued serious crisis.*

The massive expenditures, of money, effort and emotional commitment, necessary to set up, staff and operate the proposed central mechanisms would be much better spent on directly improving the number of HECS places available in the professional training programs in the universities, and on better direct funding of health (especially mental health) services. Our advice is to get the funding right first, ensure that it flows directly into the universities and health services, see how it impacts on the current problems, and then perhaps revisit the workforce productivity issue.

2 ***Genuine collaboration and consultation.*** However we would support a modest, genuinely collaborative mechanism and process (in parallel with the above improvement in funding) to consider *potential developments in health services and associated employment patterns and health workforce needs*. Instead of permanent bureaucratic structures (current versions of which seem to have proved disappointing for assessing medical workforce needs, judging from the Commission’s own evaluation), we suggest one (or more) “roundtable” be held (funded by government), involving the universities, the professions, Federal and State governments, and the professional regulatory bodies.

The inputs to the roundtable would include information about current workforce needs and trends, and of course the National Health Workforce Strategic Framework. The source of such inputs would be varied but would include the various stakeholders as well as government data-collection bodies (e.g. the ABS) and the PC. Current databases are inadequate (as the Commission and various submissions recognise), hence much preparatory data-collection would be needed. This too would require government funding support, as would the other crucial research work that the MHCA has emphasised, and would be a necessary adjunct to any effective workforce planning process.

If this collaborative/partnership process proves its worth, it could be institutionalised as a broadly-based, highly collaborative workforce planning *advisory forum*. The governmental administrative and technical supports for it could then form the basis for a more permanent support unit (probably best under the aegis of or in conjunction with the ABS).

The consequences of such a roundtable (or set of roundtables) would not be “top-down” directive processes or imposed decisions. Professions would not be emasculated, nor professional work made generic or otherwise “redesigned”. The outcomes would be self-directed, collaborative actions initiated, agreed and carried through by the stakeholders, and flowing from the National Health Workforce Strategic Framework.

Government *leadership* is needed to promote the necessary partnerships and to support this complex collaborative effort financially and administratively, not government and bureaucratic dictation and control.

## MAIN REPORT

We have structured our response to the PP in terms of the Draft Proposals. However, before going to the specific proposals, we think it vitally important to challenge the “deterministic” and “blueprint” mind-set that seems to have been applied by the authors of the PP, and to urge some changes thereto. The PP is also unhelpfully negative, at times disrespectful, and wrong, in its views about the roles of the professions and the universities. These problems are explored below.

The PP canvasses a wide range of complex issues, across a number of systems (higher education and VET, the professions, public and private health and related administrative systems, professional regulation, and so on). It deals with current and future occupational structures in the health areas and touches on vocational choice theory.

Its analysis of the major problems, with respect to workforce issues, ranges from the impressive (such as economic analyses) to the incomplete (such as regarding occupational entry issues) to the very wide of the mark or silent (notably about vocational choice processes). These variations are understandable in light of the relatively short time given to the Commission to undertake its work, and the complexity and diversity of issues and views contained in the submissions received by the Commission. But they also probably reflect the absence in the Commission of staff with expertise beyond the economic, such as in the psychology and sociology of vocational choice-making, and in specialised technological and human resource forecasting and planning functions.

The PP does not give adequate recognition to the fact that health workforce planning is not just an abstract numerical exercise. It involves the lives and careers of young (and often mature-aged) people who will need to care about and be deeply committed to their profession if they are to make a success of it, for their own and the public’s benefit. A profession is not just a job: it is a vocation in the fullest sense.

Applicants for entry at the undergraduate level (and even at post-graduate level) must not be treated as “numbers” to be “assigned” to one or other of the various professions. They are not interchangeable or “units of production” to be moulded by their teachers. Issues of vocational interests, maturity for choice-making, identification with the particular profession, and commitment to it are crucially important. Many young people are in the “trial” stage of their careers, needing the opportunity to explore career options, hence undergraduate entry should not be used as a final choice point. Undergraduate programs should be as broad as possible, not prematurely specialised. Some restriction of choice may be unavoidable (hence good career guidance at secondary school level is vital – but often not provided). Nonetheless cross-profession transfers, or within-profession changes of specialisation, must still be possible and be actively facilitated.

Why is a deterministic “blueprint” mind-set a problem? As the noted geneticist and scientist, Richard Dawkins (Dawkins 2003), wrote in his widely-known text *A Devil’s Chaplain*, a blueprint “...is a detailed, point-for-point specification of some end product like a house or car... There is a one-to-one mapping between components of the blueprint and components of the end product... There is no such one-to-one mapping in the case of a recipe... Give an engineer a car and he can reconstruct its blueprint... But offer a chef a rival’s piece de resistance to taste and he will fail to reconstruct the recipe..” (p.105.)

It may seem obvious, but needs to be said nonetheless, that the issues being explored by the PC are much more complex, fluid and intertwined than physical products or even recipes.

Understanding the nature of professional expertise and how it develops and is tapped by various employing bodies and other “consumers” is not a simple matter of obtaining the views of some chosen experts, examining and dissecting them, and making prescriptive generalisations from them (as the PP attempts). Also governments cannot undo the effects of its policies, (say) restricting entry into a profession (thereby forcing suitable applicants into other fields), by later dismantling the surplus “products” and rebuilding them.

## The Blueprint Mind-set

Yet the mind-set characterising the PP is one of attempting to find or create deterministic “blueprint” solutions to identified or alleged problems, rather than seeing education, training, professional regulation, professional work roles and service delivery needs from the perspective of complex, intertwined emergent processes that may be influenced but cannot be tightly predicted and controlled, and cannot be undone. No blueprints are possible.

This “blueprint” mind-set is evident in Figure 5 (p.xxxiv). This figure lists a linear sequence of steps to represent “processes influencing workforce deployment”, starting with “Assess emerging health care needs” and ending with “Continuing professional development”. Such a linear portrayal may be valuable as one starting point analytically, but must be accompanied by caveats about its limitations.

Certainly it should not be taken as the main basis for developing solutions, as unfortunately happens here (although at times the proposed solutions do not flow from the analysis at all). For example, the figure does not capture all the relevant and significant issues, treats complex processes as simple, ignores non-linear linkages and influences (e.g. CPD influences “assessment of health care needs” as well as vice versa), contains no feedback or feed-forward loops, has no notion of iterations, and has other conceptual limitations of a non-trivial kind.

It gives no consideration to vocational choice processes and stages (trial, establishment, maturity, disengagement and retirement). It focuses on entry issues, but only from a too-simple “classical” economics viewpoint - ignoring even such early work on the various levels of forecasting and planning needed for making projections about the functioning of information- and knowledge-based systems, as were outlined some 30 years ago by writers such as Lamberton (1971). It assumes that occupational choice is driven by materialistic considerations, opportunities and knowledge (i.e. essentially a traditional economic mixed with an “accident” theory of occupational choice). In the health workforce, issues such as choice being in part “implementation of the self-concept” are of particular importance. Not many people in the general community would be successful as trainee surgeons, or psychologists, or whatever, partly because they lack the requisite self-identity and attributes (e.g. emotional resilience, stress tolerance, manual dexterity, or empathic listening skills) to succeed. The PP is silent on these sorts of issues. It also fails entirely to consider “second career” entry routes and their implications (e.g. reducing education and training requirements where cognate training and experience have already occurred).

The “blueprint” mind-set also makes itself obvious when the PP rejects the sound cautionary advice of the RANZ College of Obstetricians and Gynaecologists Provincial Fellows Committee regarding excessive dependence on “best practice” protocols (p.175), apparently failing to see or agree with the Committee’s point that such protocols, no matter how current, well-crafted and useful, have important *inherent* limitations.

**Inappropriate assumptions and expectations about workforce planning.** The deterministic “blueprint” thinking in the PP assumes (despite the PP’s own outline of evidence to the contrary) that the future supply of, and demand for, the various types of health professionals, the key elements of future professional work, the nature of future professional expertise, and the desirable processes of professional education and training (including CPD), are fully known and/or are predictable, and are controllable by “the state”. This assumption is misleading because those issues involve large social, economic and technical systems, whose directions and momentum cannot be easily or accurately predicted or readily changed. Thus system-wide planning is very difficult. Certainly linear methods have long been rejected in forecasting and planning at that systems-wide level (and subsidiary levels).

“Blueprint” thinking also encourages “top-down control” expectations – which will ultimately prove disappointing to all concerned. To take a simple example, in the PP’s linear pathway “*identify*

*workforce skills and competencies*” is followed by “*design curricula*”. This apparently automatic linkage in a deterministic type of analysis assumes that:

- the first step (“*identify skills and competencies*”) can be readily, comprehensively and validly done without significant disagreements, which is not the case. Also there are important aspects such as values, attitudes and vocational interests that are missing in this part of the figure. Vocational choice is not driven just by perceived opportunities but also by issues such as expected vocational interest-/job-satisfaction (which the PP partially recognises but does not explore). Modern theories of labour market functioning are attempting to incorporate such variables into their modelling methodologies. There are six major vocational interest areas (as identified by the noted vocational theorist John Holland), roughly equally distributed across the working population. This step, therefore, should include an appraisal of the vocational interest areas that appear to be importantly involved in the particular occupational fields. It should also canvass the values, attitudes and other individual variables that are important for successful job performance. (These do not readily fall under the headings “skills” and “competencies”.)
- the second step (“*design curricula*”) “flows simply and directly from the first”. It does not! Not all skills and competencies can or need be taught in formal training, or can or should be taught in the early stages of professional training. Often, in designing a curriculum, it becomes clearer what are the key concepts, techniques, values, attitudes, etc., and the productive teaching-learning processes, how they interact with one another, and what may be optimal sequencing in their acquisition, hence the need for a number of iterations. These iterations eventually produce a sound curriculum and an appropriate teaching-learning climate, but they do not obviate the need for continual review and revision. Nor do they presuppose a single uniform outcome: the same developmental process may produce significantly different but equally effective programs and climates. Moreover, professional education and training is necessarily spread over the various stages of professional life, and across various types of institutions (especially university, employer, professional association, and regulatory authority). There can be no single “birth to death” curriculum applying to them all.

Unfortunately a one-directional, didactic “cookbook” teaching-learning approach and a single and universal “birth to death” curriculum are implied in the Figure and accompanying commentary. The foregoing concerns, and such important ancillary notions as “lifelong learning” and the much shorter “half-life” of knowledge these days, with CPD and retraining implications, are not adequately recognised.

**What the “blueprint” can’t encompass.** The implied approach is also defective in its scope. Where is there room for key issues such as:

- learning how to think and learn?
- theory-conceptualisation and -development, and associated research skills?
- self-directed and experiential learning beyond the formal curriculum?
- reflective and creative thinking (the *sine qua non* of a scientist, indeed of the “educated person”)?
- exploration of one’s own intellectual and professional interests?
- emotional and social maturation?
- development of empathy and inter-personal sensitivity?
- consideration and perhaps re-thinking of one’s career interests, values, and prejudices?

These issues are particularly important in the Psychology profession and the health professions where empathy, understanding, sensitivity, interpersonal warmth, personal maturity, social skills and the like are crucial for effective professional performance, as well as relevant knowledge and practical “doing” skills. They are best developed by experience on placement in applied professional contexts under experienced professional supervision, as well as in group settings



under a skilled facilitator. *Yet reduced government funding has meant the loss of adequate capacity in these areas in health systems and in the universities.*

Where, too, are the desirable variations across universities in how they conceptualise and teach a discipline and/or a profession's basics? The approach used by the PP implies the attempted imposition by government of a dysfunctional uniformity of curricula and syllabuses across institutions, rather than a valuing of diversity.

**Inflexibility.** The centralised “blueprint” mind-set is also inherently a rigid and time-bound mind-set. It cannot cope with rapid change, especially if the changes are fundamental, in basic concepts and types of methods. Rigidly applied, one step in the linear sequence locks in the others. The model of car having been decided, the subsequent production steps must be followed, everywhere.

It may be counter-argued that specification of desired learning outcomes rather than the intermediate steps would fix the problems with a blueprint mind-set. It would not. The objections remain. Moreover, in today's era of intellectual and technical volatility, predictions and projections (which drive choice of desired learning outcomes) are rapidly overtaken by typically unexpected new realities.

**Increasing unpredictability not recognized in the proposed solutions.** Who would have imagined, even 15 years ago, the massive effects on all professions of the Information Technology revolution, where inter alia computer power has been doubling about every 18 months – Moore's Law – enabling major yet mostly unpredictable improvements, in kind as well as degree, to be achieved in many fields? Assembly lines and other manufacturing and production processes have long been moving towards automated and other “machine” forms of work, displacing humans with consequent great social costs. This trend has escalated by a number of degrees of magnitude with recent great increases in minaturisation and computing power. (See for example Rifkin, 2000.)

Even in the “service” industries, labour-reducing methods due to IT have been warmly embraced managerially. This has been primarily for the benefits to managers and shareholders rather than employees. Those “benefits” are not only reduced labour costs but also (and even more importantly to them) greater social control over (fewer and more marginalised) human workers and greater production and predictability thereof. For example librarians are being displaced by IT innovations. Writers are being partially replaced by “silicon authors”. Actors are being displaced by “morphing” – the rearrangement of minute features of past movies, to produce new synthetic movies in which those actors have not been personally involved. Some of the changes do not arise from deliberate management decision, but reflect self-directed developments by people in the field. For example musicians are suffering occupationally (and in other ways) from the advent of high-tech synthesizers.

Bearing in mind that a 10 to 15 year time frame for projections and predictions is necessary in health workforce planning, due to the long period of initial and post-initial training, who in the 1980s and early 1990s would have prescribed computing competencies (beyond those needed for statistical analysis in research work) as desired learning outcomes in professional training? Even if they had done so, specific skills are very dependent on the fast-moving state of the technology, measured in months, not decades.

Who would have predicted MRI technology and the associated improvements in professional assessment and treatment of various conditions? Who would have predicted the need for MRI technicians? Who would have guessed at the development of Robodoc, a computerized robot to assist with some surgical interventions? Who would have included such knowledge in the training of surgeons?

Who would have predicted stem cell research and its various applications?

Who would have predicted the explosion of diagnostic sub-categories of Post Traumatic Stress Disorder, its theoretical, research and professional implications, its impact on legal issues such as Occupational Health and Safety and Workers' Compensation legislation, and its consequences for employers?

Even if such developments were imagined, who would have been able to forecast even their broad thrusts in terms of associated new workforce needs, let alone make the precise kinds of predictions and specifications about those needs that the Commission's Paper assumes will underpin its education and training reforms? Examination of forecasts such as those made in Alvin Toffler's book *Future Shock* indicate how wide of the mark, fundamentally, such forecasts have been.

The list is very long of things that would not have found their way into university curricula had some external central body specified desired and uniform learning outcomes.

**Centralised controls discredited.** Reports of negative experiences with centralised curriculum-setting and quality assurance bodies have emerged in countries such as the UK, in regard to teacher education.

To quote from the Leeds University website article on teacher education reforms (go to [www.leeds.ac.uk/educol/ncihe/r10\\_048.htm](http://www.leeds.ac.uk/educol/ncihe/r10_048.htm)):

#### *“Teacher Training Agency*

*24. A great many respondents express concern about the role of the TTA in funding ITT (initial teacher training) courses and suggest that this role should be returned to the funding council (HEFCE), and perhaps to a separate sub-committee. These respondents argue that the involvement of the TTA in both the funding and accreditation of courses represents an undesirable conflict of interest. These institutions argue that the different sources of funding make planning difficult and cause costly inefficiencies. There is also a feeling that the TTA does not take responsibility for or provide support to the institutions it funds in the same way as the funding council would.*

*25. There are a number of explicit criticisms of the TTA in the responses: its running costs are too high and rising; it appears to be open to political manipulation; its activities are badly planned and co-ordinated; its consultation exercises divert institutions time away from their main business; too many policies are simply imposed on institutions; it seems to take a hostile, antagonistic stance towards institutions and does not appear to recognise that those involved in training teachers do have something worthwhile to contribute to the debate about teaching; and it favours school-based schemes with a reduction in the role for higher education.”*

Similar criticisms have also been made very recently about the relatively new Victorian registration authority for teachers.

***Inappropriate solutions.*** The PP recognises technological volatility, indeed describes it well and in some detail, but (perhaps reflecting multiple authorship) it then goes on to propose inappropriate solutions that do not flow from the analysis.

For example, collecting together a number of “experts” onto a national council will not overcome the problems outlined above. Rather it may be dysfunctional in that it may cement in a superficial “consensus” about the current state of knowledge, rather than pick up early change-warnings that allow us to move with the times, and may ignore the new work roles that are emerging. (In this context, it is important to ask: “*What does “consensus” mean?*”) Such a council would no doubt be urged and expected to generate uniformity, standardisation, and detailed specification of educational outcomes— what else would be its *raison de'tre*? This would be highly dysfunctional.

## **A Better Way Forward**

**Collaboration, not control.** The best people to drive educational changes are those in the field, confronting the complexities and the trends. To assert that the people best placed to know what is happening and to respond appropriately are the academics doing the research and teaching, and the professionals “at the coal face”, does not mean laissez faire for higher education institutions, or ignoring workforce projections. It does mean decisions through consultation, information-sharing, collaboration, involvement, and negotiation, not external Government direction and control, or leaving decision-making to the vagaries of “competition” and “the market”.

Collaboration, through research and professional journals, conferences and the like is the appropriate way to stimulate integration while accepting the fact of increasing specialisation and differentiation. *Yet inadequate government funding of universities and health services has deprived and continues to deprive people in the field of these collaborative opportunities, as has its promotion of competition over cooperation.*

**Innovation, not standardisation.** Such volatility requires flexibility in curriculum design, and opportunity for universities to experiment and have freedom to change without having to obtain the permission of external government bodies. If there must be parameters (such as in course accreditation for professional purposes), those parameters must be flexibly stated, at the level of principles and broad goals. The accreditation processes must include interaction with the educational body being accredited so that arguments for doing things differently, or doing different things, are considered, and the good arguments accepted.

In short, none of us has the capacity to know the scientific and professional future. Predictions are short-lived. What is taught and learned must be modified as the field changes – an emergent, not a dictated process. Students – especially at post-graduate level - are part of the change process, contributing particularly through their research – yet perversely research funding has been slashed over recent years, and individual researchers effectively excluded from receiving government funding!

A “bottom-up” or at least a “two-way” collaborative process is needed, not a “top-down” one.

### **An alternative to the PP’s negative view of the professions and the universities**

The PP reflects a typically negative and disrespectful view of the professions and the universities. The professions and the universities are misrepresented as self-serving opponents of change. This view contaminates the analysis of the problems and the construction of solutions, particularly through being distrustful of collaborative solutions.

In reality the contrary is true. The professions and the universities drive worthwhile change, through basic and applied research, and innovations in professional practice, disseminated by publications and CPD activities, and often by multi-disciplinary collaboration and on-the-job teamwork. Professional coherence and identity are important for those change and communication processes. To see them only as “barriers to competition” is to fail to understand their essence and their crucial role in organising, integrating, evaluating and promoting professional change and improvement.

Professional work roles have been expanding in number and scope at an exponential rate over recent years as part of the knowledge explosion and increasing specialisation in the professions. Professional associations play a crucial role in simultaneously nurturing and putting a brake on such expansions of specialisation, by incorporating and synthesising developments as much as possible within existing specialties, and setting benchmarks to be attained before an emerging new sub-field qualifies as a “specialisation”.

Psychologists as one example now work in many more contexts than ever before. Many have job titles that do not include “psychologist” yet require psychological qualifications and experience (often not recognised by workforce analysts). Yet a new specialist APS College may be formed only after the sub-field matures.

Specialisation is a trend that the Commission identifies, but goes on virtually to ignore, and indeed by its support for “genericisation”, to treat as trivial or problematic. The value of specialisation is not recognised adequately.

In this regard the Commission - and a number of government health departments - appear to be “doing a King Canute”, standing against and being drowned by the incoming waves of professional specialisation, asserting that “generic” health workers are preferable to specialised professionals.

As part of this bias, the PP recognises only peripherally that the use of “generic” health workers is legally precarious (as well as inferior in service delivery terms). For example allowing a “generic” worker who is not qualified or registered as a psychologist to provide psychological services breaches the regulatory legislation. We made this point in some detail in our second submission, and commend the Commission’s revisiting that submission.

A much more major – if largely unrecognised - source of rigidities in professional practices is misplaced econometric thinking and derived public sector administrative policies. See for example the analysis of international histories in the development of science and technology provided by Salomon, Sagasti and Sachs-Jeantet (1994).

A key example is de-professionalisation and privatisation policy in the public services. This policy has denuded them of internal professional structures, expertise and leadership capacity to determine and drive desirable change in professional roles, which have become truncated and their providers demoralised under non-professional management. It is a bitter irony that the “economic rationalist” perspective responsible for that deprofessionalisation process and its negative impacts on the quality and range of professional services remains blind to these ill-effects and “blames the victims” (particularly the professions) for the service delivery problems.

The continuation of this negativity is certain to continue to alienate the professions and the universities, the last thing that is needed for effective change. *Partnership, not conflict, ought characterise the assessment of future health workforce needs and the associated planning processes.*

We therefore urge a re-examination of the “deterministic blueprint” and “anti-professions/universities” mind-set apparent in the PP, to allow better for the volatility of education and training needs as part of complex emergent processes that simply cannot be directed, controlled, or even predicted with any great accuracy. Governments or other centralised bodies cannot – or at least ought not attempt to – dictate needs, curricula, and priorities. They should not try to assign undergraduate applicants to allocated places in a centralised effort to match “inputs” with desired “outputs”. Collaboration with the professions and the universities is imperative, not simply desirable.

***The proposals would cement in serious conflicts of interest.*** We note that the centralised mechanisms proposed would place the public sector employers of professionals (particularly departments of health) in a position to attempt to dictate professional standards everywhere (including in business and commerce, and the many non-health areas of government), and the curricula and relative funding levels for the various forms of professional training; and would carry out their accreditation.

These departments have too great a conflict of interests to be able to handle the full spectrum of professional workforce planning for the nation's needs. For example they are likely to give greater weight to their own "health" needs than those of other employers, as much unwittingly through their own limited experience and perspectives as deliberately. *We consider that a "separation of powers and interests" approach should be taken instead of this unhealthy conjunction of employment powers and interests with educational ones.*

*We similarly consider that the departments of health should not continue to act as overseers of the professional regulatory legislation and disciplinary mechanisms.*

As employers of professionals, they are too implicated in the management, funding and staffing of health services to be able to function objectively and independently as regulators, or overseers of regulators. The recent Inquiry into the Camden and Campbelltown Hospitals in NSW reveals the dangers of allowing this kind of conflict of interests to occur and be sustained. An acceptable alternative might be the Attorney-Generals' departments.

**Job satisfaction.** We note that the PP places some emphasis on the importance of job satisfaction for professionals, an emphasis we would strongly support and wish to see enhanced. However there is no doubt in our view that some of its proposals would so erode professional identity, professional autonomy, and appropriate organisational structures for and managerial treatment of professionals, that their job satisfaction would be greatly diminished.

We now turn to the specific proposals.

## COMMENTARY ON THE SPECIFIC PROPOSALS

First we identify and comment on those proposals that we can support, in whole or in part.

### Proposals Supported

#### ***DP 3.1 (Endorsing the National Health Workforce Strategic Framework):***

We support the proposal even though we have some concerns about the phrase “subject to broadening of the self sufficiency principle”. If the proposal is to be considered by the Federal Government without the supporting analysis and commentary on pp 34 and 35, this phrase would be vague and could be easily ignored or misinterpreted.

Our support for the NHWSF reflects our view that serious attempts at workforce planning will continue to be bedeviled by lack of coherent strategic planning for the health sector. In saying so, we recognise (as does the PP) the great difficulty of such strategic planning, in systems marked by different governmental and organisational missions and objectives, inter-governmental tensions, politically short time frames, the complexities of emerging health needs, and so on.

We think that what is meant in the PP about the “self-sufficiency principle” boils down to two things: (i) “more active embracing of the international nature of the health workforce” (p.35 of the PP); and (ii) expansion of the endorsees of the NHWSF to include “education, finance, and central policy coordination areas of government (through CoAG)” (also p.35).

The existing wording of the NHWSF appears to us to be satisfactory with regard to recognising the international aspects of the health workforce. However we would not object to some re-wording providing it was more explicit and meaningful than the alternative wording indicated above. One issue that must, we consider, be more adequately addressed is the morality of recruiting trained health professionals from the developing countries, thus impeding the success of their health systems.

Inclusion of education, finance and central policy coordination areas of government could be either productive or counter-productive, depending on the motives involved. If increased government control and stronger assertion of its “user pays” and similar econocentric policies are the aim, it could be very counterproductive. If enhancing collaboration and cooperation is the aim, we would hope that the assistance of those areas of government could be constructive and valuable.

#### ***DP 3.2 (Senior officials of CoAG to commission regular reviews).***

We strongly support the notion that such reviews “should be independent, transparent, and their results made publicly available” (p.35). But we do not support the notion that CoAG Senior Officials should “drive the reviews and coordinate the responses of various areas of government to the outcomes of the reviews”. Such a powerful control mechanism is not “independent” and is not warranted. If the various areas of government prove recalcitrant, or their voluntary collaboration does not occur for some other reasons, then perhaps the CoAG Senior Officials’ group could be called upon to intervene, but it should not routinely do so. The CoAG Senior Officials’ group is already so loaded with high-level tasks that one could not imagine that regular review issues would receive the requisite and timely attention and consideration.

The reasons offered for it (p.35) are that otherwise (under the oversight of the current Australian Health Workforce Officials Committee, AHWOC) deficiencies may not be given “proper airing”, and “the potential for particular interest groups to undermine the reform process” could be high. This negative view of AHWOC’s evaluation capacity is not evidence-based (so far as we can establish), and appears to be a rationalisation for more centralised control over the evaluation. There is no reason to suppose that the CoAG Senior Officials group would be any more likely than AHWOC to

give deficiencies a proper airing (especially if they flow from CoAG or Federal Government policies such as reduced funding for higher education and health services) or to be immune to influence from “interest groups”, and may be under even greater pressure from governments than AHWOC to keep outcomes non-transparent.

Regarding immunity from influence from “interest groups”, there is an important role for such inputs, *so long as they are transparent and where appropriate contestable* – “immunity to influence from interest groups” is not necessarily a good feature in such reviews.

A genuinely independent evaluation mechanism should be established if there is evidence that AHWOC is not performing adequately and the various areas of government are delinquent in implementing the outcomes of the reviews.

***DP 7.2: (Improved cross-jurisdictional movements of professionals)***

Supported.

***DP 7.3: (Regulatory legislation changes to enable task delegation).***

Supported with important caveats about the care needed regarding task delegation, and the desirable limitations of delegation provisions, to ensure no loss of quality of and accountability for professional services. Also careful consideration needs to be given to the State level of legislation (e.g. child protection, human rights, client-counsellor privilege, professional liability legislation and case law, and expert evidence guidelines), which is intertwined with regional legislation for professional regulation. Governments must also adopt a much more collaborative approach than characterised the recent NCC-driven reviews of the health professions’ regulatory legislation (where the “cure” was generally worse than the “complaint”, partly because of very inadequate consultation with the professions).

***DP 8.1: (Independent review body re MBS coverage, PBS prescribing rights, etc.)*** This is an important idea and potential initiative which nonetheless will require careful and collaborative management. Ultimately, however, it can bring significant health benefits to community members and to the health of the Australian nation through access to evidence-based, cost-effective interventions and management.

The demand for mental health services in Australia exceeds the current workforce that is accessible to consumers. Psychologists have available workforce capacity but are significantly under-utilised due to issues associated with government-supported access for consumers. We identify just one area, that of mental health, as an example.

Although mental health disorders are the leading cause of disability burden in Australia, there are a low number of psychiatrists in the workforce and only a limited number of mental health-trained general practitioners currently involved in Government mental health initiatives. The profession of psychology is specifically trained to provide primary services in mental health and is the largest mental health workforce in Australia, with over 10,000 appropriately trained psychologists. However, psychologists are currently significantly under-utilised in the provision of mental health services due to issues related to affordable, government-supported access. Initiatives to increase consumer access to Medicare rebatable psychological services would immediately ease the mental health burden.

The Medicare item Focused Psychological Strategies (FPS) was introduced as part of the Better Outcomes in Mental Health Care (BOMHC) Initiative and is provided by GPs who have completed Level 2 training under the Initiative (see attached MBS Schedule). FPS are specific mental health treatment strategies, derived from evidence-based psychological therapies. The Level 2 training requires GPs to receive 20 hours of instruction in FPS, after which they are funded to undertake psychological treatment with patients presenting with mental health problems, using the MBS

items.

The techniques that GPs are expected to master in 20 hours are components of those that psychologists are required to possess to be registered to practise, involving a four-year university degree in psychology, two years post-graduate study (usually a Masters degree) and at least one subsequent year of weekly clinical supervision. We believe that twenty hours of training in psychological therapy techniques is not adequate training and does not meet appropriate professional standards for mastering the skills for effective psychological intervention.

The profession of psychology, which is more highly skilled and qualified to provide psychological interventions for mental health problems, does not have access to Medicare rebates for delivery of FPS. Many patients have little choice but to use the funded (and hence cheaper), less well-trained practitioner. As a result, a person seeking psychological help from a Level 2 trained GP may not receive a highly successful intervention, which could have been delivered by more appropriately skilled hands.

**The solution.** Enabling psychologist access to the Medicare items for Focused Psychological Strategies would use an equivalent amount of funding for treatment, yet would ensure that the highest quality and most effective, affordable care is provided for patients with mental health disorders. This initiative would provide access to best practice psychological interventions in specialised areas of great need, such as youth and aged mental health, and would ease the mental health burden through mobilisation of a significantly under-utilised trained psychology workforce.

In addition to the MBS Items identified above, it would significantly assist services to people with mental health problems if mental health specialist psychologists had the capacity to prescribe medications and to access PBS items. This would be based upon additional appropriate formal training and confined to those medications (generally psychotropic) associated with mental health disorders.

***DP 8.2: (Rebates for delegated services).***

Supported in principle but with caveats about the proposed processes, and objection to the notion that the “delegated services” be rebated automatically at a lower rate. We also consider that the service provider to whom the medical practitioner “delegates” tasks is an independent and equally qualified professional who cannot escape separate, independent professional responsibility and legal liability. The delegator cannot assure the health and safety of the client in the sense of being able to direct, control and be responsible for the work of the delegatee. The concept of “delegation” needs to be revisited and replaced with something more appropriate to multi-professional teamwork in which the traditional hierarchies of professionals are replaced by an egalitarian model based on competencies and contributions.

***DP 10.1: (Recognition of rural and remote health care needs.)***

Supported.

***DP 10.3: (Cross-program evaluation exercise.)***

Supported with the caveat that it is properly designed and conducted by independent people genuinely expert in such research work, and is fully funded.

***DP 11.1 (All health workforce frameworks to consider special needs groups' requirements.)***

Supported with caveats about the maintenance of quality standards, and quality assurance mechanisms and processes, and recognition of the need for a higher level of funding for special needs groups' service delivery systems.



## Proposals Opposed

We do not support the following proposals.

### ***DP 4.1 (Establishing an advisory health workforce improvement agency).***

This proposal envisages a highly centralised system whose brief would be impossible:

- to identify “major job substitution and redesign opportunities”. (In every health profession? On what data? For what purposes – increasing or shrinking the size of the health workforce, getting more services out of the existing workforce, making entry easier, making work more enjoyable, reducing the complexity of work, reducing its costs?) According to whose conceptual and values framework – a mechanistic, post-Fordist one, a more “organic”, post-market one, or what? On whose recommendation – a group of economists, a group of mixed professionals, or what?)
- to assess their benefits and costs. (This would require that job substitution and job redesign proposals be in a clearly specified and detailed form, and that costs and benefits are immediately discernible. Whence would they come? On what evidence would they be evaluated? Benefits are usually over-stated by proponents, and costs incompletely identified and seriously underestimated.)
- assess their implications for education and training. (Any non-trivial change proposals are likely to have unforeseeable as well as foreseeable consequences and implications for education and training. Frequent reassessments are needed. Would the assessor(s) care about some consequences, e.g. that human service workers no longer have any exposure to non-utilitarian subjects such as philosophy, politics, sociology, and history?)
- assess their implications for accreditation. (On what basis? With what degree of expertise and insight?)
- assess their implications for Government funding. (With what consequences? Would governments respond appropriately?)
- assess their implications for private health insurance arrangements. (Yet another massive “can of worms”, such as in regard to professional liability legislation and case law regarding organisational and individual professional liability! Other examples include OHS implications due to job changes leading to stress and anxiety, about potential redundancies or having to undertake work roles for which the person is inadequately prepared.)
- to have “balanced membership”. (According to whose views about appropriate representation? A horde would be needed to cover all the relevant professions and areas of expertise.)

We can envisage yet another large bureaucracy, expensive yet under-resourced, ill-equipped to do the work that it has displaced other agencies from doing, slow and dogged by all the other problems of such bureaucracies.

### ***DP 5.3 (AHMAC policy directions)***

We support the idea of better information collection, and transparency of institutional and funding frameworks, but not “explicit payments” and “training subsidies” as expressed. These terms, coupled with “addressing any regulatory impediments to competition in the delivery of clinical training services”, appear to be code for privatisation of professional training provision, some of which is clearly intended (judging from DP 6.1) to be downgraded to VET level. Such privatisation and downgrading would be very strongly opposed in Psychology and no doubt other professions, as we foreshadowed in our earlier (second) submission to the Commission.

We also oppose linking training subsidies to public benefits in the clinical training area. This is inappropriate “blueprint” thinking that is also incapable of being operationalised, especially if centralised and applied across all health professions. Public benefits take time to emerge and are broad, while funding is short-term and specific. The fit between the two is very poor. Moreover, the funding of such subsidies would have to come from existing higher education or other already-dedicated funding, to their further disadvantage, unless additional government funds were made available.

We would consider supporting well-designed collaborative processes for allocating special (additional) funds to specific projects planned to address properly identified shortcomings in the mental health arena, with safeguards against ideological rather than theory-based projects, and other similar defects. We would also support rigorous evaluation of the outcomes of such projects.

We disagree with the implication in this proposal that there are serious regulatory impediments to competition in the delivery of clinical training services, in Psychology at least. We cannot identify such regulatory impediments. This appears to be either a “straw man” to rationalise weakening of the regulatory system, or an over-generalisation from some other profession’s regulatory provisions. We would certainly not accept the provision of clinical training by unqualified, unaccredited and inept service providers, or by companies that may come and go with no continuity of training service provision.

***DP 6.1 (A single national accreditation agency for university-based and post-graduate health workforce education and training.)***

We see no merit in this proposal. It smacks of heavy-handed, “top-down” centralised control through a new, large bureaucracy, involving loss of contact with and knowledge of the particular professions.

We note that in Box 6 (p. LXIV) of the PP only 6 submissions are reported to “support a national accreditation regime”, that 4 of the 6 were government departments or AHMAC itself, and that the other 2 submissions were medical committees. The latter called for (in one case) a “coordinated approach to the accreditation of hospitals” (not of educational institutions) and (in the other case) “some rationalisation of accreditation and certification” of medical programs. (Our italics.) These figures certainly do not constitute widespread support for a national accreditation authority covering all the health professions!

The professions are already over-regulated, and this proposal will not simplify matters. What has happened to “self-regulation”, “co-regulation”, “small government”, “decentralisation”, and “empowerment”? We favour nationally-consistent regulatory provisions, but within the profession, not across professions. In developing those nationally consistent provisions, we have already achieved satisfactory and cost-effective co-regulation with the Council of Psychologists’ Registration Boards in regard to course accreditation, and do not wish this arrangement to be disturbed.

We are totally opposed to the “possible extension (of professional training) to VET” (to be “assessed at a later time”), as we indicated earlier (re DP 5.3).

***DP 6.2 (Assessment of overseas applicants to be done by national accreditation authority.)***

See our response to DP 6.1. Current arrangements – which involve the APS on a “contractor” basis to the Commonwealth Department of Immigration – are very satisfactory and should not be disturbed. If this arrangement were changed there would be a huge loss of very technical experience built up over a long period of time.

***DP 7.1 (Restricted role for registration boards.)***

Rejected. This proposal reflects a disturbing lack of understanding of the regulatory developments being achieved in the States and Territories such as the referral of some disciplinary powers to higher-order health-wide or even broader-scope tribunals. We have not agreed with all aspects of those developments, merely observe here the lack of consideration of those developments in the PP, particularly as reflected in this proposal.

We find curious the PP's elevation of the DoHA submission to the status of a "synthesis" of "widespread concerns" that registration requirements "reinforce workplace rigidities (etc.)". Whom did DoHA consult? Who expressed the "widespread concerns"? Where is the commentary and information that DoHA has "synthesised"? Who agreed that DoHA would speak on their behalf? The APS was not asked by DoHA for its views of the regulatory mechanisms, nor (we understand) was the Health Professions Council of Australia, or the MHCA. At best the DoHA submission may reflect a shared bureaucratic view, although even that comment may overstate the degree of consensus among public service staff involved in health systems.

***DP 9.1 (Centralisation of numerical workforce projections under a single secretariat.)***

Opposed as stated. It appears to entail division of responsibilities with the earlier-proposed national council. Worse, it would seem to exclude broad departmental and external involvement, and the secretariat would predictably be a remote, non-transparent unit reporting only to the relevant departmental Secretary or Minister.

In our first submission we outlined the serious defects we have encountered in regard to trying to collect sound workforce data about psychologists. This proposal fails to address our concerns here. For example it fails to contemplate the key role that registration boards may play in such data-collection, or the importance of solving definitional problems. *In Psychology, workforce projections have been bedeviled by failure to recognise that many psychologists do not work in health systems, a failure not rectified in the PP.*

We are very conscious that national collections of projections about the full range of health workforce needs will be based mainly on *health organisations'* expectations and plans about the organisation's future development, and related assumptions. There will be a confusing mix of scenarios and levels of optimism-pessimism ("equilibrium", "best case", "worst case"), and forecasting methods (some simple, some complex, some qualitative, some quantitative, some hybrid), as well as of health industry types (public, private, hybrid, hospital, NGO, community service, etc.), varying forecasts about external environmental impacts (stable, volatile, threatening, growth-enabling), varying strategic plans, different work classification systems and so forth. Any simple aggregate of these various separate sets of health organisations' projections would be inherently meaningless if not actively misleading.

That having been said, some national level of coordination of data-collection would be supported (as we stated in our second submission). Better data-collection is certainly of great importance, but the mechanism and processes must be cooperative and transparent. Moreover an existing agency such as the ABS could be charged with establishing, administering and supporting technically such a consultative mechanism and processes, rather than setting up a new secretariat.

**DP 9.2 (Use of numerical workforce projections to advise governments re education and training requirements.)**

Opposed. Such a mechanism (presumably focused on health) would cut across existing arrangements for determining university funding, in a closed, non-transparent way. While we see many shortcomings with the current DEST-based arrangements, this proposal would dysfunctionally split responsibility and accountability by shifting effective decision-making power away from the universities and the Minister of Education, in regard to the courses defined as “health”. The definitional and other problems outlined above could result in serious funding anomalies (e.g. failure to fund non-health Psychology programs).

National workforce projections do not translate readily into education and training decisions. The evidence is that they tend to acquire a false aura of precision, specificity and validity that ultimately proves dysfunctional. Moreover numerical projections are not interpretable without good accompanying qualitative information and expert understanding of the occupational areas involved.

The Research Centre for Education and the Labour Market (Maastricht University) in the Netherlands has been working for many years on developing adequate workforce estimation models and methods. Their report *“Beyond Manpower Planning: ROA’s Labour Market Model and its Forecasts to 2002”* (ROA-W-1998/6E) by Andries de Grip and Hans Heijke (1998) is commended to the Commission. It traces the Netherlands’ history of workforce planning methods, including its (and other countries’) retreat from over-prescriptive use of projections, to a two-pronged use – for information (including to prospective entrants into education and training programs), and broad policy parameter settings by governments and other institutions. Substantial error variance is anticipated and expressed in its forecasts, e.g. job prospects are expressed only in “band” terms (“good”, “moderate” etc.). Projections are for the medium term (around 5 years) and subject to continual review.

The explanation in the PP, that the main purpose of numerical projections would be to *“help inform governments on the number of students required at various points along the education and training pathway to meet future health services demand”* (p.LII), unfortunately reinforces our deep concern that excessive reliance will be placed on untrustworthy projections, and that the universities are to be treated as government-controlled “degree factories”.

We are also concerned that the PP appears to support only a quick and methodologically inadequate approach to forecasting *“future requirements for individual medical specialties or smaller allied health professions”* – e.g. on p.LIV appears the following comment: *“..such estimates could be made as and when required, and without the need for major modeling exercises”*. In fact estimating requirements in small occupational categories may pose more difficulties than are found with larger categories, due to statistical problems such as low reliability and the greater impact of unanticipated exogenous factors or unexpected variances in modeled factors. If all that the Commission expects here are forecasts of a broad kind, the ABS already provides such assessments.

The PP’s emphasis on “a scenarios-based approach” does not overcome the inherent problems with workforce forecasting. Certainly it is likely to be better than a “single benchmark estimate”, but that is a minor technical improvement that does not overcome the problems.

*However we would support a national collaborative mechanism to plan and help deal with the manifold problems in data collection, and to take whatever lessons there are to be learned from the data collected.*

***DP 10.2 (Health workforce improvement agency to consider job design/redesign opportunities in rural and remote areas.)***

Opposed, for the reasons expressed regarding DP 4.1.

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