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COMMUNITY AFFAIRS LEGISLATION COMMITTEE

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SENATE COMMUNITY AFFAIRS

LEGISLATION COMMITTEE

Thursday, 11 June 2009

Members: Senator Moore *(Chair)*, Senator Siewert *(Deputy Chair)*, Senators Adams, Boyce, Carol Brown and Furner

Participating members: Senators Abetz, Back, Barnett, Bernardi, Bilyk, Birmingham, Boswell, Brandis, Bob Brown, Bushby, Cameron, Cash, Colbeck, Jacinta Collins, Coonan, Cormann, Crossin, Eggleston, Farrell, Feeney, Ferguson, Fielding, Fierravanti-Wells, Fifield, Fisher, Forshaw, Hanson-Young, Heffernan, Humphries, Hurley, Hutchins, Johnston, Joyce, Kroger, Ludlam, Ian Macdonald, McEwen, McGauran, McLucas, Marshall, Mason, Milne, Minchin, Nash, O'Brien, Parry, Payne, Polley, Pratt, Ronaldson, Ryan, Scullion, Sterle, Troeth, Trood, Williams, Wortley and Xenophon

Senators in attendance: Senators Adams, Boyce, Carol Brown, Furner and Moore,

Terms of reference for the inquiry:

To inquire into and report on: Health Workforce Australia Bill 2009

WITNESSES

Committee met at 9.03 am

STRONACH, Ms Pamela Jayne, Executive Officer, Australian Council of Pro-Vice-Chancellors and Deans of Health Sciences

HENSLEY, Professor Michael, Medical Deans Australia and New Zealand

MAGARRY, Ms Angela Louise, Director, Policy and Analysis, Universities Australia

WHITE, Professor Jill Fredryce, Member, Clinical Placements Advisory Group, Universities Australia

WRONSKI, Professor Ian, Chair, Australian Council of Pro-Vice-Chancellors and Deans of Health Sciences

Evidence from Ms Stronach and Professor Wronski was taken via teleconference—

CHAIR (Senator Moore)—Good morning, everyone. This committee is commencing its inquiry into the Health Workforce Australia Bill 2009. I welcome representatives from Universities Australia, Medical Deans Australia and New Zealand and the Australian Council of Pro-Vice-Chancellors and Deans of Health Sciences. Do you have any comments to make on the capacity in which you appear?

Ms Magarry—I am Acting Chief Executive Officer, Clinical Placements Advisory Group.

CHAIR—That is a very big card!

Prof. White—I am also wearing another hat and representing the Council of Deans of Nursing and Midwifery.

Prof. Hensley—The Joint Medical Program is between the University of Newcastle and the University of New England. I am also an executive member of Medical Deans Australia and New Zealand, which is the representative body of the 18 Australian medical programs and the two New Zealand medical programs.

Prof. Wronski—My substantive role is Pro-Vice-Chancellor and Executive Dean of Medicine, Health and Molecular Sciences at James Cook University.

CHAIR—Are you in Townsville, Professor?

Prof. Wronski—I am in Mission Beach at the moment. I do live in Townsville.

CHAIR—That is outrageous, Professor! I do not know that we should take your evidence on that basis. I have just been assured that you are at a conference.

Prof. Wronski—Yes.

Ms Stronach—I am also Executive Officer for the Faculty of Medicine, Health and Molecular Sciences at James Cook University.

CHAIR—Where are you?

Ms Stronach—I am in Townsville.

CHAIR—We have submissions from each of your organisations. What I suggest is that people make an opening statement and then we will go to questions. It is always difficult when we are trying to balance phone hook-ups, but I am sure you are used to it, as we all have to be. I will look to the witnesses in the room first. Has anyone prepared an opening statement?

Ms Magarry—Yes. Thank you for the opportunity for Universities Australia to make a presentation today. Before I start, I want to extend the apologies of Professor Richard Larkins, as he is unable to attend due to an unfortunate personal circumstance in Melbourne. He has asked me to make the opening statement and represent Universities Australia.

We are the peak national body representing Australian universities in the public interest. Australia's 39 universities are the primary educators of health professionals, and approximately 120,000 health students are currently enrolled across a range of disciplines. You may be aware of the increasing numbers of health students entering the system over the next few years in medicine, nursing, midwifery, allied health and dentistry. We believe that effective clinical education placements are a vital component of the education of these students and, consequently, Universities Australia has shown a keen interest in the establishment of Health Workforce Australia and the accompanying bill.

In correspondence to the Minister for Health and Ageing in March this year, we stated that a correctly established and adequately funded agency will alleviate many of the issues and concerns currently experienced

by those involved in clinical education and that the $1.6 billion proposed could substantially improve the availability and effectiveness of clinical education placements.

Our concern is that the bill does not currently provide any substantive detail on the powers and responsibilities of Health Workforce Australia, and this aspect requires greater clarification before we believe it would be able to be supported widely. We believe that a national agency must act as a facilitator to provide funding, administrative and higher end strategic planning support for universities and healthcare providers. It should not impose a new level of bureaucracy that is not responsive to local needs or to changes in curricula and practice which may erode the good relations that have built up between individual universities and healthcare providers over decades.

We believe effective representation on the governing board is vital, and we note the bill envisages a 13-member board. However, we believe it is heavily weighted towards government at the moment, in a nine to four ratio. Universities Australia does not consider that such a composition will adequately reflect the relative importance of all stakeholder groupings. We understand those groupings to be government, education providers and health providers. We note that only three board places—four if you include the chair—will be expected to accommodate education providers, and those providers are currently universities, the VET sector and private education—also private and not-for-profit healthcare providers and discipline specific groups, including registration and accreditation bodies.

I have the benefit today of having Professor Jill White with me as a member of CPAG and also the dean of the University of Sydney nursing and midwifery faculty. I believe that she would be able to provide some further information for you in relation to the practical applications, as we see them, of the bill.

Prof. White—I would like to start by thanking you for the opportunity to be here. I will not repeat any of the points that Angela has made, although I do need to say, as a member of CPAG, that I absolutely agree with them and support them. The Council of Deans of Nursing and Midwifery in Australia and New Zealand also supports the points made.

There are a couple of additional points I would like to emphasise. I think that for the Council of Deans of Nursing and Midwifery, as with CPAG, it is the lack of clarity in the bill, the lack of information and detail in the bill, that is of concern in relation to governance but also in relation to the structure and the way in which the organisation will interact with clinical placements per se. The council of deans has written extensively to the National Health Workforce Taskforce advising that we believe the brokerage model would be the only one that would be acceptable, although we are very supportive, obviously, of the extra funding. We are very supportive also of a national repository of data that was accurate and timely, and that is seen to be a very positive aspect.

An area of concern is the absence in the bill of any indication of the relationship between Health Workforce Australia and regulatory and accreditation bodies, and we would seek clarity on this matter. Clinical placements and clinical education are absolutely fundamental components of both registration and accreditation, and therefore there would be some interaction. What that will be—what the hierarchy will be and what the relationships will be—is of great import and, we believe, needs to be clarified. I am happy to leave my statement at that point, thank you.

Prof. Hensley—Thank you very much for the opportunity for Medical Deans Australia and New Zealand to comment on the bill. Medical Deans Australia and New Zealand is the peak body representing, as I mentioned, the 18 Australian medical schools and the two New Zealand medical schools.

Medical Deans has responded to the consultation process, and has appreciated the opportunity to do so, and very strongly supports the initiatives in the national health workforce agency reflected in Health Workforce Australia. We think it is going to make a great deal of difference to the delivery of clinical teaching. From a medical student point of view, the figures in the COAG document indicate that, even though medical students are less than 10 per cent of the health professionals in training in universities, they constitute almost 50 per cent of the clinical training days. The nature of the medical program is a very strong insistence on clinical training days, particularly in the last few years, in preparation for medical students to become doctors from day one. The expectation is a standard of clinical practice that is both safe and effective from the first day they become interns. So the clinical placements and clinical trainings for us are fundamental to the quality of the graduates that we and all the health professions provide. That is really the focus that we have: that quality of the student experience to enable them to be effective and safe health professionals virtually from the day of graduation.

That also introduces for us a couple of areas that we think are reflected in parts of the proposal but are some of the details, and one is this continuum of education and to ensure that the health workforce initiative does not break up the continuum of education and that it supports the structures that have supported education around the country. They are, particularly, the linkages between clinical education and clinical research. There is very important investment in the future of the quality of our health care by ensuring that there is a continuum of clinical education and that clinical education informs the quality of the health provided. We think that that is very important.

We support fully the comments by Angela and Professor White from the perspective of Universities Australia and the deans of nursing. We too have concerns about the specific requirements, and we have a particular concern that we have in Australia very successful health professional training based on partnerships, particularly regional partnerships between health services and universities, and that to have a process that consolidates and enhances those would be fine but anything that would fragment them would cause concern. For us, the proposal that the agency works through flexibility and facilitates training is extremely important.

We also echo the concerns expressed by Universities Australia that the role of the board will be fundamental in determining direction; therefore, we would advocate very strongly for health educational expertise on that board to ensure that what is a very large investment by state and Commonwealth governments translates into excellent practitioners across the health area.

I would strongly support Professor White's comment that there has to be integration between the education and the health workforce planning and delivery and registration. Again, it is extremely important that the education is done in the context of our requirements for future health workforce. I am very happy to answer any questions. Thank you.

CHAIR—Thank you, Professor. It is difficult when there are so many professors. Professor Wronski—in, I regret to say, Mission Beach!

Prof. Wronski—Thanks again for the opportunity to provide evidence to the Senate inquiry. The Australian Council of PVCs and Deans of Health Sciences is the peak representative body for those Australian universities providing preprofessional education and training in the allied health areas. We welcome the focused new resources to support clinical education in Australia. We do note that $1 billion of that is new and $500 million or so counts resources currently applied to clinical education.

Our council has been actively engaged in these developments across registration and accreditation and the National Health Workforce Taskforce developments. Our starting point is that Australia's health workforce training system is of exceptionally high quality. We do want to see the building and expansion of that. At the current time, we would estimate that 80 to 90 per cent of health workforce training in Australia is of very high quality.

We would want to see the development of a broader conception of, say, a teaching health system with a research orientation that would need to occur across the public, private and NGO sectors. It is important that that builds on the strengths of the current system and is expanded to include all health professions. We think this would be best achieved by the expansion of the tried concept of the rural clinical school, the university department of rural health model, as a delivery mechanism, expanded to become truly multiprofessional and multigeographic. We wish to see the continuation of the diversity of health professional education to deal with different needs of various health professions and to continue to encourage innovation.

So we see the HWA as largely facilitative, with important planning functions, and some brokerage role around the creation of new clinical placements, and some targeted areas, with possible national approaches for very small professions. Our concern with the bill currently is that it lacks clarity about which model is being pursued and at present could be interpreted to include a wide variety of methods of operation from what we would regard as a backward step to very positive. The current wording in the bill would allow the organising of clinical placements at a national level, which just will not work and will have a very adverse impact on the integrated arrangements at regional level and the relationships that make clinical education work.

In addition, we are concerned about the broad representation and that it does not reflect the make-up of the interested parties. We think that it needs much more and clearer representation from the health education and health professional sectors. Thanks very much. I am happy to take questions.

CHAIR—Ms Stronach in Townsville, are you wishing to make any comment at this stage?

Ms Stronach—I would support what Professor Wronski has said. The lack of clarity in how HWA would operate and the proposed composition of the board with not enough health education and training

representation is of concern to us. There is already significant bureaucracy associated with clinical placement of students, and within the Pro-Vic-Chancellors and Deans of Health Sciences we represent 12 universities and those universities have at least three of a list of about 13 disciplines, so we have a very wide representation and a wide knowledge of the diversity involved in clinical placement. It is important that that diversity is acknowledged and recognised in any operations of HWA. Thank you.

CHAIR—Thank you.

Senator ADAMS—Thank you all very much. I am very pleased to hear that the 'practicality' and 'flexibility' words have been mentioned, because I cannot see this working. I have a nursing background and I have sat on a number of country hospital boards and the Metropolitan Health Service Board in Perth, so I do understand about governance and boards. That is really where I would like to start. Professor Wronski spoke about representation on the board. I would wonder whether this would be a mix-of-skills board. It cannot be representative because there are so many areas out there. We have such a great standard. I have had a lot to do with the rural clinical schools and that model works really well. What does concern me is that we have one member nominated by the Commonwealth and eight members each nominated by a different state or territory. Who do you see as being this person from each state or territory and at what level? Have you got any idea about that member or those members?

Prof. White—One of our concerns is that they will be nominated by health ministers and they will be workforce people from departments. That is of considerable concern.

Senator ADAMS—But are they going to be practical people?

Prof. White—Even if they were practical people, from workforce components of departments, it is still a single industry voice. It is not a voice that also brings into play the understandings that come from the disciplines and from education. That is a significant component of Universities Australia's submission—a suggestion on how one might constitute a board differently and with a slightly larger composition, but at least with acknowledgement and representation. It must come from universities, it must come from the major disciplines—and I think, progressively, we are seeing that there are three major councils. There are the major councils of deans. They are the ones represented here today—and in the ether! But also there is, as our submission suggests, the need to understand that there is all of the private health care industry that is not necessarily going to be represented by department of health nominees from workforce. There is also no mention of the registration or accreditation bodies—and particularly the accreditation bodies, that even the communique from COAG suggests must be independent—that are still critical in terms of informing the work of Health Workforce Australia, because they are the ones who set the standards for entry to a profession and accreditation of a program. To leave them out of the mix leaves one important voice absolutely silent.

Senator ADAMS—Ms Magarry, any comment?

Ms Magarry—I would agree with what Jill has said, and say that universities are headed up by a -chancellor and president, who are responsible for a number of disciplines in their universities. We have felt that the governing board should at least have one eminent vice-chancellor on the board, and reflect the range of disciplines that will be affected by an agency seeking to broker arrangements for clinical placements.

Senator ADAMS—Professor?

CHAIR—Judith, I will just check whether Professor Wronski has a comment to make.

Senator ADAMS—Yes. I am going to go to him.

CHAIR—With that same question or your next one?

Senator ADAMS—Yes. I was going to ask the five.

Prof. Hensley—As Medical Deans Australia and New Zealand, we have indicated in our submission that we support the concern that the board should be able to contribute to the major business of HWA, which will be enhancing clinical education, preparation of a workforce—

Senator ADAMS—Surely that is its role, Professor.

Prof. Hensley—and I think the concern of the jurisdictions, given that Professor Wronski said that they are contributing $500 million to the process to have a degree of governance, is understandable, but I would hope that that can be achieved by ways other than a domination on the board. I think that is where all of us have a concern. This is a fabulous opportunity to really not only support expanding clinical education but innovation as well, and there is a lot to be done.

Senator ADAMS—And get it right.

Prof. Hensley—And to get it right for the future.

Senator ADAMS—Thank you for that. Professor Wronski?

Prof. Wronski—Boards can be very important, and this is maybe a once in a lifetime opportunity to reshape and facilitate the further development of high-quality health professional education in Australia, so the inputs at board level, we think, are very important. Size of boards has an implication too, but I think that the states possibly do not need to be represented individually, just as it would not be possible for every health profession to be represented individually. I mean, we have a dozen or so across the allied areas. But what people bring is a perspective of the world from their own profession that is very useful in understanding how to take a system forward, and so we need some balance of disciplinary dimension to the sort of decision making that HWA is going to make. When you get into the details of how professional education is carried out, it is remarkably divergent, and needs to be because the health professions do things quite differently in some areas, and it is required to be so. What is important to be established through the board process is the representation of views of the world from across the health professions, as well as from universities and from the disciplinary areas that are important in making these sorts of decisions. Also, if we are going to expand clinical placements, the great untapped areas are the private sectors and the NGO sectors, and yet they seem to have been excluded, so I think there is some rethinking to do about that.

Senator ADAMS—Yes, they will be giving evidence later today. Ms Stronach, would you like to comment?

Ms Stronach—I agree with everything that has been said so far.

Senator ADAMS—Thank you very much. We have got eight members that we have talked about for the states and territories, and then there are up to three other members. Would you consider that, because of the budget of this particular proposed board, you would need legal expertise plus financial expertise on that board? These other three members, we do not know who they are, what they are, or what role they would have to play, but would the board—

Prof. White—And possibly community representation.

Senator ADAMS—I was about to get to that, because that was my role before I entered parliament. But it is terribly important. I really wanted to tease out how you felt about that. We do not know who these people are that come from the territories or from the states, and somewhere there has to be a balance. Something I was rather shocked about was that the board has a minimum number of three meetings a year. I would think that, with the things that have to be covered by this board, once a month would be an absolute minimum requirement, because it is a huge area, and then having all these sorts of advisory committees coming in from different areas of expertise, and the staff—from the bill—will not be Commonwealth public servants. So I am wondering who the staff are and what the composition is going to be. There are just so many questions to be asked. I would like to hear from you about whether you have had the same sorts of ideas as I have, reading this.

Ms Magarry—Can I answer that one?

CHAIR—Yes, thank you.

Ms Magarry—I would make the comment that we have observed exactly the same issues in relation to the bill and what it actually states. We have raised the issue of the composition of the board and its skills, the people on it, with the department, and I note that they are coming to speak this afternoon—

Senator ADAMS—They are, later on.

Ms Magarry—so you could ask them. In relation to the employees, my understanding is that, as this bill enables the agency to be established under the Commonwealth Corporations Act, the employees would morph across from wherever they currently are working, in say the task force, and be employed in the corporation. I would not see that it would be that big an issue, whether they are Commonwealth public servants or not. Once they are employed in a Commonwealth statutory authority, I would think they would have the same responsibilities as any of us who work in any corporation. We have raised these questions with the health department and have been told that some of these issues will get fleshed out over time.

Prof. White—I agree with what Angela is saying. I think that, in each of our professional groups, exactly the questions that you have raised have come up, and the bill does not go very far at all in answering those questions, and that is why we are here. But particularly in relation to the frequency of meetings, three times a

year seems incredibly tokenistic, rather than something that drives the agenda; and I would see that it should be the board that would drive the agenda. So I agree with you.

Prof. Hensley—I would support the need to think about this and go back to the first principle of addressing the core business of Health Workforce Australia, the composition of the board and obviously the recruitment of the chief executive officer, to ensure that that core business is followed out and that whatever due processes are required from a financial area are also accepted, given who is funding the organisation. But it would be important that the core business is managed through the board and the CEO.

Professor Wronski indicated some of the programs now through the Rural Clinical Schools Program, the university departments of rural health, the practice improvement program, where there is a great deal of experience of appropriate management of Commonwealth funds and reporting against KPIs to ensure that what has been agreed to is done. I think there has been a very good track record with those initiatives and very much the management of those initiatives is with the educators, with a process of contracts and monitoring and auditing to ensure that everything is done appropriately. So I believe very strongly that there is an opportunity to make a big step in education of health professions by having a board, CEO and an approach that focuses on health professional education.

Prof. Wronski—I think we need to be a little careful. I agree that the representation of the board is not appropriate at the moment. Nonetheless, I am not keen to see the establishment of a central agency that tries to run clinical education from the national level. A board that meets all the time would be tempted to expand its role. I think what is important about the current system is its devolution, and that the methodology of the sort of rural clinical service or UDRH sort of model for delivery of this system of clinical education and its expansion is best.

Given that, it might be that a board, appropriately constituted, could meet three times a year and the managers be allowed to manage. It is not so important that the board meets a lot; it is important that it is well constituted and that we expand the distributed model of clinical education around a model like the university departments of rural health, rural clinical schools, all of whom have their own boards but they are regionally made up and take on issues of interest around the community.

Prof. White—Just for clarification, my comment really in relation to the frequency of the meeting of the board particularly related to the set-up phase—

Senator ADAMS—That is right.

Prof. White—as Health Workforce Australia is trying to determine exactly what it is that it does and how it does it. Once it makes those determinations and is in full operation, it would not need to meet as frequently. I would like to pick up the issue of the rural clinical schools, and I know that is a model that has been promoted. I would like to draw attention to the fact that at the moment that is predominantly medicine, and it is medicine that is funded, so it would require a significant expansion of that role to take in nursing, midwifery and allied health, but we would not want to see the diminution of what has been at the moment provided for medicine, which is a fantastic model and one that we would aspire to be part of.

Ms Stronach—The composition of the board will be important in ensuring that we continue to produce quality professionals. We should not get away from our focus of producing quality health professionals, and that is a partnership at the moment between the training and education institutions—be they universities, TAFE and some private providers—and also health services, which are predominantly at the moment state based. But if we are to increase clinical capacity, it needs to include the private sectors, the NGO sectors, and some of the more community based organisations perhaps, which I think are missing from here. I think it is necessary to have that broad representation and not just have government and a few other providers which are not detailed as to who they would be. Thank you.

Senator ADAMS—As far as the role of the board goes, I certainly agree with Professor White. At the start, they have to set the direction. The board will not be dealing with day-to-day issues. That is why the CEO is employed and the staff. But without direction, they have to abide by what the board directs them to do as to how everyone is going to fit into this. Do you think there will be a number of education facilities that will fall through the cracks with this? We have a huge conglomerate of organisations out there that are all involved with education, whether it be with medical education or with the allied health side of it, and, with the focus towards primary health care, this is just huge. I agree with the concept of the board but I wonder how it is going to work practically, because it is going to take a lot of time and depth to work through this process. As to

flexibility, geographically I have been based in a rural area so I am fully aware of all the issues in that respect, without getting into teaching hospitals and the other areas as well. Could you comment about that?

Ms Magarry—The only comment from Universities Australia would be that we would hope that none of the clinical education facilities would fall through the cracks and that the agency should be established in order to maintain the goodwill and not break any of the current arrangements. We have always said that we think 80 per cent of the current circumstances in relation to clinical education and the training of health professionals work well. The agency should try and facilitate and broker for that extra 20 per cent, either in new growth of students required for the future or to fix some of the arrangements that may not work that well in certain jurisdictions. We would be very disappointed if the agency was established to result in further fragmentation or destructive behaviour. That is our position.

Prof. White—My concern primarily is getting it right for the major contributors to the health workforce, and I think that again they are represented by the deans of medicine, of allied health and of nursing and midwifery. We cover the major areas and, if we can look at a model that gets it right for that, we can look at the small amount that is around the fringes. One would not want anything to fall through the cracks. I think if we look at not disturbing some of the arrangements that are in place at the moment, the relationships have been built up over decades and decades, and I can assure you that we have looked with fine toothcombs at some of the arrangements that are possible. So I think that there would be a strong vested interest in all of the universities not letting clinical placements fall through the cracks.

Prof. Hensley—I would strongly support that comment, and also to say that—as I am sure you know from your own experience—there is a wealth of work being done on these partnerships in the metropolitan and outer metropolitan and rural areas; very strong partnerships between public health service providers, individual hospitals, community centres, divisions of general practice, GP training programs in our instance. I think what the new Health Workforce Australia has generated is a blossoming of thoughts on how to expand that, but it is very much based on regional and current partnerships, on flexibility, on making sure that there is attraction for new educators to come into the system, and that is where the funding comes in, that is where the simulated learning environments come in. I think it is a great opportunity. I would doubt if a person who genuinely wishes to participate, or an organisation, in health professional education would be left out of this process.

Senator ADAMS—The communication, of course, is going to be absolutely critical here. Professor Wronski?

Prof. Wronski—Yes, I think it is a very important point. If you look at areas that use the non-health sector for clinical training, it is a very important part of occupational therapy and speech pathology, for instance, which use the education sectors a lot and subsequently employ quite a lot of the occupational therapy and speech pathology workforce. What the regional partnerships that deliver these programs are able to do is embrace them, and so it will be important at the national level to consider the role of at least the education sector in the clinical education of a number of the allied personnel.

Senator ADAMS—Ms Stronach, can you comment?

Ms Stronach—Yes. I think that HWA is going to have to work quite hard, actually, to ensure that different arrangements do not fall through the cracks. I am just thinking of our experience in a rural and regional area where we have a lot of students placed in sole practitioner type situations in very diverse geographical areas, and even within Queensland Health a lot of those placements are based very much on one-on-one personal relationships, so there may not be much corporate knowledge at a higher regional level and, I suspect, at a state level as to what actually occurs. If you then expand that out into the private and non-health sectors I think that, if they are going to use the opportunity to expand clinical placement, a lot of work is going to have to be done in identifying a lot of those smaller, non-standard, non-large health facility type placements to ensure they do not fall through the cracks and to try and find ways of expanding those sorts of placement opportunities.

Senator ADAMS—Just on the research arm, I was wondering how you see the Australian Institute of Health and Welfare fitting into the research that is proposed.

Prof. White—Utterly critical. It is my understanding that one of the arms of this new body is in relation to innovations research and I know that our council—and, I would believe, the others—believe that it is as important an arm as the clinical funding arm. Being able to engage in research into new and innovative models of care as well as clinical education models, models that would give greater primary health care access, new maternity service models, is really important. They are all models that link into both care delivery and better

educational models for clinical education, so I think that the innovations research arm is absolutely fundamental to Health Workforce Australia.

Prof. Hensley—There are two elements here. You mentioned the Australian Institute of Health and Welfare. I think one very important part here is to take the opportunity to really understand our health workforce, how they are trained and where they go. The Medical Deans Australia and New Zealand, through support from the Commonwealth, has set up the Medical Students Outcomes Database, which is a comprehensive database of all medical students entering the system, which then follows on where they go afterwards, where they have their practice. I think we do need to have more information about the effort we put into health workforce training, to find out why people go where they go and why some of them drop out of the profession, to see whether during the training program and support program we can make sure that they stay in or can come back. That is an important arm.

The other area is innovation in health professional education. I think that is where, to take Professor Wronski's point, the consolidation about a regional base, whether it is a metropolitan or rural area—having a skill base of academics, healthcare providers, educationalists—will give you the critical mass to do the research. That is where, again, we come back to a model that facilitates a critical mass of educators, and hence educational researchers, to try new ways of providing education, to evaluate them critically and to find out whether or not they work. I think the research arm is absolutely essential, but it does need to build around academic strengths across the health spectrum.

Senator ADAMS—Professor Wronski?

Prof. Wronski—I think health systems research generally has been not as strong as it should be in Australia. In many ways, AIHW mostly plays a collections role around measuring trends, and that will continue to be very important in understanding what is happening. In addition, universities and others are engaged in research around new models and evaluation. It is not as strong as it should be in Australia. It is striking, when you are trying to find data and trying to understand trends, that there are huge gaps in understanding, for instance, what happens to health personnel who undertake a degree and then do not practise. There can be a significant proportion of people lost to the health workforce over, say, the subsequent five or six years after they graduate, and it is not always the intuitive things you think of.

Understanding how the cohorts of health professions behave, how the health professions are redefining their role as the health system changes, the behaviour of different population groups in accessing health professional education, are all going to be important in providing a relevant future workforce, as well as recruiting students from populations or subpopulations that do not normally get access to education systems in the proportions we would wish. For instance, focus on remote area populations, the rural populations in some places, Indigenous populations, some of the populations in the ex-industrial suburbs of major metropolitan cities. Understanding these trends will be really important.

Senator ADAMS—Ms Stronach?

Ms Stronach—I agree with the other speakers that the HWA research role is critical. I think the establishment of the HWA is a real opportunity to promote innovation in, for example, multidisciplinary clinical training or different models of clinical supervision. These sorts of areas will be especially important so that we can actually increase the clinical training opportunities. I think the research role for the HWA will be critical.

Senator FURNER—In respect of your introductory comments about substantive information on the powers, as with most pieces of legislation, you generally find the devil is in the detail. I can appreciate that you do not have the legislation before you now because this is a new act. I am wondering whether you would agree that that is the concern here: where you will have further explanation, particularly when it comes to the powers; where those sorts of details will be provided to you; when that is possible.

Ms Magarry—We do have a copy of the bill and have observed the second reading.

CHAIR—I think, Ms Magarry, Senator Furner means the regulations.

Ms Magarry—Oh, the regulations.

Senator FURNER—Sorry, the regulations.

Ms Magarry—We do not have the regulations. So, yes, of course we would agree with you. If there is further detail in the regulations, then obviously we will know more.

Senator FURNER—I take on board the comments by Professor Wronski that 80 to 90 per cent of training in the medical profession is at a high quality. I would concur with that. I am just wondering where your concerns are coming from with the possible changes in curricula.

Prof. White—They come in a number of forms: firstly, the variety of roles that might be taken by Health Workforce Australia in engaging with the clinical areas in the universities in determining clinical placements—how hands-on, how hands-off. I think all of us have been to more National Health Workforce Taskforce meetings around the country on possible models than we would care to remember. At those, there are always a whole array of models put out, right from the idea that every clinical placement would be organised from a computer system in Canberra through to a completely hands-off suggestion.

Not knowing where on that spectrum this is likely to fall is of concern, but probably more particularly the movement between funding and accreditation and standards development would cause the greatest concern; hence the need for an understanding of the relationships, whether they are superordinate or not in terms of accreditation and registration.

I give you an example: if Health Workforce Australia is funding a certain number of positions, presumably they will want to strike a number of hours of clinical training per discipline per award. That in itself creates no issue if there is discussion with the particular accrediting body as to what that needs to be and it is a professional decision in relation to appropriate standards and quality. If there were some movement towards a minimum and some pressure to only fund a very minimum number of clinical experiences, we would be very concerned; so the concern is on a number of levels.

Senator FURNER—I guess that comes back to your next concern about the governance and who is represented upon the board.

Prof. White—Absolutely.

Senator FURNER—I have been on boards myself and I do understand that the composition of a board, committee or organisation needs to be reasonable. You cannot have everyone on the board or organisation, otherwise it becomes unwieldy. What would be your view of the size or the composition of that board, if you had an ideal world to have true representation on it?

Ms Magarry—Universities Australia would be pleased to provide a nomination for the chair of the board—an eminent ex-vice-chancellor for example—and then we would be happy with the composition adequately reflecting the disciplines and, obviously, the government. That is as far as we have gone at the moment. You probably have another view.

Prof. White—I would not necessarily like to come up with a figure. I completely understand the desires for the states and territories to be adequately represented in that they carry the burden of needing workforce on the ground and they are contributing a significant amount of money, but it would be absolutely inappropriate for there not to be representation from medicine, from nursing and midwifery, one from allied health, and I think there does need to be a representation from accreditation in some form. I do not think that that necessarily would need to be at individual disciplinary levels because all of us conform to the desires of the World Federation for Medical Education in relation to composition and issues that relate to accreditation.

Senator FURNER—You suggested at least one vice-chancellor on the board should be appointed. How would you see that practically? How would that be arranged amongst the universities?

Prof. White—Universities Australia has that role at the moment.

Senator FURNER—So that has been achieved. There is no politics involved in how that selection is achieved?

Ms Magarry—No. Universities Australia work on any boards. There is always an agreement amongst our members.

Prof. White—Vice-chancellors, obviously, can always have a disagreement, but they would make a decision. There are a number of eminent vice-chancellors due for retirement this year who are available to take up the position of the chair, should you wish it.

Prof. Wronski—I agree with the thrust of that. With boards larger than 14 or 15 or so, there is a trade-off, as you know, between tightly knit boards and decision-making and broadly representative boards. I think that HWA would be at great risk of making a situation worse if it did not have representation from at least three of the sectors. Medicine, nursing and midwifery and allied health at least, I would think, would bring an understanding of how the systems operate nationally. Without that, I think the HWA board would struggle to

get across the issues. That poses some risk for it. All of us, by the sound of it, want this to work. If HWA, particularly in its early stages, falls over because it has representations from, say, the way medicine or nursing do clinical placement allocation but does not cover areas like pharmacy, speech pathology or one of the other areas, it will result in arm-wrestles and difficulty. In some ways, a political opportunity could be lost to do something terrific.

The board being able to function with the sort of knowledge that is required, that the professions and the education establishments bring to the table, is critical. I can understand the states wanting to be represented individually, and this is a child of AHMAC in a sense, so that is not surprising. Nonetheless, I think there is a trade-off here. If the board is going to be only 13 or 14, then I cannot see a system whereby the states are all represented. If we are going to go for a more representative structure and then deal with the difficulties of having a larger board, that may be the case. But the price of not having adequate on-the-ground knowledge of how clinical placements work across the health professions is too great a price to pay.

Senator FURNER—The proposed act provides for the establishment of committees. No doubt that would provide greater representation and expansion of knowledge to be transmitted back to the board for particular issues, whether it be training, accreditation and so on for the matters that have been raised here today. Would that be acceptable?

Prof. White—Committees are an absolutely necessary part of doing the business, but they are not a substitute for having the appropriate voices at the key table. I would not see them as a substitute; I would see them as an important adjunct to the work of the board. But it is fundamental that medicine, nursing and midwifery, and allied health are represented at that board level; and the vice-chancellors, I would believe, as well.

Prof. Hensley—I had assumed that the committee structure would be under the executive arm of the HWA, not necessarily under the board arm. It would depend upon how that was set up. Go back to the first principle of saying, 'This is a wonderful opportunity to make a substantial contribution and difference to health professional training,' and have the board that represents those best interests, and cover accountability and other matters in a way that is efficient but does not overload the board. That would be the argument we would make.

Senator BOYCE—Professor Hensley, I wanted to ask you about the comment in your submission regarding the need to spell out what professional entry level education should be and the fact that there seems to be a use of professional and preprofessional without perhaps sufficient definition.

Prof. Hensley—Some of that has been clarified in the notes from the minister. I think the understanding that we all now have is that the support will be provided for clinical training related to approved university and TAFE courses for health professional education, and I think the words 'preprofessional' and 'professional' have been interchanged. There is with all the professions, as you know, a series of prevocational and vocational training extending after graduation.

Senator BOYCE—Do we have sufficient definition of the words now?

Prof. Hensley—I should check with Angela as well. I think that has been clarified in the notes to the minister but I think it is very important that we define the clinical training as related to approved and accredited health professional programs based at universities and TAFE.

Senator BOYCE—I think all the submitters currently present have noted the relationships that have been built up over some considerable time between educators and the clinical training placements that they have. Someone has described them, I think, as 'hard won'. What is so special about these relationships that might be threatened by an overweening bureaucracy?

Ms Magarry—I think it is best for Professor White to answer it from more of a practical perspective because she has dealt with the coordination of clinical placements in the past. So I will defer to Professor White.

Senator BOYCE—I am happy to hear from anyone.

Prof. White—Clinical placement has been the rate-limiting step in the number of students that universities can take into nursing programs for some time now, and I know the government is only too well aware of that. It is the reason that we say we cannot take all of the places that have been made available. We have tried as hard as we possibly can to winnow out, where we can, appropriate, reasonable quality placements.

Senator BOYCE—You are talking in relation to nursing at the moment.

Prof. White—I will confine my conversation to nursing and midwifery, if I may. Finding those placements has been a problem that has faced all of the universities, so the universities have collaborated with each other and have collaborated, in turn, with the area health services. If I could give you an example, from Newcastle north in New South Wales, all of the universities, the area health service and some of the private providers have worked together very closely to try and align their practice needs, align their clinical calendars, so that they could absolutely maximise the number of students going through the maximum number of placements that were possibly available within that geographic area. That took a very long time to establish and it is a model that many of the other areas are emulating at the moment.

To have a system go in and then dismantle it would seem counterproductive really, so where there are already fairly strong geographically based models that are working, I think it is really important to keep those where possible, to look within those for best practice and then to emulate those further. I do not think it is being precious to say, 'I'm this university and I've got my picket fence up around this area health service and no-one can come in.' It is not that at all. That would be a strong misreading of the situation. This has been universities collaborating with each other and, in turn, collaborating with both public and private sector area health facilities.

Senator BOYCE—Professor Hensley?

Prof. Hensley—Yes. With medicine in particular, the final two years of every medicine program in the country is spent off campus at a clinical placement, so these are full-time placements. That requires development in terms of recruitment of clinician teachers, recruitment of their training, and review of curriculum quite often. The Australian Medical Council accredits each of our programs. Within that accreditation we can make sure the students leave with the same skills and knowledge, but the achievement of the curriculum may be different if we do it around the New England area, where we operate, compared to central Newcastle in terms of the availability of teachers.

There is a big investment in IT and there is an investment in academic development, but what we would like to see at outer metropolitan facilities—rural, regional and remote—are academics going there to live and stay and work. That development is a major community investment, and the relationship is with that university or provider.

Senator BOYCE—Why couldn't Health Workforce Australia do it?

Prof. Hensley—I think they can facilitate it in the form of funding and some brokerage, but I do not think they have the expertise or the on-the-ground experience and skills to build those relationships. I think they can facilitate them with new providers, such as the private sector and the community sector, and I think they can facilitate that, as with the model of the UDRH and rural clinical school, but I do not think that will achieve the same degree of quality of education and safety, security and flexibility for the students. There is a lot of flexibility entered into on compassionate grounds, where students cannot travel.

There is a very complex operational mode to ensure that students get an excellent clinical training but do so under circumstances that are long lasting and are investments. I think that there would be enormous disruption to break that completely. Health Workforce Australia needs to focus on areas of new placements and innovations, and I think Professor White has mentioned the need for all of us to look critically at curriculum so that we can have similarity in curriculum to minimise an institution having students from three or four places, all having different curriculum. I think that has been achieved quite well with many of the centres, where they have three or four universities participating.

There is a very strong health professional education base for Australia that provides us with great health professionals, and the requirement is for it to be enhanced and facilitated. I do not think it would fare well if it were turned upside down and became a central funded process.

Senator BOYCE—Professor Wronski?

Prof. Wronski—It is regional communities of interest that really drive successful clinical placement programs and it is based on trust and relationships. We have had some experience of this in North Queensland, where we have needed to create health workforce capacity up here. We have needed to expand into new townships and communities. That has meant that communities have had to invest as well, to try to create facilities. With that goes a whole lot of trust in relation to quid pro quo. They have an interest in trying to target health professionals for the future, so many townships encourage rotations. There are quite often outstanding clinical placement opportunities in small townships because of the diversity of clinical material

and so there are a whole lot of networks and trust relationships across these communities of interest that are critical.

There is another dimension to this. If you look at a whole range of different health professions, the network relationships within, say, speech pathology or occupational therapy or physiotherapy or pharmacy are very important in identifying new opportunities and smoothing out the rough bits that happen much more frequently than we care to think about.

How would Health Workforce Australia, which operated at the national level, work on those—I do not know what the percentage is—say five or 10 per cent of occasions on a Sunday night where a student rings up sick or the supervisor of a facility with a small number of people in a rural town gets sick and is unable to take people? Someone takes the phone call and spends several hours fixing it up. Across Australia every Sunday night there are these events.

Senator BOYCE—Particularly after a big weekend!

Prof. Wronski—I cannot see how a national system is going to cope with that. In addition, if you look at national IT systems, there has been something made of the Canadian experiments coming out of British Columbia. I guess there was lots of optimism initially as the IT systems expanded, but one by one in the last few months we have seen professions pull out. In large and complicated provinces like Ontario, the reports back are that even at the state or the province level, they have been unable to allocate adequately clinical placements across different parts of the state. They tried to do it across professions, but the point made to me by a recent visitor, who is looking after that in Ontario, was that they could not even get the nursing schools to agree on how to do it. So even at the province level in Canada, they were unable to do it in complicated situations. Central allocation could well work at a regional level, and you could then uplift data to gather information at the national level, but actually running that allocation in a country as large as Australia, with as much diversity as Australia, is just never going to work.

Senator BOYCE—Thank you, Professor Wronski.

Prof. White—Senator Boyce, if I may add to that, I think within nursing and midwifery we have some doubt about whether the quantum of this job, if it were to be considered centrally, has fully been understood. If I could just give an example: in my last job, which was at a larger nursing school than my current one, we had over 5,000 individual placements every year. That is just one nursing program. When you multiply that out across the country and then across the disciplines, it is mind-bogglingly large when you consider that every one of those requires the individual student understanding, and the placement that they are going to understanding, who is supposed to turn up, when they are supposed to turn up, and what they are supposed to do, let alone when a ward closes because there has been an infection in the ward or some catastrophe, or when the students have some problem. It is the depth of that really one-to-one knowledge that makes it function.

Senator BOYCE—Minister Roxon, in her second reading speech, said:

> For the first time, there will be one single body responsible for the delivery, funding, planning and oversight of all clinical training in this country.

Could I ask for reactions, if that is how Health Workforce Australia pans out?

Prof. White—I think it is a fantastic ideal, and I think that we can go a very long way to meeting what Minister Roxon wants to accomplish. If it is done at a high-level planning and deeply-engaged way, with all of the sectors that are important, and if it particularly is focusing on the planning aspects, and if it focuses also on the means by which it gathers—

Senator BOYCE—Delivery.

Prof. White—accurate data, I think it is not impossible. But it would only work if it takes notice of the sorts of relationships that we have been speaking about this morning.

Senator BOYCE—And includes delivery of all clinical training?

Prof. White—No. It depends how one looks at the word 'delivery'.

Senator BOYCE—Indeed.

Prof. White—If 'delivery' were to suggest, as we have spoken about this morning, that there is a centralised computer in Canberra that looks at individual placements, it is going to be a total catastrophe. But if 'delivery' suggests that there is a known process by which this will happen, and that process is elaborated, then delivery is possible.

Prof. Hensley—I would support Professor White. I think it is a fantastic opportunity. I would support the minister's comments very strongly. The Commonwealth is responsible for the delivery of general practice care in the country, but they do not organise individual patient appointments; there is a decentralised structure. I think the delivery can work through Health Workforce Australia under a model where there is maintenance of regional partnerships and encouragement of partnerships. I think the words can be achieved, but the micromanagement of those placements, we believe, would threaten the current successful—

Senator BOYCE—Thank you. Could I just ask our two witnesses on the phone if they have comments.

Prof. Wronski—Yes. We support the development of HWA. I guess part of this discussion is trying to understand the detail behind the words. There are many partners in this. The Commonwealth role in this around delivery would be to deliver a devolved system that expands on the success of the current system and adds a great deal more capacity. In that sense, the Commonwealth delivering this is a positive step forward. The detail of what that means I guess will be important, but my assumption is that the Commonwealth would not, or should not, consider getting involved in the details of a centralised computer allocation system, where decisions are made at the national level—and there is no historical experience from overseas about where that would work. To the contrary. Nonetheless, the Commonwealth has a very important role in delivery, around making sure that clinical placements are delivered through a comprehensive, distributed model of clinical education that expands on something like a multidisciplinary, rural clinical school.

Senator BOYCE—Thank you.

Ms Stronach—I agree that the establishment of the HWA is a wonderful opportunity to get consistency in funding and also, hopefully, expanding clinical placement opportunities. The caution would be that, as all the participants have alluded to, clinical placement is incredibly diverse. There is a huge amount of work involved in it. There are a huge number of students and a huge number of clinical placement events that take place. It would be tempting, I think, for an organisation that had national responsibility to try and look for efficiencies and impose efficient models that might work in some of the larger disciplines, but would be catastrophic to smaller disciplines and smaller geographical areas. So, yes, it is waiting to see what the detail is of how the work of HWA will be organised. Thank you.

Senator BOYCE—Thank you.

CHAIR—Thank you very much. I would like to thank all the witnesses. I appreciate your time and your ongoing efforts in this area.

[10.33 am]

METZ, Professor Geoffrey Lionel, AM, Member, Committee of Presidents of Medical Colleges; and President, Royal Australian College of Physicians

STITZ, Professor Russell William, AM, RFD, Chairman, Committee of Presidents of Medical Colleges

Evidence was taken via teleconference—

CHAIR—Good morning, Professors. I am so sorry to keep you waiting. It was a combination of my poor chairmanship with the first witnesses and the impossibility of a telephone connection. I deeply apologise to both of you for holding you up. I know, Professor Stitz, you have been through this before. I am not sure, Professor Metz: have you been in one of these inquiries before?

Prof. Metz—Yes, about three weeks ago.

CHAIR—So you know the gig. Professors, we have your committee's submission, thank you very much. We do not want to keep you too long because we know the value of your time, so if either or both of you would like to make an opening statement, we will then ask the senators for some questions.

Prof. Stitz—Thank you very much. You would be well aware that the committee of presidents is the unifying organisation for the 12 specialist medical colleges of Australia, and the medical colleges are primarily interested in standards of care and standards of education and training for the medical specialty vocations, including general practice. We provided a submission because we believe that this whole process has got considerable benefits, and potential problems. We welcome a national focus because we believe that may well do much to resolve some of the challenges that we have as national colleges—in fact, binational colleges—engaging with multiple jurisdictions, and the considerable variation in the jurisdictional approach to some of these issues. So to have a national process which is common across all the jurisdictions is in fact a welcome initiative. We believe also that that may have better planning with respect to clinical placements, and that in turn will benefit the public.

The focus of the bill at the moment is on preprofessional entry clinical training, and obviously as medical colleges we are mainly interested in the training of specialists, so this does not currently concern us directly, although we believe that this is a process which ultimately will do so, and of course it is important in education and training to understand that it is a continuum of training. It starts with the undergraduate degrees but then continues into postgraduate years 1 and 2 and then on into vocational training in the appropriate specialty disciplines. So obviously it is a very important concept to understand.

In our submission you will note that we proposed a number of principles. I will not go through all of these in detail, but I will make some special comments. The first is most important, and that is that any process which involves health workforce has to be predicated on safety and quality for the patients, for the people, and also the standards with which we deliver not only the care but also the education and training, so any training placements must be in the context of those standards. Training numbers are just one element and we would not like to see any denigration of those standards to expedite health workforce matters. Of course, as you well know, the national accreditation and registration process has indicated how important it is to have independent accreditation of those standards.

The universities at the moment obviously have a lot of expertise, but there is no question in the lifelong learning cycle that we need to be integrating with clinical carers as soon as possible. So these clinical placements are very important, particularly in medicine, where we will have doubled the number of medical graduates by the year 2011. The overarching principles of the Health Workforce Australia concept are good in terms of the longstanding relationships, but they must in fact understand that service provision and teaching and learning cannot be separated in the health professions. We actually learn how to be good doctors, in our case, and to develop judgement by being with patients, so it is critical in any education and learning programs that there is adequate clinical interaction with the service requirements—you cannot separate both of those—and the funding for the clinical training component must be adequate.

It is very important that we have common essential educational objectives across all our jurisdictions and all our medical courses, but we do need to allow of course for local innovation. Just a quick word about simulation: we are very supportive of simulation, and we believe that the technological support processes will continue to improve. There are technical and non-technical components for that, and obviously the non-technical components can be simulated currently to a great degree. Technical competence, however, at the

moment with simulation is providing basic or early support for our training programs. Obviously, it has to be put in perspective. We would like to foster that, and do already have considerable expertise in this area.

In summary, we are concerned that some of the wording in this bill may in fact imply that the standards are going to be a function of the Health Workforce Australia concept. I will ask Professor Metz if he would like to comment on the particular parts of the bill that refer to that—namely, (3)(b), (4)(a) and (4)(b) under 'Functions'.

Prof. Metz—Thanks, Russell. Would the committee want to take any more? Would you like me to speak now?

CHAIR—I think so, Professor Metz. If we can get all your concerns out first, that is best.

Prof. Metz—Thank you. We have obviously had a brief opportunity to see this bill. I think everyone is rushing to get these things through. I support all the points that Russell has made in terms of why we are here. It is a very soft line that I have got and I missed the names of people who are on the committee. I do not want you to repeat them all, but I am not sure if any of you or all of you were present when we made our submission on the national registration and accreditation interview about three weeks ago.

CHAIR—Most of us were, Professor.

Prof. Metz—If I could make a quick point, which is maybe a throwaway line but it is worth saying: we are not the AMA. We are not here for industrial reasons. We are here for standards and safety and quality, and that is what I am going to be emphasising. In the outline that accompanies the bill, it says words along the lines that the health workforce authority will encourage:

… best value for money for the workforce initiatives, a more rapid and substantive workforce planning and policy development environment …

We certainly welcome a more rapid and substantive workforce planning and development environment. We understand why people would wish to have best value for money. That sort of wording, though, could easily be interpreted as saying that 'value for money' may mean that we do not necessarily need to have the high standard, highly trained professionals doing the work that has hitherto been done. Obviously, it is not the intention of the government to throw the professional workforce out the window, but there is a potential in the wording there and there is a potential for the workforce authority to use those words to say that, 'Well, we don't actually necessarily need to have highly trained professionals in the workforce.' That is the first point.

The second point that I am concerned about, to go with that, is that if you look at the constitution of the board, there is a chair, there is a Commonwealth member, eight members—one from each state and territory—which totals now 10, and then three others. The three others may or may not be jurisdictional; I suspect that they are not jurisdictional. If we assume that they may be professionals, they would not all be doctors obviously. There may be a doctor and a nurse and a something else. This really means, to my reading of it, that the health workforce authority will have almost no professional input into its deliberations and recommendations.

You may say, 'Well, it's an overarching group and that doesn't matter,' but we looking at that do worry about it because it smacks of changes in the United Kingdom recently where they had a similar statutory authority—and I note in reading the fine print that this will be a statutory authority—called the Postgraduate Medical Education and Training Board. That is a statutory authority which means, according to the chairman, who I had breakfast with about six weeks ago, that it is not able to modify or move around any of its delegations without changes to legislation. It meant that they were really in a straitjacket in terms of what they were able to do and were not able to do, one of which was that they were not, according to their chairman, to interact with the professions. They were to make decisions independent of the professions and at the direction of the UK government. This is a second issue which worries us in terms of the connection between this authority and the professional people who it will be directing.

The third point I would like to make is that it talks about the minister making legislative instruments specifying kinds of students eligible and kinds of clinical training eligible. Again, obviously the minister does not want to make every decision, but the minister will delegate these decisions to what appears to be an authority that will make decisions about the kinds of students that will be eligible and the kinds of clinical training that will be eligible, without actually having professional people on the board.

CHAIR—Thank you, Professor. We do not want to take too much time, so I am going to ask the senators if they have a question each.

Senator CAROL BROWN—Professor Metz, on the point about the membership of the board and whether they will be experts in particular fields, what is your view on the expert committees and consultants that will also be engaged to assist Health Workforce Australia?

Prof. Metz—Reading further down, it also says that the health workforce authority will have the ability to establish subcommittees and it will determine the membership and the terms of reference of those subcommittees. Again, it may be that HWA will establish subcommittees which will have all the expertise and all the professional input that we would wish, but on the other hand it may not.

It is a real concern to us that we are going down the same path that the United Kingdom went down. The former chairman of PMETB, who has just stepped down and become chairman of the General Medical Council, is Professor Peter Rubin. His observation to me was that, under his direction as chairman of the PMETB, because they were in a straitjacket with a statutory authority and did not have professional input into their deliberations—I think they had three professional people in a board of 15, and this looks like the potential for three professional people in a board of 13—they really lost the plot in terms of the direction that they were going in in relation to how they should engage with the professions and how they should train people. His view, which is certainly held by the colleges in the United Kingdom, is that postgraduate medical training in the United Kingdom has gone backwards in the last six years, and they are only now changing the legislation this year.

Senator CAROL BROWN—I think the minister has been talking about the committees being expert committees, so it would follow that they would be professionals in whatever field the committees are being set up. Does that allay any of your concerns?

Prof. Metz—They are welcome words, but one would need to see exactly how such committees were being appointed and how they were constituted. It may allay fears. I am not a paranoid person but I am just fresh from the United Kingdom experience, which has been a disaster for them and could be repeated, depending on who chairs this committee and who constitutes the board.

Senator FURNER—I want to get an elaboration on your comment, both in your submissions orally and in writing, that HWA will lead to better planning and result in better access to appropriate care for the public. Can you expand on that comment, please.

Prof. Stitz—Maybe I should take that one. We believe that at the moment there is a considerable variation in the clinical placements and the clinical exposure that students have and that, by having better planning across the whole of the country, we will produce better quality people and that they will then go on and be better prepared for their specialty training. That is the first thing.

The second thing is that, with the increased numbers of medical students, there is considerable pressure on the clinical exposure that is going to be available to these young people. If we have national planning which looks at that, then we are better able to use all the capacity that we have.

The third thing is that in this process we need to be able to engage the human resources. It is all very well saying that we have considerable funding for this, but the reality is that you need experienced professionals to educate and train the health workforce. There needs to be considerable support and orientation towards the human resources available if we are going to maximise the training, which in turn will produce a high-quality health workforce, and that will benefit the community.

Senator FURNER—When you say it will benefit the community, will it lead to the chronic shortage we have currently?

Prof. Stitz—With the increased numbers, in our case, of medical graduates, there would be a great hope, of course, that we would be able to service the shortfall. As you well know, there are considerable waiting lists around the country, not only for people having operations but also for people being seen in outpatient clinics. By having better numbers of well-trained doctors, hopefully the community will be better served.

That also impacts on the regional areas, which at the moment are underserviced, and there is certainly inequity, so one would hope that this whole process of addressing the health workforce would be looking additionally at the opportunities and the capacity and the ways in which we may be able to encourage clinical placements in the regional areas. There is very good evidence now that, if you can encourage doctors to go to a regional area for their training, a considerable number of those people will in fact stay in that area for their professional life, or at least a part of it.

Senator FURNER—Thank you.

Senator BOYCE—Professor Stitz, I suspect you may be the one to answer this. Your submission notes:

The role of accrediting medical education and training must continue to be delegated to the AMC and HWA must not seek to intrude into, to fetter or to influence the AMC's accreditation functions in any way.

What gives you concerns that they may?

Prof. Stitz—The wording of the bill certainly supports the view that Health Workforce Australia is going to be primarily concerned with education and training, and we do not have any problem with that being fostered by HWA. However, we have put a strong view in previous submissions that in relation to accreditation of standards—both of standards of care and of education and training—it is very important that those accreditation processes are independent of government and of the profession concerned so that the community can be assured that those standards are high and not influenced adversely by expeditious problems in the health workforce. What we are saying is that this whole process has to be underpinned by maintaining the high standards that we already have and we must not compromise those standards by any of these health workforce initiatives.

Prof. Metz—If I could supplement that, I absolutely agree with what Russell has said. If you ask, 'Is there a real danger?' the real danger, if you look at the wording currently, is that the HWA has the ability to go into the area of delivery of clinical training. As I said before, the wording suggests that it can have legislative instruments specifying the kinds of clinical training eligible. That really is getting into the area that the AMC does so very well now.

We interact a lot with professional people in Europe, North America and Asia, and they look to our current set-up with the AMC as really very good, on the basis that it is independent of the profession but it is also independent of government. The potential with the current wording of the bill is that a government agency—a statutory authority—can take this over. The warning bell rings when we see that PMETB in the United Kingdom is a statutory authority which has taken over a lot of functions from the colleges, with some terrible mistakes made that created chaos, not to exaggerate.

Senator BOYCE—Could you give us some examples of that?

Prof. Metz—For example, they took over the placement of trainees into intern positions around the United Kingdom. They did it in such a ham-fisted way that there was marching in the streets from the recently graduated doctors. They produced forms which they thought were very smart, which would give them a new way of selecting interns which would not include their professional results from their undergraduate training. It was a form which enabled them to say what they saw as their future career in medicine, with some very woolly and waffly, wordy questions. In fact, it meant that the students who were doing well in undergraduate training and got high marks were not allowed to put their marks on the application for their hospital jobs. They were not allowed to have referees from the training they had done in the hospitals or in the universities. It was a totally new, greenfields approach which was a disaster. If they bothered to ask the professional people who had previously been involved in placement of interns in the United Kingdom, they were trying to tell them that it was all wrong and would not work, but PMETB said: 'Don't you worry! We know better.'

Senator BOYCE—Your concern would be that that situation could develop under the current legislation that we have?

Prof. Metz—The way it is written, yes.

Senator BOYCE—I wanted to ask you to expand a little on your comments regarding 'the ever-present tension between service provision and teaching and learning', the need for that to be recognised and managed effectively and equitably. What concerns do you have about Health Workforce Australia not doing so?

Prof. Stitz—I will take that one. Currently, some of the jurisdictions believe that their core business is just service provision. In recent times, for example, in Queensland the department of health has accepted the concept that core business also includes education and research. There have been some major advances since that acceptance has been published. The reason for that is that you cannot train a clinician, as I said earlier, unless they are in a clinical environment; and that clinical environment has to be in a service environment. You cannot have effective training which is separated from the service requirement in terms of the clinical component of it. You can learn, obviously, theoretical knowledge from textbooks and the web and so on, and you can learn some of our competencies in the simulated environment, but the reality is that in the health professional groups you can only learn your craft by being in an environment where service is the component of it.

What happens with the pressures on public funding of health is that there is little funding available for the educational component of it and the pressure is always that we have to deliver the service and not concentrate on the education and teaching to the same extent. We believe that in this process there is a golden opportunity for us to integrate and emphasise that the two are integral to each other.

CHAIR—Thank you very much, Professors. I again apologise for the delay that you had to have before we could get you online. We have the department coming to see us later today, so we will ask them some of those questions on your behalf.

Prof. Stitz—Thank you very much.

Prof. Metz—Thank you.

[10.59 am]

LAVERTY, Mr Martin John, Chief Executive Officer, Catholic Health Australia

CHAIR—Our next witness is from Catholic Health Australia. Good morning, Mr Laverty. Welcome back. I know that you have information on parliamentary privilege and the protection of witnesses. We have your submission, thank you very much. If you would like to, make an opening statement and then we will go to questions.

Mr Laverty—Thank you for having Catholic Health Australia appear again before this inquiry. If you do not mind me observing: we are pleasantly surprised that this inquiry exists in the first place. We would have hoped that this piece of legislation was relatively uncontroversial, could have been put to the Senate and all those present might vote yes, because we think this is worthwhile and, in fact, overdue legislation that we are delighted to give our support to.

We offer that support in part because some 12 or 10 months ago we put a proposal to the Australian government to establish what we called a national health workforce commission. We suggested in our policy blueprint that we might establish a national health workforce planning resource. We were looking for the coordination of clinical training across the nation. We were looking for long-term policy planning to advise health ministers around the country on solving some of the shortages within the health workforce. We were also seeking an injection of new funds both to incentivise school leavers into the health workforce and to overcome some of the blockages that exist between education and service providers in managing clinical placements. That was our aspiration some eight months ago. When we look at the drafting of this bill, literally all of those areas are covered, so it would be very difficult for us to give anything but our absolute endorsement to the legislation.

Because we have appeared before this inquiry before, you will be aware that Catholic Health Australia represents some 75 hospitals around the nation. Within our organisations, there are some 38,000 staff. We employ 27,000 nurses and, appearing before you today, we have vacancies or shortfalls of nurses within our own hospitals of about 1,600, so the pressure for our network of not-for-profit hospitals is significant. That pressure around the nation for nurses, doctors, allied health workers and those that are serving the sick and the elderly in our community should not be understated.

We think this legislation goes a long way to remedying some of the problems that are the causes of those shortfalls. Some years ago, education of doctors and nurses in particular was principally conducted in hospital. When that change occurred to teaching of nurses in universities, we perhaps as a community did not put in place the infrastructure sufficiently to manage the training of nurses in universities and their clinical placements in hospitals. That problem has become more obvious in recent years.

We now have a situation where some of our universities that interrelate with our hospitals are saying, 'We, as hospital providers, are not offering enough clinical places.' The universities have in recent times been putting that pressure on the hospitals. They have said that is indeed our problem. This bill, and the funds that are supporting the establishment of Health Workforce Australia, will go a substantial way to resolving that particular issue—that is, the reasons why we have blockages in being able to take particularly nurses on clinical placements into hospitals.

With our endorsement of the bill, there are some questions that we think need to be considered. The principal one is whether or not, in the construction of the governance arrangements for how Health Workforce Australia is going to be overseen, the needs of the non-government sector, the not-for-profit sector, are going to be properly respected in an ongoing manner. The proposal to establish a board to oversee Health Workforce Australia would give, if I am correct, nine or eight board positions to governments from around Australia and then four, if you include the position of chair, to representatives outside government.

It is creating a governance arrangement whereby governments around Australia will still have a very important, indeed a majority, say in the direction that this body takes. That is appropriate. We recognise that it is government funds that are establishing this. But we think one of the opportunities that Health Workforce Australia has is to recognise that it is not just government hospitals in which clinical training is undertaken. Of our not-for-profit hospital network, eight are teaching hospitals. The introduction of this bill and the changed opportunity to access new resources for clinical placements is creating within our hospitals the opportunity to expand our teaching or tertiary hospitals from eight to a larger number. Some of our hospitals are now looking

at this opportunity to expand their teaching facilities because of this very positive initiative that the Australian government and the Council of Australian Governments is supporting.

So within that context we would say to this inquiry that we recognise the need for governments to be represented in the majority of the board that is to be put in place, but we are looking for assurances that the needs of the not-for-profit sector, the non-government sector, universities, colleges, are also going to be properly represented in this governance structure, such that when Health Workforce Australia comes to undertaking its work, it will not simply become another funding stream for state and territory governments to access clinical placements; that there will be a genuine commitment to ensuring that those hospitals, those aged-care services and those community care services, where clinical placements can occur outside of the government system, will be able to utilise the opportunity that Health Workforce Australia is providing.

In referring to aged care, I think that is an opportunity that Health Workforce Australia is also going to open up. Clinical placements occur within some aged-care providers around Australia at the moment. We see an opportunity for many more clinical placements to occur within aged-care service providers. You will be aware that one in nine aged-care beds around Australia is operated by Catholic service providers. We are very interested in ensuring that we can expand opportunities for clinical placements within aged care, and we think the establishment of Health Workforce Australia, the funding that comes with it, provides that very opportunity.

If we do not get the governance structure right and if we do not have a commitment from the establishment of Health Workforce Australia that the not-for-profit sector, the non-government sector, is equally respected in the priorities of the work that Health Workforce Australia is going to undertake, this opportunity could be missed, and we think that would be an opportunity that we can avoid in the way that we establish the governance arrangements for Health Workforce Australia.

There are some things that the bill does not allow for that are still problems that will continue to persist in addressing health workforce needs around Australia. It is not explicit, within the construct of the bill, that there will be a focus on strategies to attract school leavers or people looking for new careers to enter the health profession in the first place. It is inferred in the legislation, in that there is the ability for Health Workforce Australia to develop strategies and to provide advice to the ministers, and indeed, the ministers can then give directions to Health Workforce Australia to undertake certain works. So we are not saying that the legislation necessarily needs to be redrafted to ensure that we are putting effort into attracting people into the health workforce in the first place.

We are also aware that the bill will not necessarily be undertaking the redesign of health workforce positions that we think is so important. We have to acknowledge that we have a scarce resource of people willing to work within our health system around Australia, and indeed around the world. One of the ways in which we can properly solve the challenges that we face is to look at redesigning who does what within our health system. Others do not necessarily share this view. Perhaps those that spoke immediately before me do not necessarily share this view.

CHAIR—Or later today.

Mr Laverty—I would not be at all surprised. But we think that Health Workforce Australia, in the way that it is being established, with the opportunity for it to provide advice to ministers on what is necessary—and, indeed, for ministers to give directions to Health Workforce Australia on where it should be focusing—at a point in time it may be that this body is the forum within which we have this important debate. One of the challenges we have at the moment is that we do not have a forum in which those that have interest in medical training, those that have interest in nursing training, those that have interest in the provision of service, and then, indeed, the consumers themselves, can come together to look at how we properly allocate who does what within the health system. We think Health Workforce Australia has that opportunity, and for that reason we look forward, in the years ahead, to be able to encourage ministers, and indeed encourage the board of governance of Health Workforce Australia, to take that on.

We also recognise that perhaps the most important issue as to why I think we have too few nurses, too few staff available to work in aged care in particular, but also within hospitals around Australia, is pay for health professionals. We note Health Workforce Australia is not commissioned to address that but, again, the drafting of the legislation perhaps gives that opportunity at a point in time to be looking at and considering these issues. In fact, I would go as far as to say many of the arguments that are going to be put before this inquiry will probably relate to some of the outlying issues, or some of the overarching issues indeed, as to why we have a shortage of health workforce in Australia.

Others might criticise the legislation as not trying to capture all of those particular problems. Legislation should not have to do that. It should create a forum, a vehicle—in this case, an independent body—in which all governments will be represented, in which these issues can be dealt with at some stage in the future. We would say to the government, to the Council of Australian Governments, through its sponsorship of this body that is to be established, do not think that the passage of this legislation is the end of the game when it comes to solving health workforce shortages around Australia. This bill is a terrific step, but it is only one component of a very complex set of issues about why we do not have enough people working in hospitals, in aged care and community care today, and why, once this legislation is passed, we must continue to work to address those other issues.

It is our hope—indeed, it is why we put the effort, some 10 months ago, into proposing that a body like this be established—that this in time becomes the forum in which all of these issues can be properly addressed to improve the availability of staff for today and into the future to serve the sick and the elderly around Australia. Thanks, Senators.

CHAIR—Thank you, Mr Laverty. Senators, you have time for one question each. I am just going to say thank you for putting aged care into the discussion, Mr Laverty. It is the first time that it has come up in the submissions we have had.

Mr Laverty—Thank you.

Senator ADAMS—I will ask you about the research side of Health Workforce Australia, a question I asked the group before. In relation to the Australian Institute of Health and Welfare, how do you see them fitting into the research arm of this body?

Mr Laverty—I would hope that it remains, as it is today, an independent entity. But there is a risk that, when you put everything under the one umbrella, you are not necessarily having the sufficient diversity of opinion that I think is healthy in these types of questions to lead yourself to what are sensible solutions. So whilst Health Workforce Australia needs to take on a policy, a research function, I would hope very much that that does not necessarily mean that we are somehow rearranging the responsibilities that the institute has at the moment, and that it can retain the independence and the premier position that it has as the provider of reliable and independent data on health workforce and other issues affecting the Australian community.

Senator ADAMS—Good, thank you.

Senator CAROL BROWN—I want to talk about what effect you think Health Workforce Australia may have on the workforce shortages, particularly in the rural and remote areas. How do you think that going to this new system will assist in that area?

Mr Laverty—We have been in a fortunate position of being able to work with the National Health Workforce Taskforce, and I would like to commend their CEO, Peter Carver, for the way in which he has undertaken a consultation process with the non-government sector, the not-for-profit sector, to provide for us an opportunity to contribute to how the clinical placement structure is likely to operate at the coalface. One of the operational proposals that is being considered is that regions be established to oversee the operation or allocation of clinical placements to government hospitals, to non-government hospitals, and to interrelate with the university and the training system. That provides the opportunity for rural, regional and underserved areas to be properly represented. If regions around Australia are established, and if there is an equitable allocation of resources—and, again, that would be for the board of governance of Health Workforce Australia to properly oversee—we would have a degree of confidence that, by having a new focus on clinical placements in country, regional and underserved areas, this would enable students to undertake their training within those country, regional, underserved areas. As the evidence that was given before me indicated, if a person undertakes their training in a country area, they are more likely to stay or contribute to that particular geographic area. That also opens up the important need for a reporting mechanism to ensure that when Health Workforce Australia reports back to the Australian parliament, through either an estimates process or its annual report-back to the minister, there is a transparency or an accountability in place to ensure that country and underserved areas are properly addressed.

How do you best do that? Our hospital network is broadly represented in parts of country Australia. We have some 550 aged-care providers around Australia. Our aged-care network is perhaps the dominant provider of aged care in country, regional and underserved areas. Our country hospitals, our aged-care providers, are most interested in creating and providing opportunities for nurse clinical placements and medical clinical placements within country areas. That will only be properly put in place if the balance of the allocation of

clinical placements between government and non-government service providers is properly managed and the voice of aged care is very firmly represented at the board table. I have a concern that aged care could very easily be lost in this process, because the needs of doctors, the needs of nurses in urban settings, are very obvious, and that has perhaps been a traditional method by which we have trained doctors and nurses in the capital cities and within some of our own hospitals—the Brisbane Mater; St Vincent's in Sydney and Melbourne—so we are guilty of that to a certain extent. But this is an opportunity for a circuit-breaker, to say that there is a strong network of hospitals and aged care run by the non-government sector in Australia, which are in a position to access the opportunity that these new clinical placements provide, and the only way we will ensure that is if the governance arrangements of the establishment of Health Workforce Australia give proper regard to aged care and country and regional needs. That is the role that we will be focusing on as Health Workforce Australia moves to its establishment and implementation stage.

Senator BOYCE—Mr Laverty, are you suggesting then that Health Workforce Australia should be taking over all planning for workforce or, as earlier submitters have suggested, that their role should be some oversighting and some development of innovative models by Health Workforce Australia in the planning area?

Mr Laverty—If we get it right, that is the opportunity that HWA has. At the moment, the different states and territories and the Commonwealth each undertake their own individual initiatives in attraction, retention and governance.

Senator BOYCE—But you are seeing Health Workforce Australia operating at a high level, not at an individual placement level?

Mr Laverty—I think that if it were to find itself caught up in the detail of the individual placements it would spend all of its time on that and it would be ignoring the goodwill and the infrastructure that already exist to take care of that. The universities, the hospitals and the aged-care providers are properly positioned to oversee the clinical placement allocation around the country and we think the proposal for the establishment of health regions to which responsibility is given for the allocation of places is a model that has a degree of merit. There are some others that we would seek to explore in more detail.

The role of Health Workforce Australia at a national level should certainly be to bring to one place the coordination, the policy planning, of national strategies so that we do not have, as we have at the moment, states competing against each other to attract nurses and, in effect, stealing them from each other. One of the initiatives that we have put in place in this current uncoordinated environment is a program called Nurse the Nation and I would invite you to visit nursethenation.com.au.

CHAIR—Is Nurse the Nation yours?

Mr Laverty—It is a Catholic Health Australia sponsored initiative. It is seeking to provide opportunities for nurses around Australia to find job vacancies and to easily transfer themselves around the nation from one hospital to the other, recognising that the history of Federation means that that is a pretty complicated thing. We have put in place our own arrangement whereby you might, through a very simple website, register your interest in working in another state, and the hospital that is looking to appoint someone with your qualifications then takes care of that easy transfer to get you to that job anywhere in Australia. That is something that the Catholic community has put in place in response to the lack of coordination that currently exists between states, territories and the Commonwealth.

I would encourage all governments around Australia to put a clause or a sunset provision into their own workforce initiatives at the moment and, at a point in time, roll them all into Health Workforce Australia. If we set it up right, if it is given the support that it needs to do the job properly, it provides that opportunity in the years ahead.

Senator BOYCE—I think we have had almost unanimous concerns raised about the structure of the board. How would you propose that the legislation would be amended in that area?

Mr Laverty—Greater balance needs to be given to those who work outside the government sector. Greater balance needs to be given to the university sector. Greater balance needs to be given to private hospitals, to not-for-profit public hospitals, to aged care. There should be an acknowledged provision for a space on the board of governance to address the needs of the aged-care community. If it is not there, it will become the second cousin to the hospital network. The government representation should be in the majority. The majority of funds are coming from government. This is a government initiative. We are not arguing against that, but we certainly think there could be a greater balance.

We are not actually asking for dedicated positions, either. We do not think that would necessarily be helpful. But we would be seeking, in the construct of this board, a greater balance. At the moment there is a representation of, if I am accurate, nine—or, rather, eight government positions to—

Senator BOYCE—Nine government positions.

Mr Laverty—So it is nine government positions to four. That is a two-thirds/one-third allocation and we do not think that provides sufficient balance.

Senator ADAMS—I have a question on the way the board is made up. With the amount of money that is going to be allocated to the organisation, do you think that you should have people with legal and/or financial skills on that board? This is a very complex thing, because you have got representation from the states and territories. We do not know who those people are going to be, whether they are high-profile government officials or how much practical background they have got, and then we have got this one member to be nominated by the Commonwealth and, once again, we do not know where that person is coming from. How do we make sure that the chief executive officer in the day-to-day management has got the financial skills or the legal skills? I just see this as an area competing with your organisation, with all the allies—the nursing, the universities. Should the research arm have a place there? It is getting to be a very heavy type of board and we have really only got those three positions available. I am just trying to tease out where we go with this. What is important?

Mr Laverty—I would not be proposing to this committee that specific portfolios be allocated. I think all of us have experience on particular boards, and it is an unusual arrangement where, particularly in legislation, you say, 'There shall be one lawyer and there shall be one accountant.' I do not think that is necessarily the solution. I have a degree of faith in the ability of the selection process to ensure both a representation of the various interests that need to be on the board and a mix of—

Senator BOYCE—You are suggesting that the states would consult each other on this, Mr Laverty, are you?

Mr Laverty—I would not dare suggest that for a minute! But I have a degree of confidence that the Commonwealth, in exercising its selection power, will give opportunity to ensure there is a sufficient professional skill set. The funds that have been allocated on an annual basis—from memory there is $25 million in year 1 for the establishment of the staff and I think that rises to $35 million in year 2—suggest that there should be the ability to employ sufficient legal counsel on the staff of HWA and to have sufficient financial advice, which will work its way up to the board.

This board should have the job of representing the sometimes diverse—in fact, nearly always diverse—interests of the healthcare community. I think that is the proper role of this board of governance. Is its current proposed size sufficient to achieve all of those interests in the one go? Perhaps not, and there is an opportunity to consider if we need to be reviewing the size of that board. I would not want to leave this inquiry with the suggestion that we want to go to war on that one. I am quite happy, with all of the gains that this particular bill is giving, to live with some of the downsides, and if it is only governance and board positions that might be the concern before this particular inquiry, I would say, 'Vote yes in the Senate and let's get on to actually establishing it. We'll work it out as we go along.'

Senator ADAMS—I do not look at it that way, but the board sets the direction. This board is supposed to start on 1 July this year. If you do not have the right direction, where are you going to go with the rest of it? That is the reason that I have been concentrating so much on the composition of the board, because I have seen boards fail, as you will have, and there has been a reason: because they have been put together too quickly and their role has not been defined.

Mr Laverty—It is for that reason that the only black mark we put against this legislation is whether or not the governance arrangements are right. We think there is an opportunity for a slight expansion in the size of the board, to bring balance to the non-government and not-for-profit sector so that we are properly ensuring this board does have all the representative interests in the one place, and we are then putting faith in the selection process to ensure that the right people are selected, because I do not think you can ever enshrine in legislation the selection process to ensure that you get the right people. That needs a degree of discretion and, indeed, the opportunity for the minister to withdraw a board director's commission if an appointment is made that is later found to be inappropriate.

Senator CAROL BROWN—Health Workforce Australia is about taking a national approach, and you in your submission talk about the perception that state and territory health departments have focused more on

workforce needs or their own publicly operated services than the entirety of the health system and your hope that Health Workforce Australia will see the end of a more narrow, short-term approach. It is great that the federal government has got the states and territories together and that they have come together and signed off on a COAG agreement. In terms of governance, you would understand that there would need to be their stake in that board as well, and to me that is pretty simple to understand, because you want them to stay on board and you want them to implement any changes or reforms across the nation. That brings me to the expert committees, which to me is where you have that opportunity to bring in the professionals that have worked in the area and know what is going on. I suggest to you that at this point in time we obviously need the states and territories to be involved quite closely.

Mr Laverty—I think in my opening remarks I suggested that the nine positions that exist for governments are appropriate, given that that is where the funding is coming from. I would, however, point out that the Catholic sector alone, across our 75 hospitals, has 10 per cent of all hospital beds in Australia. So one in 10 hospital beds is operated by the Catholic community. That makes us larger than some states that are going to have representation around this board table.

Senator CAROL BROWN—That is Tasmania.

Mr Laverty—I wouldn't dare suggest it! In that context, I would be seeking that the board, from its establishment, have regard to the non-government sector, and in that I refer to the for-profit private hospitals and the not-for-profit private hospitals operated by the Catholic Church and, indeed, some other faith based organisations around Australia.

A substantial amount of hospital care—in our case, one in 10 beds nationally—is operated outside of the government sector, so it would be a lost opportunity if we allowed the establishment of a board of directors, and indeed an agency, that was not properly focused on the fact that this large amount of training can occur outside of the government system, with the opportunity for more training to occur outside of the government system.

Again, our discussions and involvement with the National Health Workforce Taskforce to date have given us the confidence that the needs of the not-for-profit sector in an operational sense are currently being considered. The National Health Workforce Taskforce is to be commended in the way that it has gone about involving the non-government sector in its work. I am looking to ensure—and, indeed, looking to enshrine—through the establishment of the governance arrangements that that role for the not-for-profit sector, hospital and aged care is properly considered so that in a few years time you do not have to have people like me agitating to say, 'We got this wrong back in 2009 when we set it up.'

CHAIR—Senator Boyce, you have a couple of questions on notice.

Senator BOYCE—Yes. Firstly, does Catholic Health Australia represent the Catholic private hospitals and the Catholic educational institutions offering health teaching?

Mr Laverty—Within the membership of Catholic Health Australia are 21 public hospitals, 54 private hospitals and 550 aged care providers.

Senator BOYCE—So not the teaching institutions?

Mr Laverty—Sorry, eight of our hospitals are teaching institutions, within which universities, both Catholic and non-Catholic, have a substantial presence.

Senator BOYCE—The question that you may want to take on notice is the number of clinical placements that Catholic Health Australia currently offers.

Mr Laverty—To date?

Senator BOYCE—If you could break those down by profession, that would be good.

Mr Laverty—We will have a go at that.

CHAIR—You do not have those on tap, Mr Laverty?

Mr Laverty—Hardly.

CHAIR—Thank you very much for your submission and your evidence.

Mr Laverty—Thank you.

[11.32 am]

MENZIES-McVEY, Ms Drew, Research and Policy Analyst, Australian Medical Council

CHAIR—I think it is the first time you have appeared before this committee, which is exciting. We have heard much about you. Good morning, Ms Menzies-McVey. Thank you for your attendance.

Ms Menzies-McVey—I would like to thank the committee for the opportunity appear today before you.

CHAIR—Thank you. Information on parliamentary privilege and the protection of witnesses and evidence is available. We have your original submission, thank you very much, and I see that you have provided documents today which the secretariat has just distributed, so we have not read them yet. Would you like to make an opening statement, and then we will go to questions.

Ms Menzies-McVey—Thank you. The background documentation I have handed out relates to the accreditation framework and standards of the Australian Medical Council. They are also available on our website, but I thought they might be useful for you to have in hard copy as well.

I would like to take this opportunity to reaffirm the commitment of the Australian Medical Council to playing a key role and a positive role in the reform process to improve the Australian health system. We have been an active contributor to date on the discussions relating to the establishment and implementation of the National Registration and Accreditation Scheme. We have also been involved in a number of discussions with the National Health Workforce Taskforce in their work. We see this as an important opportunity to drive improvement and to maintain those high standards of education and training and also an opportunity to give stakeholders a chance to contribute to that quality improvement process in maintaining those high standards.

We are an independent national standards and assessment body for medical education and training. We have been established since 1985. We do not have a role in the allocation or management of clinical placements, so our perspective purely comes from that of an accreditation body.

To reiterate our purpose, we ensure that the standards of education, training and assessment of the medical profession promote and protect the health of the Australian community. We have four core functions which relate to that purpose, the first of which is the assessment of medical school courses in Australia and New Zealand, at both the basic medical education level and also the programs for specialist training, and accreditation of those programs against our standards. We assess overseas-trained doctors who wish to practise in Australia. We work closely with the state and territory medical boards with issues related to the registration of medical practitioners and we provide advice to the Commonwealth Minister for Health and Ageing on the recognition of new areas of medical specialties.

With regard to our particular submission related to this draft legislation, we have highlighted a couple of areas of key concern, the first of which relates to the broad scope of the proposed functions. In our view, there are some areas that could be improved with a bit of clarity in the language, and we also recognise that this is a health workforce authority, so it is meant to cross over a number of areas related to health workforce planning and development, not just clinical placement. We would like a little bit more clarification on the relationships with existing or proposed bodies which have similar mandates. We would like to see a recognition of the need for stakeholder engagement and the value that brings to the operation of such a central authority. The composition of the board, in our view, could be better balanced and recognise the need, again, for stakeholder engagement and professional engagement.

CHAIR—That seems to be a common statement.

Ms Menzies-McVey—Sorry to repeat things. Also, we recognise that there is a challenge whenever you are drafting these types of legislation and that you need to have a balance between the powers of the central authority and preserving local good practices, and that is a point we would like to see maintained, as recognising the strengths that exist in the system such as it is now.

CHAIR—Thank you.

Senator BOYCE—On page 5 of your submission you talk about 'all-important ambulatory and community settings'. I must admit I do not understand that use of 'ambulatory'.

Ms Menzies-McVey—Sorry?

Senator BOYCE—In dot point 3, 'Support infrastructure development', line 6.

Ms Menzies-McVey—I would have to take that one on notice and get back to you with more clarification.

CHAIR—What I suggest is that we each have one question and then keep going around. That would be fairest. Senator Adams?

Senator ADAMS—Thanks very much. I was about to explain what 'ambulatory' was, but never mind.

CHAIR—Senator Adams, if you can clarify, for that point.

Senator ADAMS—Yes. This is a term that has been around for quite some time. With community settings and primary care practice, it is about people being mobile, where they can go, how they can get to different services, and the provision of—

Senator BOYCE—It is about walking patients, is it?

Senator ADAMS—Yes. Well, it is anybody that has got problems.

Senator BOYCE—Thank you, Senator Adams.

Senator ADAMS— Disability services comes into that, well and truly. So that is the area that they are looking at. If we could just go to the composition of the board for a start. What would you see could be changed, as far as the composition that is there? The governments have put the money in, so therefore they are going to have a representative of some sort, but we do not know who those people will be, or the expertise that they will bring to the board.

Then we have the teaching side, the university side, the allied health, the nurses and the medical people. There are all sorts of different organisations and education facilities involved that really would like a seat at the table. Then there are the not-for-profits, and aged care has been raised as well. With all those representative bodies that form a very big part of the health workforce, how do you see them accommodated in the structure of the board as mentioned in the bill?

Ms Menzies-McVey—I can only speak of course from the perspective that we have, which is from medicine, so I cannot speak for the perspectives of the other health professionals. Having said that, it would be good, from our perspective, to see representation from both the education and the profession side of medicine; whether it is medical deans, more professional engagement, a voice at the table would be something we would desire. We do not have a strong view on the exact composition or numbers to be allocated to particular professions or to particular expertise, but for us it is key that both the education side—such as the medical deans—and the profession be represented on the board.

Senator ADAMS—If you did not have representation, what sort of process would suit your organisation to feed back up to the board?

Ms Menzies-McVey—I suppose there are a number of ways in which that could be done. Our concern was that in the legislation there was no indication of any way in which it could be done. I suppose one way would be to look at the committees and the structure of those committees and which ones could be organised, either thematically along key issues or professionally. But, again, our concern came back to the fact that the legislation did not actually specify how that engagement would occur.

Senator ADAMS—Good.

Senator FURNER—Some of the other submitters have expressed concerns about changes to the curricula. I am wondering whether your organisation has similar concerns?

Ms Menzies-McVey—Sorry, I am not sure in what sense you—

Senator FURNER—They believe that the HWA may influence, or have some changes, to curricula of their profession. I am wondering whether you have that similar concern?

Ms Menzies-McVey—We support diversity in how medical schools develop their curricula. We set out a number of standards—which you have in front of you—in terms of what we are looking for to develop the safe and competent medical practitioner, but we do not get into the business of prescribing exactly how those curricula should be developed. As long as the standards are met and they can meet the accreditation standards, and the practitioner at the end of the day is competent and fit to practise, that is our position on these issues.

Senator FURNER—So you have had a look at the proposal of the board. Does that give you any concerns at all, in terms of an erosion of the curricula, given the stakeholders that would be involved from each state and territory and the likelihood of up to three additional independents and, additionally, the opportunity for committees to be structured to feed back through to the board? Does that concern you at all in respect of that composition or structure?

Ms Menzies-McVey—Our concern would be that we would like to see the arrangements that exist at the moment continue, where there is a collegial process in which the curricula and the standards are reviewed in a peer review process. There is continuous quality improvement that stems from that process, because the accreditation reports are made public. The assessment teams are comprised of individuals from the profession and from related professions who have an important contribution to make on how those standards are developed, and it is very much a local bottom-up approach to accreditation, to continuous quality improvements, where the needs of that particular college or medical school are taken into account. The one-size-fits-all approach in our experience has not been one that has been particularly well suited to medical education and we would like to see the current arrangements continue.

Senator FURNER—Thanks.

Senator CAROL BROWN—The AMC have a close working relationship with the medical boards in each state and territory, and in your original submission on page 2 you talk about really wanting to know how the relationship with the AMC is going to work with the authority. Have you been involved in any of the consultations that have led up to the legislation?

Ms Menzies-McVey—We were involved in the two consultation forums that were held by the National Health Workforce Taskforce on capturing data related to clinical placements and on clinical governance.

Senator CAROL BROWN—Can you just remind me of when those consultations were held?

Ms Menzies-McVey—I believe they were earlier this year. I do not have the exact dates in front of me. I would have to get back to you on those dates.

Senator CAROL BROWN—The AMC are not the only ones that have indicated that their issue is more about the substance of how relationships would work with Health Workforce Australia, and the connectedness of all the professional groups is not really spelt out in the legislation. Have you any suggestion as to what you would like to see in the legislation?

Ms Menzies-McVey—Again, we recognise that there is a balancing act between having legislation that says too much and restricts the capacity of a central authority to actually deliver on its functions, but also recognising those relationships that already exist. There are no strong views from our perspective. We would just like to see some acknowledgement of the importance of stakeholder engagement, and some mechanisms which allow for the stakeholders' views to feed into the operations of the health workforce authority.

Senator CAROL BROWN—Thanks.

Senator BOYCE—You are pointing out that you have recently been given the accreditation functions for the medical board under the proposed national registration and accreditation system, and yet you are unclear on the relationship and degree of interconnectedness between the changes that are going on in the system. Why is that, Ms Menzies-McVey?

Ms Menzies-McVey—From our perspective, there are a lot of changes that are going on right now in the health policy space. We are not sure what the relationship will be between the bodies that currently fulfil a function related to clinical training and something like Health Workforce Australia. There have also been some new proposals put on the table through things like the National Health and Hospitals Reform Commission, the Bradley review, and the Garling inquiry in New South Wales, which again suggests the establishment of bodies whose mandates would relate to clinical education and training and the quality thereof. This is why it is not clear to us, at this particular juncture, in this transition period, between what is the current system and what is being proposed as the new and improved system, as to what those relationships and linkages will be.

Senator BOYCE—Who would have a clear view of those linkages and interconnectedness, do you think?

Ms Menzies-McVey—I am not entirely certain who does have the clear view. I would hope it would be those people who are drafting the legislation and the people on the National Health Workforce Taskforce, who are about to transition into a central authority, who have a clear view of where they fit into the larger picture.

Senator BOYCE—Our concern from the opposition perspective is that we are not convinced that anyone has a clear view on how this is all going to work out together. You have also mentioned skills interactions with other bodies, such as Skills Australia. Could you talk about how that should work? You do go on to talk about clinical education and training in New South Wales, Queensland et cetera. Where should the flows, coordination and communication be in that system?

Ms Menzies-McVey—Again it is difficult from our perspective as an accrediting body to provide the recipe for how these things ought to work in the best possible way but, broadly speaking, the principles that ought to

govern those kinds of relationships ought to be those of collaboration and mutual respect; recognition of the importance of the contribution from the profession, and transparency between the organisations so that you avoid areas of duplication and overlap.

Senator BOYCE—You also note that there has been only limited stakeholder consultation from the perspective of the AMC. Would you like to tell us what the limitations were and how that might be repaired?

Ms Menzies-McVey—It is more a function of the time line at the moment. It has been limited consultation because it is early days yet and the pace of reform, as you can imagine, is quite quick and we are all trying to get a sense of where it is going and how fast we need to be able to react to any of the initiatives and proposals that are put out there. So with regard to Health Workforce Australia and in particular the issue of clinical placements, the consultations on that only took place a few months ago. There is still a fair amount of work to be done, we understand, from National Health Workforce Taskforce's perspective. It is on their website that they have other issues they want to produce discussion papers and see consultation on. We have not seen those yet because, again, it is early days, so it is a little hard to be able to project into the future and get a sense of what the global picture is, given we are still at that early stage of consultation.

Add to the mix that you have all the initiatives that are under way with relation to the National Registration and Accreditation Scheme and it starts to become a very fast-moving landscape for all of us. We still do not know what is in the contents of the exposure draft for bill B, for instance, and that is another area of unknown for us. Until we have a bit more information on how all this is meant to work we are, like everyone else, waiting to see what will happen next.

Senator ADAMS—Does your organisation use the data from the Australian Institute of Health and Welfare?

Ms Menzies-McVey—I am not sure which areas of our organisation use it most extensively or in what capacity. I will come back to you on that.

Senator ADAMS—As far as your organisation is concerned, how would you see the research arm work through Health Workforce Australia? Research is one of the roles that they are going to play.

Ms Menzies-McVey—We do look at some of the reports and data that get published out of the institute, but again I would have to come back to you in terms of the actual utilisation of their research, what they do and how it overlaps with us.

Senator ADAMS—With the research arm of Health Workforce Australia, would you see a duplication of research with the Australian Institute of Health and Welfare?

Ms Menzies-McVey—I am afraid I am not in a position to comment on that.

Senator ADAMS—You were just talking about the speed with which all this has to happen. Are you aware that the bill establishes Health Workforce Australia by July 2009 and that the management of undergraduate clinical training will take place from 1 January 2010?

Ms Menzies-McVey—Yes, we are.

Senator ADAMS—Have you any comment about how the clinical training will be organised in that short space of time, which is about seven months?

Ms Menzies-McVey—I cannot comment on how the clinical training will be organised. Our concern remains that it is a very tight time frame in which to implement such a huge initiative. Planning for the academic year for 2010 is already under way, so to a certain extent the more information that becomes available earlier on, the better it will be for everyone involved in the process.

Senator ADAMS—Could you expand a little on your last comment about preserving local functions?

Ms Menzies-McVey—It has been our experience that the arrangements between universities and the training providers or the training placements in their region are the ones that tend to function best, because they are able to negotiate at local level and they take into account the particular needs and focus of a medical program. We would like to see that kind of arrangement maintained because it has worked.

Senator ADAMS—How do you see that feeding back to this body?

Ms Menzies-McVey—This is the area that remains uncertain to us because of the way the functions of Health Workforce Australia are described in the legislation. There is a lack of clarity in terms of the level of training that is meant to be covered by this authority and how or if local arrangements will be taken into account.

Senator BOYCE—You noted in your concerns about section 5 of the legislation that there would be a broad range of functions there but there were no mechanisms for engagement with the stakeholders whose roles will relate directly to the HWA. The response to that would be that that will be in the regulations or the instruments underpinning the legislation. What would you like to see in there in terms of providing a mechanism for engagement?

Ms Menzies-McVey—Again, we do not have a strong view on what that mechanism needs to be, but the voice of the stakeholders in the professions needs to be taken into account. We recognise that a lot of the legislation is drafted in such a manner that it just establishes the Health Workforce Australia authority, and the detail remains to be fleshed out later, but it is not clear to us in any way, shape or form at this stage, given the language that is contained in this draft piece of legislation, where and how the stakeholders will be engaged.

Senator CAROL BROWN—Following from Senator Boyce's question: you would like to see consultation on the regulations that might further describe the relationships and how the board would work?

Ms Menzies-McVey—That would certainly be one step in the right direction, yes, and would help clarify a lot of the ambiguity that currently exists.

Senator BOYCE—And my follow-up question would be: what would you see the outcome being if, at some future stage, Health Workforce Australia and the AMC were to disagree about what constituted adequate clinical training?

Ms Menzies-McVey—I am sorry, Senator, could you repeat that? That was a fairly complex question.

Senator BOYCE—Health Workforce Australia will oversee clinical training arrangements. We have had some concerns from a number of our witnesses this morning that this might lead to them wanting to change or adapt clinical training quality or length of training et cetera but to have a view in that space. Given that a strong part of AMC is accreditation work, what would you perceive to be the outcome were there to be disagreement between the AMC and Health Workforce Australia on what constituted adequate clinical training in a specific area?

Ms Menzies-McVey—This comes back to the point that we have made in the submission about being unsure of the relationship between Health Workforce Australia and the national boards that are to be set up under the new Registration and Accreditation Scheme. This is yet another area of ambiguity or lack of clarity where it is not clear what would happen in that kind of situation. If we have been delegated the roles to do the accreditation function, we set the standards in conjunction with the profession and working with those stakeholders that we have traditionally worked with. I do not know what the answer to that question is because there has been no indication of what would occur in a situation like that further down the road.

Senator BOYCE—Nevertheless, it is a fairly important area to get a developed response to, and you have highlighted one of the concerns that we have with the legislation. In the same area of the guiding principles, I was wondering if you might explain a little more what you mean when you express concern on page 4 of your submission about the capacity or the potential for Health Workforce Australia to be influenced by short-term workforce considerations in developing priorities.

Ms Menzies-McVey—The concern there draws a line back to the point we made about the composition of the board and the perspective being perhaps not as balanced as it could be. If you have an organisation that is primarily composed of the jurisdictions, you will get a jurisdictional view on a particular issue. Health workforce involves the jurisdictions, it involves the universities, the training providers, the professions. It is a much more complex and broader group of views and considerations which need to be taken into account in order to deliver on health workforce planning and development. Our concern is that if you only have one particular—

Senator BOYCE—The state departments of health, for instance, would be the people that you would expect to be on this board at the present time.

Ms Menzies-McVey—That is our expectation from the way that the language is drafted.

Senator BOYCE—What is the outcome of that likely to be, in your view?

Ms Menzies-McVey—There is always the possibility, when you have a heavy jurisdictional government representation, that you have more of the government representation in whatever decisions are made and how those decisions are taken into account. It comes back to the issue of stakeholder engagement and where the stakeholder views get taken into account—at what point and at what stage of the decision-making process. For us it has always been important to have the profession engaged from the very beginning and to have our

stakeholders engaged in every step of our process. This is, again, not clear in the draft legislation, such as it is crafted, and our concern would be that, if you have a health workforce authority, you need to take into account all of those stakeholders who have a say in how health workforce development and planning takes place.

Senator BOYCE—There might be the argument put that, 'Well, what does it matter? If short-term workforce needs are being met on a regular basis, what does it matter?'

Ms Menzies-McVey—True, that argument can be made. It has been our experience, though, that it is better to also plan for the medium and longer term because any decisions you take in the short term can have repercussions down the road and it is better to have that planning in place.

Senator BOYCE—Thank you.

CHAIR—Thank you very much, Ms Menzies-McVey. If there are more questions that come out when we have a look at the further document that you have given us, we will put them on notice for you.

Proceedings suspended from 11.59 am to 12.16 pm

KEARNEY, Ms Gerardine (Ged), Federal Secretary, Australian Nursing Federation

THOMAS, Ms Lee, Assistant Federal Secretary, Australian Nursing Federation

CERASA, Mrs Debra Y, Chief Executive Officer, Royal College of Nursing, Australia

McLAUGHLIN, Ms Kathleen, Director, Professional Services, Royal College of Nursing, Australia

CHAIR—I welcome representatives from the Royal College of Nursing, Australia and the Australian Nursing Federation. You have information on parliamentary privilege and the protection of witnesses and there are more available from the secretariat if you require it. We have your submissions. Thank you very much. I would now like all of you or any of you, if you want to make an opening, to do it now and then we will go to questions. Most of you are very experienced at this, so you know how it operates. Would you like to start?

Mrs Cerasa—Thank you for inviting us here today.

CHAIR—It wouldn't be a show without you!

Mrs Cerasa—Thank you. We, obviously, continue to support the position that we presented in our submission and reiterate that, as the peak professional organisation, ours is a global perspective on the issue of clinical placement. We have made a number of comments within the submission, but could I just quickly dot-point the significant key points we would like to reiterate or highlight.

One is the experience of clinical placement for nurses and midwifery students and how we continue to inquire into that, and request that the experience for that clinical placement is a worthwhile one, because it does influence the careers of these young professionals. Simulation training is talked about considerably. Whilst we recognise the benefit and certainly the advancement in technology with simulation training, we would want that to be a supportive or conjunctive type of training model and be supportive of clinical on-site training and not an 'instead of' proposition in any way, shape or form.

The clinical placement issue definitely links into continuing professional development for nurses and how that will link in with continued placement models and we would like to see how that links in for nurses. Also, we were interested in the structure of the NHWA and the professional representation in that model. We feel that there needs to be certainly a very strong education/academic and professional/clinical representation within that body.

CHAIR—Is that on the board, Mrs Cerasa?

Mrs Cerasa—Yes.

CHAIR—So it is particularly on the board?

Mrs Cerasa—Particularly on the board. We felt that we would perhaps like more dialogue or discussion or input into how the current model is structured. There was still some clarity that we were seeking around that, in making sure that there is certainly very strong nursing education and clinical representation on that board. That was a very quick summary.

Ms McLaughlin—Leading on from the point that Debra Cerasa has made in terms of the experience of the clinical placement, we feel strongly that the development of the workforce is shaped by the experience of the clinical placement and that, where there are significant workforce shortages in nursing, they can certainly be addressed through, in part, the quality of the clinical placement. For example, evidence shows that a poor experience by an undergraduate will influence their decision to work or not work in that area following graduation; therefore, there is a high need for adequate financial support for the resources to ensure an adequate and valuable clinical experience and that there are some quality measures, such as demonstrable positive outcomes, from the clinical placement—whether it be through quality indicators or performance indicators, that there be some measure of the quality of the clinical placement.

There has been a suggestion that funding follow a student in terms of choice of clinical placement. We would propose that any model that is developed up does not create a market driven process whereby there is a higher cost where there is the highest demand for placements; therefore, where there is the lowest demand, there would be possibly a lowest cost in terms of how adequately resourced those clinical placements are. We are just concerned about any equity issues that may be associated with that.

CHAIR—Ms McLaughlin, can you explain to me 'demand' in that sense. Is it that an attractive placement would be more expensive? We talk about aged care in this committee all the time and getting nurses into aged care. Would it be if there is a great demand for placement in aged care but it is often hard to fill?

Ms McLaughlin—It works both ways. There may not be a high demand for aged care if it is not well resourced, therefore it will be a lower cost. It is that reflection.

CHAIR—Sure.

Ms McLaughlin—Also, if there is any differential in costs between the professions for clinical placement—for example, the cost of a nursing placement versus the cost of a medical placement versus the cost of an allied health placement—will that influence health services in what placements they offer in terms of the financial benefits? We have concerns around that.

And the last point—this is more of a question I suppose—is that we seek clarification on whether TAFEs are considered Commonwealth supported Australian tertiary institutions and make a recommendation that the bill include appropriate specifications relating to institutions and clinical learning that will be funded. Clinical learning within TAFE programs requires financial support. Div 2 nurses are educated in the TAFE sector; therefore, we are just looking for confidence that their clinical placements are also captured here.

Ms Kearney—In the interests of time, our presentation is going to be made by Ms Thomas, but just briefly, I think the cost of clinical placements is an important issue, because economies of scale come into play. If you are a large hospital, you have lots of resources and it is much easier to arrange a large number of students. If you are a small facility—for example, an aged-care facility—it is very difficult and it needs a lot more resources.

CHAIR—And none of that detail is in the bill.

Ms Kearney—No.

CHAIR—So that is the kind of thing you want fleshed out.

Ms Kearney—Yes. I think that is an important question.

CHAIR—Sure. Ms Thomas.

Ms Thomas—Thanks very much. There are three issues that we would like to raise from our perspective. Firstly, we understand the function of Health Workforce Australia, but we are concerned that from time to time, it says in the bill, the ministerial council may confer additional powers or functions on Health Workforce Australia.

CHAIR—You are a bit worried by that, are you?

Ms Thomas—Yes. To be frank, there are two issues at play here, I think. One is that currently we have a range of organisations or agencies set up that deal with issues to do with health workforce and health professionals. For example, we have the new national nursing and midwifery boards that will be set up under the registration and accreditation schemes; we have the Industry Skills Council—and I will talk a bit more about that; there are rural clinical schools. A whole range of organisations are set up. If additional powers were to be conferred upon Health Workforce Australia—or functions, I should say—what will be the connection between existing bodies and Health Workforce Australia? There is nothing in the bill or the explanatory memorandum that gives us any hint about that. That is the first point.

The second point is: what might those additional functions or powers be? Certainly, from nursing and midwifery's perspective, we are very proactive and try to keep abreast of what is happening with the professions at the higher level. We would want to be involved in some sort of consultation around what those additional powers or functions were, and certainly want some reassurance in the bill that that would occur, that there would be some connection between the professions and a range of stakeholders and organisations that are already in existence.

Our second issue goes to what Mrs Cerasa has raised also, and that is board composition. We do believe quite strongly that there must be health professionals at that level on that board. We understand that the board is currently composed of around 11 people. We would be looking to up that to probably a maximum of 15 for a good functioning board, and add in health professionals—one from medicine, one from nursing and midwifery, one from allied health, at a minimum. It is really important, I think, that we are there at that level. We also think in the composition of the board that there should be somebody from education as well. I digress. I apologise.

The third issue that we would like to raise is something that we have put in our submission, which is that Health Workforce Australia, we understand, in the first instance will be focusing on the higher education sector. Nurses are also trained in the TAFE or VET sector. We would want to see where the connection is

between Health Workforce Australia and other sectors that provide educational preparation for nurses, and certainly one of the issues that the Industry Skills Council has done quite well is that at all levels in that process they have included health professionals, even to the board level. So it is about external stakeholders: it is about unions, it is about including the industry, and of course that goes to our issue again about consultation. They are really the three big issues that I would like to raise.

CHAIR—Senators, everyone will get one question and then if we have the time we will go around again. I am sorry, Senator Adams. Senator Adams has a particular interest in your area, as you know. There could well be questions on notice from her.

Senator ADAMS—Yes, I have got lots. I will start with the research side, Ms Thomas. How do you see the Australian Institute of Health and Welfare working with the research arm of Health Workforce Australia?

Ms Thomas—I do not know that we have given it any consideration. But if you are meaning in regard to the data collection—

Senator ADAMS—Duplication really is what I am getting at.

Ms Kearney—That is a good point, because currently, as you know, the AIHW get data from the nursing registration boards. The problem we have with that data is that it is very old.

Senator ADAMS—It is very old.

Ms Kearney—One of the major problems with data collection for the AIHW's currency—and I am not quite sure why it happens—is that we certainly have not had any data since 2005 on the workforce currently. So you raise a very good point. I think if there were to be any data collection that came from the registration boards, there would have to be very good links between AIHW and a body that is planning for workforce. You cannot plan for the workforce if you do not know how many you have got currently.

Senator ADAMS—That is exactly right. That is the reason why I am asking the question.

Ms Kearney—Absolutely. You are as flummoxed as we are really about the current situation, and it is something that needs to be addressed.

Senator ADAMS—That was a short one!

CHAIR—You can have one more. You can have two each.

Senator ADAMS—Coming back to the composition of the board, there are eight members—one from each state and territory—plus one Commonwealth person, so there are nine government people. Who do you think would be the representative from the various states and territories? Have you got any idea of who that person would be?

Ms Thomas—To be frank, we assume that they will be bureaucrats. From my reading of the bill in its current form, I do not think it gives any specificity—

Senator ADAMS—No, it does not.

Ms Thomas—around who those people might be. We assumed, maybe wrongly, that they would be bureaucrats. What we are saying is that, irrespective of who those eight people are, there should be state representatives, but we need to have consultation, we need to have representation from the health professionals as well.

Senator ADAMS—That was the next thing I was going to say. You have got the chair—we do not know who that person will be—and then you have got your eight government people. You then have up to three others. As you can imagine, all of our witnesses have come along and said, 'We think we should have a seat at the table.' Being involved with health organisations practically all my life, I know the feeling: you do not like missing out. Another thing is mix of skills. With such a large budget, do you feel that there should be someone with perhaps financial skills, or legal skills, that would take up one of those three positions?

Ms Thomas—Certainly we think that there is benefit in having some of those members who have legal skills or financial skills that assist in the operational functioning of Health Workforce Australia. We have some of those models already set up in some of our state registration boards, so in nursing and midwifery that is not a new phenomena, and having some of those skills is often helpful around the table.

Senator ADAMS—The board oversees the role of whatever the CEO and the day-to-day management do, and they have to set the direction. This is the reason why I am asking that question—to see if we have enough expertise on that board on the practical side, the people with all the experience plus the government

appointees. That composition is concerning me, but of course we have not got much detail. The board is going to be set up by 1 July 2009 and the actual undergraduate clinical training commences at the beginning of January 2010. Could you comment on the time frame?

Ms Thomas—I am happy to comment. July 2009 is next month, isn't it? It does seem that that is very quick. Maybe it can occur, but certainly then to implement a system whereby there is involvement in clinical placement in six months hence does seem very quick.

Senator FURNER—Regarding your concerns in relation to statistical gathering of information, we have been fortunate enough to have been provided with the submissions of the department this morning in attachment A. On that point, in clause 5(1)(b), the submission states:

This provision is intended to cover functions other than funding—for example, including establishing an IT system, statistical analysis to support planning and the promotion of clinical training opportunities to non-traditional areas such as aged care facilities.

Does that alleviate your concern of the previous issues that you had concerning statistical deficiencies in the current organisation?

Ms Thomas—Can I just reframe your question. Are you asking whether the implementation of a new data system will help with the collection of data?

Senator FURNER—That is right.

Ms Thomas—One of the issues in relation to clinical data is the distribution and timeliness of it. Whatever works to get that information collected, analysed and available to be used in a timely fashion would be acceptable to us.

Senator FURNER—In your submission you indicate:

The ANF does not support the imposition of artificial barriers to entry into a profession that create shortages that have the effect of significantly boosting earning capacity …

Can you drill down a bit further into those issues that concern you?

Ms Thomas—I think that was a statement around wanting to promote any agency or any organisation that adequately plans and implements good health workforce numbers now and in the future. One of the issues of course that we have faced is workforce planning being often done at the state level, and having an instrument or an agency such as Health Workforce Australia to coordinate planning and education around health workforce is terribly important to us.

CHAIR—Mrs Cerasa or Ms McLaughlin, do you have any comment on that?

Mrs Cerasa—I think we are in agreement with what Ms Thomas and Ms Kearney have said.

Senator CAROL BROWN—You have indicated in your submission that you do welcome a coordinated approach regarding a number of issues relating to Health Workforce Australia, and you acknowledge the situation that we are currently in, where there has been:

… little or no co-ordination or leadership resulting in a massive and growing shortage of appropriately skilled and qualified health practitioners.

Your concern about the membership of the board is one that has been stated here on a number of occasions today, and we have also talked about expert subcommittees. I wanted to know your view on that. Also—when you talk about that—the issue as I see it is that there is no information currently before us that can satisfy you that the membership of the board is going to be able to do what it is setting out to do, and we currently do not know what the subcommittees are going to be charged to do or the membership of that committee. Have I got that about right?

Ms Thomas—Yes. There is very little evidence before us from the bill about the composition and how things are going to work. If you are saying that there has been some evidence before you that subcommittees could be set up in order to overcome some of those concerns, we do not necessarily have a position on that, but the issue in a global sense is that, if Health Workforce Australia is set up to deal with health workforce, health professionals should be on the committees and on the boards, where appropriate, to assist with that process.

Ms Kearney—If your question is do we think a subcommittee will suffice, no, we think that there still needs to be professional representation on that main board as well.

Senator CAROL BROWN—Of course, there are three other independent people to be appointed, and this committee does not know who they will be or where they will be from, or if they will be from the professions at all, so we do not have that information before us. Some of this information will ultimately be put in the regulations. From what you are saying, you would like to see some consultation around regulations that are put in to support this bill.

Ms Thomas—Most definitely, and consultation at all levels, even after Health Workforce Australia is set up and working. You cannot cut the professions out of this.

Senator CAROL BROWN—What I would want to ask you is what 'consultation' means to you.

Ms Thomas—It is involvement. It is—

Senator CAROL BROWN—What would you like to see?

Ms Kearney—That is interesting. First, we would like to have somebody there actually on the board—that sort of consultation, with professional representation on the board. Second, if there are reference groups set up, discussing regulations, we would like there to be lots of discussion—even input from the different nursing bodies about that. We would be very happy to go on committees and we would be very happy to man reference groups, if that is the way it goes. The usual consultation mechanisms would flow on from there. But certainly in the first instance we would like to be at ground zero, so to speak.

Ms McLaughlin—My only point—and it is probably reiterating the obvious and the well known, and certainly the reports capture it—is in relation to the data in terms of nursing: the greatest number of clinical placements, clinical hours and numbers of undergraduates. The nursing significance is great, and I do not need to labour it.

CHAIR—The sheer volume?

Ms McLaughlin—Absolutely.

Senator BOYCE—My initial question is directed to Ms Kearney and Ms Thomas. Your submission, obviously, states that you have significant concerns about this bill and you have gone on to say that you:

… will object publically and campaign against these provisions if they are pursued in the current form.

What minimum change would you require to this bill for it to be acceptable and for you not to feel obliged to campaign against it?

Ms Thomas—Really it is the issues that I have addressed very briefly. It is about the role and function of Health Workforce Australia and, in particular, the additional powers that may be conferred upon them. It is about the composition of the board. Please, it is important: if this is about health workforce and health professionals, health professionals must be there. We do not want to end up in a situation where there is a body that deals with our professions and we do not have a say over it.

They are terribly important to us. We have had similar concerns about national registration and, of course, we have been able to make some change to the powers of the ministerial council in respect of their nursing and midwifery standards. We would like to see some movement around those additional powers and functions and about consultation and board composition.

Senator BOYCE—You have also noted perhaps an unusual conflict of interest when you talk about a deliberate attempt, apparently, to stop external stakeholders being involved at board and other levels in Health Workforce Australia. But, of course, the most self-interested group of all are the state and territory departments of health, who are the only people guaranteed a seat at the table. Would you like to expand a little bit more on where you see the conflict with these people, as the principal employers in the field, being the only voice in the organisation.

Ms Thomas—It goes to what I previously submitted in evidence, which is the issue about having a range of people who have an interest, but may not be health professionals, sitting at that level. I think it goes to the same point.

Ms Kearney—There may be workforce constraints, budgetary constraints et cetera, that force employers to make decisions that we, as a profession, feel might lower quality, for example, of education or of care that can be given, and we would like to avoid that situation if possible.

Senator BOYCE—I note that the department of health submission on the subject talks about ensuring best value for money for the workforce initiatives, which of course is an extremely good goal as long as it is bound up within a very strong governance situation.

Ms Kearney—Absolutely. That is a concern of ours.

CHAIR—Thank you very much for your submissions and for your evidence today. Do you have things you want to put on notice, Senator Adams?

Senator ADAMS—Yes, I have lots that I am working through.

CHAIR—She will get them to you as quickly as possible. We are due to report on this one this coming Tuesday, so it is tight, but then the debate will happen in the chamber and all the information you give us will be able to be used in that debate. Thank you very much.

[12.45 pm]

HOUGH, Mr Warwick, Senior Manager, General Practice, Legal Services and Workplace Policy, Australian Medical Association

SULLIVAN, Mr Francis, Secretary General, Australian Medical Association

CHAIR—Welcome, Mr Sullivan and Mr Hough, from the AMA. I know you have information on parliamentary privilege and the protection of witnesses. We have your submission, thank you very much. Would either or both of you like to make some opening comments. We will then go to questions. You know that we always have questions!

Mr Sullivan—Thank you very much once again for allowing us to appear. On behalf of our new president Dr Andrew Pesce, I extend his best wishes too. In summary, the AMA welcomed the COAG announcement back in 2008 about the health workforce package. We believe it made a lot of headway towards addressing the challenges, particularly the commitment to lift funding for undergraduate clinical training.

From that perspective, we are supportive of the extra funding that the health workforce agency will bring. We welcome the fact that the funding made available through the agency will support much more undergraduate clinical training to take place in the community. This will better utilise available infrastructure and will mean that available training opportunities better reflect the reality of how healthcare services are delivered and the growing burden of complex and chronic disease.

We do, as you would expect, have a number of concerns in relation to the bill as it is currently drafted. Essentially, they come down to the fact that the bill does not clearly specify the role of the agency; it allows the Minister for Health and Ageing to establish many of their functions via regulation, the details of which we have yet to see. The bill does not give any comfort to the various health professions—as you just heard from the previous presentation—that they will have a role in the activities of the agency.

As it is currently drafted, the bill could allow the agency to interfere with the accredited undergraduate medical education courses for the use of funding conditions, the overall placement coordination et cetera. It could expand its role into the prevocation specialist education training. It could exclude the profession from input into workforce planning and reform activities. In the context of other health workforce reform measures that are presently before you in other settings, it is at least fair ground for us to have concern over the encroachment of another agency into the whole accreditation field.

We know already that Australia has a renowned system of medical education, and it is built on accreditation arrangements that are independent of government. We consider this to be the gold standard, and it means that the role of the agency should be focused on activities that boost our capacity to deliver training according to these standards, rather than lowering the benchmark, or in some way having a role in setting standards, or having a role in how those standards will be applied. We do not think that the Senate should reject the bill outright, but we do think the Senate should seriously consider amending the bill, so that it preserves Australia's high standards of medical education and ensures an ongoing and meaningful role for the various health professions in the activities of the agency.

It is interesting to note that, in the department's submission, it gives clear assurances that the agency will not interfere with accredited training courses, nor will it try and set standards for clinical placements, but the submission also says that postgraduate education is out of the scope of the agency. Given these assurances are not in the bill, we would humbly submit that it could fall to this committee to recommend that amendments in the bill could go to make sure that those assurances are there. Thank you.

CHAIR—Mr Hough, are you going to make any comment at this stage?

Mr Hough—No, thank you.

Senator ADAMS—Thank you both for appearing. I would like to go to the composition of the board. We have earlier had evidence from your old organisation, Catholic Health Australia. They raised the issue of the not-for-profits and for-profits, non-government agencies, and also aged care. Again, as have most witnesses before us today, they have said that they should have one of the three positions available. We have got one Commonwealth position, eight members from states and territories, which we presume will be—definitely, I would think—bureaucrats because of the funding that has gone in, an independent chair and up to three other members. So could you give us an idea on who your organisation thinks these new three members should be?

Mr Sullivan—The first principle I think you recognise—and clearly the others have as well—is that the engagement of the health professions, not only at the governance level but at the health workforce and planning processes, data collection and decision making, is essential. Like everything, when you have only got three spots up for grabs, everyone will think it is theirs. The truth of the matter, though, is that this agency has the potential to do a lot of good, and at the same time has the potential to undermine what is already good, and the undermining is particularly in the areas of standards setting, particularly in the area of how courses are conducted in local situations to adapt to local circumstances so that there is diversity, and we think that is of value.

Just quickly, the medical profession was involved in the past in an established workforce planning process called AMWAC. It was subsequently wound down. There is the Medical Training Review Panel whose future now is uncertain. We support the AMA, through its junior doctors as well as the AMA more broadly, and we have concerns there that the medical profession's input could be at risk in the planning process. So, of the three, I think we could have a strong case that the medical profession could have one. I understand the concern around the representation of for-profit and not-for-profit and aged care—and I wish them well in pressing their case, because there is probably one to be heard—but in the context of what we are talking about, the medical profession, I would think, would need to have a place on the board. But certainly—and I am sure it is echoed by my friends behind me—we need to also have very established, collaborative working arrangements over the planning processes per se.

Senator ADAMS—It is terribly important for the success of the board that the board sets the role and direction of where the whole organisation is going, and if that is not right from the start we have got huge problems with it. So the next question I would like to ask you is that, if there is no position on the board, how would you see your input—or input from all agencies—coming forward to the board so that they can use the expertise that is out there—and there is an awful lot of it—wisely?

Mr Sullivan—I will go to the first part of your commentary, which is that the bill is not very clear on the criteria on which a lot of operational matters will be progressed. I think this is why it is so difficult, even for the department—and it says this in its own submission—to give you a comprehensive analysis of the bill and its implications, because there are many questions we have around the overall influence of the agency, particularly when it says it is part of workforce redesign and reform and advice and planning and function. What does that mean? We have seen this through the whole national registration and accreditation process; that there is, whether wittingly or not, the potential for bureaucratic processes to actually interfere with established accreditation processes. So, firstly, the governance arrangements need to be based on clear direction from the legislation, which we do not believe is there. Secondly, I think the board would need to be charged to put in place a transparent planning process which is about engagement, not just collaboration in the broad or consultation at a conceptual level but, rather, the protocols of how consultation will occur with the various professions in a mutual way. I think that is important. Thirdly, the accountability of the agency along those performance indicators should be clarified in the regulations.

Senator FURNER—Notwithstanding your concerns expressed about the composition of the board—and I would be surprised if that is not the case with every submitter that appears before this inquiry—HWA will be empowered to apply and establish expert committees. I imagine people like your own organisation or previous witnesses would be in a position to be on those committees and provide more appropriate information to feed back up through the board. This is not dissimilar to what happens on many other boards. Does that alleviate your concern of not having a voice, if you were to be one of those players on the expert committees?

Mr Sullivan—Board governance obviously instigates committees for various interests that the board has, but in the first instance, the health workforce agency, it appears, will have a fundamental role in planning the workforce needs, and that in itself is a core governance activity. Certainly, it may put aspects of that to committee work, but in the instance as a function, we would have much more comfort if we were part of the formal governance arrangements, because we are talking about the workforce into the future.

We already know, through previous government decisions, that there are going to be more medical graduates by 2012 and we want to make sure that not only is there adequate training in the undergraduate space but clearly in the postgraduate, the post-medical school period, for medical education. I do not think it would suffice to simply be on an expert committee that may get heard at the governance level, depending upon the other competing interests.

Secondly, and it goes to the first question, the board is primarily populated by state governments. State governments primarily have an interest in public hospitals. We would not want to see that the public hospital

interest overcomes the other genuine interests in the health system. As we said earlier, general practice, community settings, community nursing settings, the evolving way in which we are going to have to manage chronic disease and the evolving primary care rollout and reform are not found in public hospitals.

Senator FURNER—I guess it comes down to the number of people and that will be the issue here with the number of stakeholders. It is so broad and far-reaching that you cannot possibly imagine a board consisting of complete representation across the whole of industry. That is the reason why—once again, not too dissimilar to other boards—there is the establishment of committees to provide that information back to them to make sure their position is heard and dealt with.

Mr Sullivan—If we are just brainstorming it, there is no set magic number for board members. We have seen some very successful boards with greater than nine people or greater than 12. It comes down to how well they function, how well they are led and if they stick to their core business, which is a question for the committee generally.

Senator FURNER—Exactly.

Senator BOYCE—Mr Sullivan, we have had a lot of concerns across what is going to go in the regulations and that we do not have a clue how this is all going to function until we see the regulations, but I note that you say:

The Bill does not provide a clear definition of clinical training ...

Is that something that could go into regulation?

Mr Sullivan—It is clearly a hope it would be at least in regulation but one wonders whether it should not be brought into the bill more properly because it is fundamental.

Senator BOYCE—Is it a fundamental?

Mr Sullivan—It is a fundamental issue if we are talking about workforce. Warwick, you might want to say some more.

Mr Hough—What we have suggested, rather than try to define 'clinical training', is that there be some provision in the bill that requires Health Workforce Australia to recognise accredited clinical training—that is, accredited by the relevant accrediting body. That is the approach we suggested, because clinical training takes place in a wide variety of settings, and putting forward a definition may not pick up some of the granularity between different professions and different settings.

Senator BOYCE—We had a conversation with the Australian Medical Council before about what would happen if there were disagreement between the two bodies on what constituted accredited training. The answer is, 'No-one knows.' My other question—and I think you started to touch on this earlier—related to your comment in your submission:

There is now deep suspicion about the workforce agenda being pursued by the states and territories through the NHWT—

which is about to go out of existence for the HWA. Could you explain to me what you mean by that comment?

Mr Hough—To give you an example, up until 2006, as Mr Sullivan discussed, there was the Australian Medical Workforce Advisory Committee, which was involved in workforce planning and research related to the medical profession. There were similar bodies established for nursing and other professions. As a result of the Productivity Commission recommendations, that body was wound up in 2006. It had broad stakeholder representation and engagement around workforce planning activities. Those responsibilities were taken over by the National Health Workforce Taskforce. As a profession, we have not been engaged in almost any further workforce planning activities, other than some discussions around clinical placements in the last couple of months.

Senator BOYCE—I can see from behind you that the Nursing Federation shares this view, from the head-nodding going on, Mr Hough.

Mr Sullivan—We are always at one on these matters.

Mr Hough—From that perspective, NHWT is a creature of the jurisdictions. Whatever it is doing is a mystery to us at the moment, and obviously it is very much driven by—we think, anyway—the jurisdictions' agenda, which is primarily linked to public hospitals and their role as employers in those public hospitals.

Senator ADAMS—The bill says it is required to establish HWA by July 2009 and to ensure it is operational within the time frames agreed and the COAG national partnership agreement. They are also going to

commence management of the undergraduate clinical training from January 2010, which is seven months away. Can you comment on that?

Mr Hough—As we understand it presently, the National Health Workforce Taskforce is carrying on the work that will ultimately become the function of Health Workforce Australia. What level of engagement they are having with stakeholders around clinical placements, funding and so on is still unclear, and what resources they have to do that is not clear either. From our perspective, it is a very ambitious time frame for the bill to establish the authority and then allow it to get on with its work. Our preferred approach, given that current arrangements are working relatively well, is that in the interim we get the bill right and make sure it has the right operational basis to move forward. Whatever means there are in the meantime to get the extra funding into clinical training, the government ought to examine that. Certainly we need to get the bill right, given the importance of the issue.

Senator ADAMS—Do you have a research arm associated with your organisation?

Mr Sullivan—Yes, we have research.

Senator ADAMS—This body, of course, is going to have a research component to it. How do you see how that will fit in with the Australian Institute of Health and Welfare and the other research sectors throughout the profession? Most of our organisations do have research to a point. A lot of the data that is available to them from the national point of view is very old, not up to date. Could you just make some comments about how you see the research side of this can work.

Mr Hough—The relationship is unclear at the moment, but the AIHW, which does collect much of the data, whilst it has its limitations, is regarded as doing a much better job over time. But what relationship it has is unclear. We think the HWA should work with and support bodies such as the AIHW to improve their data collection, which is very important for making sure we have reliable future workforce planning.

Mr Sullivan—The last point is important. As we mentioned, when there were earlier processes where the medical profession was involved in workforce planning directly, there was a degree of confidence in what was coming out of those considerations. You would expect that. Here we will have a situation where, firstly, if you are not directly involved in the governance and planning of the research and therefore in the implications it brings, that in itself will not help with the application of what the findings are.

Secondly, the frustration many people have at the moment is the supply question. How do you actually define the number of bodies on the ground that are needed in particular areas, particular craft groups or whatever? The concern we would have is that other agendas, which sometimes are being driven by more short-term needs of a workforce nature, can prevail and become the orthodox view, when all that is needed is a more considered strategy so that a better balance of the workforce can be achieved. That sounds like rhetoric. It is not meant to be. It is simply saying that it is another reason why there needs to be a very direct engagement, at least of the major professions, in the governance level as well as the planning level of the processes.

Senator ADAMS—Thanks.

CHAIR—Mr Sullivan, Mr Hough, can you put on record the consultation that you have been involved with in this process?

Mr Hough—We have certainly been invited to provide a submission, which we have done.

CHAIR—Yes.

Mr Hough—And we have also welcomed the opportunity to appear before the commission today.

CHAIR—My understanding is that the department will tell us the consultative processes that have taken place over the last few months, and you have added to your submission some papers that you have submitted to letters that were sent out through other parts of the consultative process. Exactly, from your perspective, how has the consultation worked?

Mr Hough—To clarify, firstly, the material that we have attached relates to consultations undertaken by the National Health Workforce Taskforce.

CHAIR—Yes, which was the precursor of this one, is my understanding.

Mr Hough—Precursor of this body. They have released two discussion papers around clinical training. One was to do with governance, and the other one was to do with data collection. The consultation process has involved an invite for submissions and attendance at one forum—

CHAIR—One forum.

Mr Hough—in relation to those. There were forums organised, obviously, in different capital cities. Essentially, we were given an opportunity to provide a submission and a face-to-face opportunity to participate in a forum around that. Given the important nature of the questions in those discussion papers, had NHWT been much more rigorously involving the professions in a governance level, and in terms of forming expert committees to look at some of these issues, that could have been a much more robust process.

CHAIR—To the two letters that you have attached, did you get responses?

Mr Hough—I understand that there has been a paper released in response to the discussion paper on data collection around clinical training. As yet, I am not aware of any response from the NHWT in relation to the governance arrangements for clinical training.

CHAIR—Thank you very much.

Mr Sullivan—Thank you.

CHAIR—The committee is going to adjourn now for a few minutes.

Proceedings suspended from 1.10 pm to 1.17 pm

COLE, Ms Natasha, Assistant Secretary, Workforce Development Branch, Department of Health and Ageing

WINFIELD, Mr Craig, Director, Workforce Reform Section, Department of Health and Ageing

FLANAGAN, Ms Kerry, First Assistant Secretary, Health Workforce Division, Department of Health and Ageing

CHAIR—You have information on parliamentary privilege and the protection of witnesses. As departmental officers, you know you shall not be—well, we try not to—asked to give opinions on matters of policy, though this does not preclude questions asking for explanations of policy or factual questions about when and how policies were adopted. I now ask all of you or any of you if you would like to make an opening statement, and then we will go into questions. I assume that you have been watching the coverage today.

Ms Flanagan—We had somebody in the room, who has reported on what has been going on.

CHAIR—Good. After you make an opening statement, we will go to questions, but it would probably be useful to go through some of the questions that the witnesses have raised so that we can get an immediate response. That would just make sense. Do any of you have an opening statement?

Ms Flanagan—No, we do not have an opening statement. We put in a submission.

CHAIR—Yes, we have got that, thank you very much.

Ms Flanagan—We do not wish to make an opening statement, thank you.

CHAIR—We will go to Senator Adams, then I have a note of some questions here and then we will go to Senator Boyce. We will try and tick off some of the questions that have been raised today for the department.

Senator ADAMS—I am going to start on the governance issues, as that seems to be the biggest problem that has arisen: the composition of the board and the up to three other members that may be appointed and where they might come from. As far as the eight members from the states and territories, do have you any idea at what level or who they might be?

Ms Flanagan—I will start. The governance board is exactly that, it is a governance board, so it is there to be a management board for the agency, to ensure that the agency carries out its functions appropriately. There is always the issue, as you would know, that everybody would like to be a part of this, but really we need to have a board that is workable, and trying to have everybody represented on the board is just not going to work. As I say, it has a different purpose, and that is to make sure that the agency runs effectively.

Allowed for in the legislation are a number of expert committees that will look at particular aspects of the work of the agency, and we would see that as providing an avenue for more representation from organisations to put their views into the workings of the agency through a committee structure rather than through the board structure. In terms of the representation from states and territories, I understand they are going to be the health CEOs of each jurisdiction.

Senator ADAMS—Each jurisdiction?

Ms Flanagan—Yes.

Senator ADAMS—Coming back to the committee structure, or the expert advisory committees if we can call them that, how do they feed back into the board? Do they feed through the CEO or through the board chairman?

Ms Flanagan—I think in the first instance they feed back through the CEO, but Ms Cole might have some more information.

Ms Cole—That is right. In the first instance they would report to the CEO, but it is intended that they would be providing advice to the board, where relevant, on issues relating to the clinical training subsidies, for example.

Senator ADAMS—Would they be appointed by the board or by the CEO?

Ms Cole—It does not specify in the legislation who does that appointment process. We imagine that the board would do that appointment process, on the whole.

Senator ADAMS—So the board would make a decision as to what expertise they needed to be able to carry out their role?

Ms Cole—That is right. We would probably have some standing committees on the issues that are particularly relevant to the activities of the agency. For example, you might have a standing committee on the clinical training subsidy and another standing committee on day—

Senator BOYCE—Who would set up the standing committees? Who would decide what issues required a standing committee?

Ms Cole—I imagine that the CEO and the board will have that discussion. As I mentioned earlier, the legislation does not specify who sets up the committees.

Senator ADAMS—How would you describe this board? Would you describe it as a representative board or as—something I have been tossing around today—a mix-of-skills board as to the actual budget and the relationship with the CEO and the day-to-day management? Would you have anyone on the board with financial expertise or legal expertise?

Ms Flanagan—That is exactly the purpose of the board. It is a governance or management board, and we want it to make sure that the $1.5 billion under its administration is effectively utilised. So we would be looking for a skill mix, for people with perhaps backgrounds in accountancy or law et cetera. It is not a representative board.

Senator BOYCE—That would be for the other three positions?

Ms Flanagan—CEOs of health departments can often have that, but there is also—

Senator BOYCE—No, it was just a question.

Ms Flanagan—We would be trying to find a balance between, I suppose, expertise and those sorts of skills so that it can be a management board, and we also of course have the position of independent chair.

Senator BOYCE—What do you mean by 'a management board', Ms Flanagan?

Ms Flanagan—They are responsible for the activities of the agency.

Senator BOYCE—How does that differ from some other board?

Ms Flanagan—The other sorts of boards are advisory boards, where legislation—

Senator BOYCE—Yes.

Ms Flanagan—The advisory board does not have responsibility for the functions, for example—

Senator BOYCE—No, but this is not an advisory board.

Ms Flanagan—No, it is not. You asked me what other sorts of board structures there could be.

Senator BOYCE—Yes.

Senator ADAMS—This board is really setting the role of the agency and ensuring that it carries out the directions of the board.

Ms Flanagan—Yes.

Senator ADAMS—That is really its purpose to start with.

Senator BOYCE—Have positions been advertised for it?

Ms Flanagan—No, not at this stage. We need to talk to the minister, and ministers, about how we are going to go about that, but I imagine we will be going out there and asking for people that might be interested in—

Senator BOYCE—Aren't we expecting it to be functioning in three weeks?

Ms Cole—No. We are hoping to have the legislation passed within a timely period so that we can set this organisation up. It needs to be up and running in a substantive sense by the end of this year.

Senator BOYCE—I understood that you wanted the board functioning from 1 July. That is not the case?

Ms Cole—No.

Senator ADAMS—It would be established by July.

Ms Cole—Yes. We need to get the legislation passed before we can appoint any members. That is the timing imperative.

Senator ADAMS—You would not be advertising for the independent chair. The only positions would be those up to three positions.

Ms Cole—And the CEO.

Senator ADAMS—Yes, but the CEO is not a member of the board.

Ms Cole—That is correct.

Senator ADAMS—I am only talking about board members at the moment.

CHAIR—Any more questions on the board?

Senator BOYCE—What consultations did you have around board composition with interested stakeholder groups?

Ms Flanagan—We have had many and varied stakeholder groups indicate that they would be interested in being on the board and we are in constant contact with, as I say, many of the stakeholder groups who have indicated an interest. In terms of the getting the board settled, it will be trying to find, I suppose, a skills mix, expertise et cetera that will be brought to the board. Certainly we have been in consultation with many in the sector about this issue.

Senator BOYCE—How many stakeholder groups expressed satisfaction with the proposed composition of the board?

Ms Flanagan—That will really be determined about who is on the board, Senator.

Senator BOYCE—I am sorry?

Ms Flanagan—That will really be determined—

Senator BOYCE—No, how many stakeholder groups that you spoke to said, 'We're happy with the proposed composition of the board'?

Ms Flanagan—We are talking about, I suppose, the size and the number of people on the board rather than the composition of the board.

Senator BOYCE—The structure of the board, then.

Ms Flanagan—Yes.

Senator BOYCE—I think you are aware, Ms Flanagan, that there was almost universal objection to the fact that it is so dominated by governments at state, territory and federal level.

Ms Flanagan—As I say, there is $1½ billion under administration through this.

Senator BOYCE—Yes, but—

Ms Flanagan—We believe that the expert committees—

Senator BOYCE—who thought the composition was good?

CHAIR—Please wait until Ms Flanagan finishes her answer.

Ms Flanagan—We thought that the appropriate way to get input from key stakeholders was through the expert committee structure rather than on the board itself. As I indicated to Senator Adams earlier on, there are many stakeholders that want to be involved in this, and we welcome that involvement, but actually trying to find positions on the board for everybody would mean that we would have an unworkable and unwieldy board structure. We think the way to do this is as expressed in the legislation—through expert committees.

Senator BOYCE—However, you must have received a lot of objections, did you not, to that perceived structure?

Ms Cole—We have had some comments about wanting to have representation in the structure as a whole.

Senator BOYCE—What I am asking about is not whether people wanted to be on the board but whether they liked the structure that you were proposing. Were there not comments, not simply saying, 'We'd like to be represented,' but, 'We don't think this is a good structure'?

Ms Cole—There have been some comments from some stakeholders that they would like a board which had a representative of their profession on it. I think that has been in part a misunderstanding of the role of the board and the other structures within the agency that can provide that important stakeholder and expert opinion that is needed to make this agency work correctly.

Senator BOYCE—What about the view put this morning—which I do not think was confined to the AMA but perhaps best expressed by the AMA—as a deep suspicion of the agenda of the states and territories to simply preference public hospitals and no-one else through this organisation?

Ms Cole—Are you suggesting that some stakeholders believe that only subsidies will be available to public hospitals? Is that what you are asking?

Senator BOYCE—I am saying that the AMA expressed a view held by, I think, every stakeholder we spoke to this morning, of deep suspicion of the agenda of Health Workforce Australia, given that its board is comprised almost completely of states and territories whose only interest in the health area, from the perspective of these stakeholders, is in public hospitals.

Ms Cole—I think the whole purpose of the clinical training subsidy arrangements is to bring other sectors into the pool of potential training providers for undergraduate students and for prevocational students. The clear kind of ambit of the organisation is to make sure that there is adequate clinical training and that that clinical training occurs within a wide variety of settings so that it actually reflects where people will work afterwards, so they are as work ready as possible. If you go back and have a look at the original policy documents, it is very clear that one of the main roles for this agency will be to look to a wider group of providers of clinical training, and that will be the objective of the states and territories, as well as the Commonwealth and any other board members, because it is accepted that it will be impossible to meet the growing number of students using solely the public sector as the provider of clinical training, and that it does not provide a good educational opportunity.

Senator BOYCE—Are you suggesting then that the stakeholders who spoke here should take comfort from the fact that all the clinical funding cannot go to the public hospitals because they do not have the capacity to expend it?

Ms Flanagan—I think, again, referring back to the functions that are specified in the act that the board will need to carry out whatever its composition, it is talking in the broad around providing financial support for the delivery of clinical training for the health workforce. While there may be a suspicion that it occurs in public hospitals, I think all of us agree and know that, for example, the majority of surgery is now performed in private hospitals, and their remit is to ensure that we have a trained, ready workforce right across all settings, including public hospitals.

Senator BOYCE—They are all my questions on the board.

Senator FURNER—No doubt there has been some criticism today expressed about the numbers and the composition of the board, but I accept the point you have raised here today—you cannot have everyone on that board. No doubt that is the reason why you have decided to look at expert committees. Some of the issues that have been raised about curriculum, training and accreditation, are they matters where you would be seeking to have expertise on those committees to provide feedback through to the board for resolution?

Ms Cole—Yes, that is right. Basically, this agency needs to work in conjunction with the universities and the accreditation agencies and the service providers, so we need to have all of those three parties in place and engaged in the discussions.

Senator FURNER—Who do you perceive will be the person or persons charged with the appointment of people to those expert committees? Is that a task of the board?

Ms Cole—Yes. We did get a question about this earlier. The legislation does not specify who the committees will be set up by, but we envisage that it would be a CEO and board discussion.

Senator FURNER—There has been criticism also levelled today about the number of board meetings, being I think a maximum of three per year. Is that correct?

Ms Cole—A minimum of three.

Senator FURNER—That is a minimum. I think most boards meet monthly or every six weeks. That is a possibility, isn't it?

Ms Cole—It is, indeed, a possibility, particularly during the first year, two years, while everything is being established, so I would imagine they would meet much more frequently than that.

Senator FURNER—Just going back to the committees for a moment, I imagine that they will be meeting, equally, around the same period of time to provide relevant information to the board. They will have tasks to perform and reports to be given to the board to deal with.

Ms Cole—It will depend a little bit on the nature and function of each of the committees. For example, one of the functions of the agency is to do some workforce modelling—supply and demand type modelling. That committee might meet much less frequently, for example, than the committee on clinical training subsidies or

a committee on general sort of educational issues, because the data fed into the agency might only be every six months or so and their work will be around their workload or the possibility of change, rather than necessarily tied to every single board meeting.

Senator FURNER—I take it that it would be appropriate for the board to make sure that certainly not each and every stakeholder but a fair representation of stakeholders would be on those expert committees.

Ms Flanagan—Without pre-empting what the board might do, that is exactly what we would be looking at. It would be the only sensible thing to do, to get the best outcomes.

Senator FURNER—Thank you.

Senator ADAMS—I would like to come to research by the board as one of its functions. I have been asking questions about the Australian Institute of Health and Welfare, which provides a lot of the data that possibly the research arm of the board would be providing. How do you envisage working with that organisation?

Ms Cole—There is a little bit of a chain, which I will describe to you, if that is all right?

Senator ADAMS—Yes.

Ms Cole—As you would be aware, the National Registration and Accreditation Scheme will be developing a very good set of workforce data, which is updated on a regular basis, for all the registered professions for the first time ever. We are currently discussing with the AIHW about the data from the National Registration and Accreditation Scheme being sent to the AIHW and deidentified. The AIHW would then basically be the holder of that data, because they have legislative provisions in place around secrecy and privacy, which are very stringent and well respected within the sector. They would then produce a series of reports, similar to those that they already produce, which are available to everyone around the medical labour surveys and so forth.

Senator ADAMS—Yes, I am fully aware of their work. I was just trying to work out how they all fitted in.

Ms Cole—Yes. The other thing they will do is send that deidentified data to Health Workforce Australia, who will then be able to use it for planning for demand and supply purposes, which is not a role that the AIHW currently has. So the AIHW will be in the middle of the train of data, if you see what I mean, will be the custodian of that data, and will continue to provide to stakeholders and to governments the standard reports that they do now, which give us a good picture of the current workforce.

Senator ADAMS—Then that would be portrayed to these various committees, would it? I can see an awful lot of duplication, if you have got the medical people doing their own data as to where workforce shortages are, the nurses are doing it and the allieds are doing it. There is an awful lot of expertise out there that really is going to have to be collated and brought forward, and this is why I am trying to see how you are going to get to the end result.

Ms Cole—Yes. The AIHW basically has expertise in telling us what the current situation is. What we are hoping will develop in Health Workforce Australia is expertise around projections and demand analysis and supply analysis, which is a kind of an art to some extent because you are forecasting. That work is not currently done in any cohesive way across all of the professions, because the basic data is not available at present to give us the time series that we need in order to do that data. It is a fairly new role that the Health Workforce agency will be taking on, and it reflects the availability of this new dataset that we have not had in the past.

Senator ADAMS—What concerns me is that HWA, as stated in the minister's second speech, is to commence management of undergraduate clinical training from January 2010. This is really why I am working on this research thing: to see where the shortfalls are with the workforce, and how the organisation is going to be able to commence with the undergraduate clinical training in such a short time frame of seven months.

Ms Cole—I expect that the research part of the agency will develop over time, because the datasets are not going to be available from the National Registration and Accreditation Scheme until it is up and running on 1 July in any case. So I expect that the research function will lag a little bit behind. The clinical training subsidy deadline that you talked about is the subsidy going out to service providers, so it is a slightly different activity.

Senator ADAMS—So they are just going to continue on as they would have, but be overseen by Workforce?

Ms Cole—Clinical training is currently happening, as you know. It will continue to happen in the next academic year, of course. The difference will be that providers will get a subsidy for that clinical training activity which they are undertaking at present.

Ms Flanagan—As Ms Cole has said, we need to keep winding these out. We have got an imperfect system at the moment, but we now have the capacity to improve that, and that is what we are going to do. So we will not have the perfect system next year from 1 January 2010, but we now have the capacity to develop it much better and to refine how we identify where we need to put the places.

Senator BOYCE—Could I just ask some questions regarding the regulations that are going to underpin this? A number of witnesses pointed out that they could not comment in certain areas until they had seen what the regulations are. What stage are the regulations at?

Ms Cole—Are you referring to the regulations under the section of the subsidies, relating to the subsidies?

Senator BOYCE—No. I am referring to all—I imagine more than one lot—of the regulations which will be needed to underpin the bill. For instance, there is no definition of 'clinical training' in the bill. There is no clear view of who does what. There is a large degree of confusion apparently within the industry at the moment as to which bits Health Workforce Australia are going to do and what other people are going to do. I have no idea which particular regulations I am talking about, but I am talking about the regulations that will assist this legislation to function.

Ms Cole—There are only a couple of regulations that are envisaged in the act, and those are to do with defining the eligibility for the clinical training subsidy.

Senator BOYCE—Yes.

Ms Cole—Basically. there are two elements of eligibility: one is which students themselves are eligible, and the other is which courses are eligible.

Senator BOYCE—So they are the only proposed regulations?

Ms Cole—At present, yes.

Senator BOYCE—Have they been developed?

Ms Cole—There is some work being undertaken by the National Health Workforce Taskforce. They have begun some consultations around the clinical training subsidy arrangements, and part of that discussion will be, in essence, who should be eligible. In the end, though, this is a decision under the legislation. The minister has to make a regulation in consultation with her state and territory colleagues, as it is a fairly significant decision, as you can imagine, which affects the majority of funding administered by this agency. The minister will have to have that discussion with her colleagues within the next six months.

Senator BOYCE—So who decides on regulation? Is it the ministerial council or—

Ms Cole—Yes. The minister must consult with the ministerial council before she makes a regulation.

Senator BOYCE—I take from that that consultations are occurring now with stakeholders and that the regulations will be in force within six months.

Ms Cole—Yes.

Senator BOYCE—So when would you expect to have them finalised?

Ms Cole—That will depend a little on the progress of the bill, the structure of the board, the board being put into place, and when the ministerial council is available to have that discussion.

Senator BOYCE—So the board would be involved in discussions around the regulations?

Ms Cole—I imagine that the board would want to express some opinions about that. It is a decision for the ministerial council and the minister as to whether they took those opinions into account.

Senator BOYCE—And the consultations that are going on at the present time, what is their time frame?

Ms Cole—There were a series of consultations generally around the clinical training subsidy and how that might best be delivered and rolled out.

Senator BOYCE—Within regulation?

Ms Cole—No, in general—how it might be financed and how it might be administered. I understand that the National Health Workforce Taskforce is planning on putting out a summary document of those consultations in the next little while.

Senator BOYCE—A 'little while' being?

Ms Cole—It is not a body run by the department, so it is difficult for me to tell you what their time frames are.

Ms Flanagan—But what we could do is to speak to them and see whether they do have a time and we can let you know.

CHAIR—Ms Flanagan, can we get from the department a one-pager setting that all out—how the regulations are to be developed—

Ms Flanagan—Yes.

CHAIR—and the expected time frame? The questions you have just answered for Senator Boyce, to have those clearly defined would be very useful for the committee. It reflects a longstanding concern of this committee about legislation coming before us regularly without the supporting regulations and then expecting senators and members to make decisions based on unknowns. It certainly has not been something that is peculiar to this parliament. It goes back for at least several parliaments, and we always try and put it on the record. It has been raised by numerous witnesses that one of the key issues they have with the legislation before us is that there is nothing in it. So if we could get that in a clear statement, it would be very useful.

Ms Flanagan—Yes. We will do that.

Senator BOYCE—There was one other issue that I wanted to discuss. The Australian Medical Council in evidence said that, should they and Health Workforce Australia have different views on what constituted accredited training, there is currently, in their understanding, no view as to whose views would prevail. What is the department's response to that?

Ms Cole—The Australian Medical Council, as the appointed accreditation agency under the National Registration and Accreditation Scheme, will always have the final say.

Senator BOYCE—I am sure they will find that encouraging.

CHAIR—Senator Brown, do you have any questions?

Senator CAROL BROWN—I just wanted to follow on from your comment, Chair, about being provided with a time line. Also, you talked about stakeholders being consulted. Is it possible to have a list of the stakeholders that are being consulted?

Ms Flanagan—Again, we can ask the task force that has been carrying this out whether they are happy to provide that and, if they are, we will get that to you.

Senator CAROL BROWN—We have had people here today that were looking for some answers because they felt that there is not enough information currently before us.

Ms Flanagan—I am flying off to Sydney today, to talk to people about this legislation and Universities Australia tomorrow, so we as the Commonwealth are also out doing consultation, as well as the task force. We are trying to involve the stakeholders in this and hear their views. That was done before the legislation was drawn up in its current form as well, so we can let you know who we are consulting with as well, if that would help.

Senator CAROL BROWN—Yes, please. I understand there were a series of consultations. Some of them are mentioned in here today. But the main issue was about wanting to know how expert committees were going to be set up, who the three independent committee board members were going to be and where they might come from. They are the sorts of concerns we have been hearing here today.

Senator ADAMS—Where would consumers fit in? Would they be an expert group? They are a very important part of this whole structure of health workforce—consumers of health workforce treatment. What feeling do you have about that? Have you thought about them?

Ms Flanagan—We always think about consumers, because we are consumers of the health systems ourselves.

Senator ADAMS—That is right.

Ms Flanagan—We agree completely that there needs to be a consumer voice in all of this. It may be possible that that is represented on the board, again, if a consumer also has a particular skill set that we might be requiring. I would imagine that the board would look to have, where it is important to do so through the expert committee structure, consumers' views represented on those committees.

Senator ADAMS—Cancer Australia is a good model. When they started off, they were not sure about consumers at all, but it is amazing now that all their expert advisory committees have a consumer voice on them. Hearing them speaking at estimates, we know how much input they do have, so I would like to flag that.

The other thing is that TAFE has been mentioned today. The states would be still covering the training with TAFE, would they?

Ms Cole—Yes. At this stage, TAFE courses, unless they are university level, would not be covered by this agency, but it is possible that over time they might be.

Senator ADAMS—The university-level ones would be?

Ms Cole—That is right. There are one or two TAFEs—I think one in Victoria and one in the Northern Territory—which provide bachelor level qualifications; and they would be.

Senator ADAMS—It is a little bit confusing in that respect, but because you have representatives from each state and territory I thought they would probably be feeding back the input from there.

CHAIR—Any further questions?

Senator BOYCE—I have one which I think I mentioned earlier, but I am not sure if I got a complete answer to it. It was a concern—I cannot remember which body it was—that there was no definition of 'clinical training' in the bill. Is there to be in the regulations?

Ms Cole—I think what the regulations will specify is which courses are eligible and which students are eligible. Defining 'clinical training' in itself is in a sense part of the job of the universities and the accreditation agencies. It is not really the role of this organisation, because it is tied up with quite complex issues around competencies and skill levels, and what can be done in a classroom situation and what needs to be done through practical experience. We are not envisaging that this agency would be responsible for trying to tie down a clinical training definition in the way that you might be envisaging, because it differs quite significantly from course to course and profession to profession.

Senator BOYCE—The other concern from a lot of the health professional bodies, given their lack of representation at board level, was about the interconnectedness, communication overlaps et cetera between their activities and Health Workforce Australia and other bodies that might undertake training, such as Skills Australia and others. What were the mechanisms for managing this?

Ms Flanagan—I think the reality of doing business in Australia these days is that there are often many organisations or agencies that interact. You are asking: should there be a communication across them? That does make some sense and we can certainly take your suggestion back to the agency.

Senator BOYCE—I think the reason that this was raised by these organisations was their concern about how big the footprint of Health Workforce Australia in the sector was to be and whether, because of their superior resources et cetera, it could in fact take over the work of other groups in the area, rather than interact with the groups.

Ms Flanagan—We note the concern, thank you, Senator.

CHAIR—Ms Flanagan, Ms Cole and Mr Winfield, thank you for your submission and also your evidence. We will be in contact with the department immediately if some more questions on notice arrive.

Ms Flanagan—Thank you, and we will get that information to you.

Committee adjourned at 1.55 pm