The Senate

Community Affairs Legislation Committee

Australian National Preventive Health Agency (Abolition) Bill 2014 [Provisions]

Health Workforce Australia (Abolition) Bill 2014 [Provisions]

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44th Parliament

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Chapter 1

Introduction

1.1 On 15 May 2014, the Senate referred the provisions of the Australian National Preventive Health Agency (Abolition) Bill 2014 (ANPHA) and the Health Workforce Australia (Abolition) Bill 2014 (HWA) to the Community Affairs Legislation Committee (committee) for inquiry and report by 14 July 2014.[1] These bills were referred separately and are reported in separate chapters.

Conduct of the Inquiry

1.2 Details of both inquiries, including a link to the bills and associated documents, were placed on the committee's website.[2] The committee also wrote to 59 organisations and individuals, inviting submissions by 6 June 2014. Submissions continued to be accepted after that date.

1.3 The committee received 17 submissions for the ANPHA inquiry and 22 submissions for the HWA inquiry, which are listed at Appendix 1. All submissions and the transcript of evidence may be accessed through the committee's website.

1.4 The committee held a public hearing on 2 July 2014 at Parliament House in Canberra. A list of witnesses who appeared at the hearing is at Appendix 2, and the *Hansard* transcript is available through the committee's website.

Human Rights

1.5 The Parliamentary Joint Committee on Human Rights considered that both bills do not appear to give rise to human rights concerns, however, did note that the bills may be seen as engaging the right to health.[3]

Acknowledgement

1.6 The committee thanks those organisations who made submissions and who gave evidence at the public hearing.

Note on References

1.7 Reference to the committee *Hansard* is to the proof *Hansard.* Page numbers may vary between the proof and the official *Hansard* transcript.

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1 *Journals of the Senate*, No. 29—15 May 2014, pp 818–819.

2 See: http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs

3 Parliamentary Joint Committee on Human Rights, Examination of legislation in accordance with the Human Rights (Parliamentary Scrutiny) Act 2011, Bills introduced 13–29 May, 2014, Legislative Instruments received 8 March–30 May 2014, p. 4, 28.

Chapter 2

Australian National Preventive Health Agency (Abolition) Bill 2014

Australian National Preventive Health Agency

2.1 The Australian National Preventive Health Agency (ANPHA) was established by the *Australian National Preventive Health Agency Act 2010* as a component of the National Partnership Agreement on Preventive Health. The objective of this Council of Australian (COAG) initiative was to establish preventive health infrastructure.[1]

2.2 The ANPHA's main functions were to:

(a) provide evidence based advice to federal, state and territory health Ministers;

(b) support the development of evidence and data on the state of preventive health in Australia and the effectiveness of preventative health interventions; and

(c) put in place national guidelines and standards to guide preventative health activities.[2]

2.3 The ANPHA was primarily focused on preventive health programs that target lifestyle risk factors including obesity, and alcohol and tobacco use.[3]

Purpose and key provisions of the Bill

2.4 The Bill seeks to abolish the Australian National Preventive Health Agency and transfer its functions and programmes to the Commonwealth Department of Health (the Department). This will reduce duplication of functions and reintegrate essential on-going functions currently undertaken by ANPHA within the Commonwealth Department of Health.[4]

2.5 The key provisions of the Bill are as follows:

(a) repeal the *Australian National Preventive Health Agency Act 2010* (Part 1);

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1 National Partnership Agreement on Preventive Health, COAG, 2008, http://www.health.gov.au/internet/main/publishing.nsf/Content/phd-prevention-np, accessed 26 June 2014.

2 National Partnership Agreement on Preventive Health, COAG, 2008, http://www.health.gov.au/internet/main/publishing.nsf/Content/phd-prevention-np, accessed 26 June 2014.

3 The Australian National Preventive Health Agency, http://www.anpha.gov.au/internet/anpha/publishing.nsf/Content/about-us , accessed 27 June 2014.

4 Australian National Preventive Health Agency (Abolition) Bill 2014, Explanatory Memorandum, p. 1.

(b) transfer of records and documents to the Department at the end of the transition (Part 2, Division 2, Item 3); and

(c) transfer of ombudsman investigations under the *Ombudsman Act 1976* into the actions of ANPHA to be transferred to the Department (Part 2, Division 2, Item 4).

Issues

2.6 While the majority of submissions received by the committee expressed concern at the proposal to abolish ANPHA, a number of submissions acknowledged the benefits of minimising duplication of functions.[5] A consistent theme throughout the submissions was the importance of preventive health and the on-going savings to the community through reductions in chronic disease. Most submissions emphasised the importance of preventive health programs and recommended that preventive health programs and policy should continue when the responsibilities are transferred to the Department from ANPHA.[6]

2.7 Some submitters raised issues about the scope of preventive health policy and whether it could be expanded to capture a number of different areas[7] including oral health[8] and issues around diet.[9]

Proposed savings—reducing duplication

2.8 Upon introduction of the Bill into Parliament, the Hon. Peter Dutton MP, Minister for Health (the Minister) stated that:

> There is currently a lack of clear demarcation of responsibilities between ANPHA [and] the Department of Health. This current arrangement has led to a fragmented approach to preventive health and inefficiencies through duplication of administrative, policy and program functions between ANPHA and the Department.[10]

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5 HSU National, *Submission 9,* pp 1–3; Australian Nursing and Midwifery Federation, *Submission 5,* pp 1–2; Foundation for Alcohol Research and Education, *Submission 2*, pp 1–3; Dr Jackie Street, *Submission 15,* p. 1.

6 Queensland Department of Health, *Submission 1*, pp 1–2; Social Determinants of Health Alliance, *Submission 4*, p. 1; Australian Primary Health Care Nurses Association, S*ubmission 6,* p. 1; Victorian Health Promotion Foundation (VicHealth), *Submission 10,* pp 3–6.

7 Public Health Association of Australia and Australian Health Promotion Association, *Submission 8,* pp 13–15.

8 Australian Dental Association Inc., *Submission 3,* p. 1; Dr Carmello Bonanno, Australian Dental Association, *Proof Committee Hansard,* p. 15.

9 Dieticians Association of Australia, *Submission 7*, p. 1; Ms Annette Byron, Dieticians Association of Australia, *Proof Committee Hansard*, p. 41.

10 P. Dutton (Minister for Health), 'Second Reading Speech: Australian National Preventive Health Agency (Abolition) Bill 2014', House of Representatives, *Debates*, 15 May 2014, p. 2.

The government is proposing to achieve savings of $6.4 million over five years through the abolition of ANPHA and a number of duplicated consultative groups.[11]

2.9 Submitters recognised the need for government departments and agencies to deliver services in a tight fiscal environment.[12] The Australian Physiotherapy Association stated:

> [S]treamlining the functions of the two separate agencies could result in better coordination of preventive health efforts and would remove unnecessary duplication and costs.[13]

2.10 A number of submitters emphasised the long term fiscal and social benefits from investment in preventive health and the likely reduction in chronic disease. The Consumers Health Forum of Australia (CHF) expressed concern that the Bill is too narrowly focused on immediate cost savings and submitted:

> The minimal savings the Government will realise from the abolition of ANPHA will be dwarfed by the rise of presentations of otherwise preventable chronic illnesses to the health care system.[14]

2.11 This view was shared by Public Health Association of Australia who emphasised that investment in preventive health must continue stating:

> [T]he idea is that an investment in prevention now results in a decent return on investment in the long term, and that return on investment is not just financial, it is also social, and that is really a major driver for us.[15]

Importance of preventive health strategies

2.12 Evidence to the committee emphasised the benefit of preventive health strategies to the overall healthcare system. The Foundation for Alcohol Research and Education discussed the health, social and economic burden of chronic diseases, citing the importance of an individual having access to evidence based information in order to make informed decisions.[16] This was highlighted by a number of other submissions which emphasised the need for a nationally co-ordinated preventive health policy.[17]

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11 Budget Paper No. 2, 2014–15, Budget Measures, p. 145; Mr Nathan Smyth, Department of Health, *Proof Committee Hansard*, p. 49.

12 Victorian Health Promotion Foundation (VicHealth), *Submission 10*, p. 1.

13 Australian Physiotherapy Association, Submission *11*, p. 1.

14 Consumers Health Forum of Australia, *Submission 13*, pp 1–4. See also: Budget Paper No. 2, 2014–15, Budget Measures, p. 137. The government also proposes the cessation of the National Partnership Agreement on Preventive Health with projected savings of $367.9 million over four years.

15 Adjunct Professor Michael Moore, Public Health Association of Australia, *Proof Committee Hansard*, p. 1.

16 Foundation for Alcohol Research and Education, *Submission 2*, pp 1–2.

17 Royal Australasian College of Physicians, *Submission 16*, p. 2; National Rural Health Alliance, *Submission 17*, p. 1; Osteopathy Australia, *Submission 14*, p. 2.

The Social Determinants of Health Alliance cited a number of publications that detail the cost-effectiveness of preventive health strategies in advancing public health.[18]

2.13 VicHealth, a state-funded and operated preventive health agency focused on promoting good health and preventing chronic disease, recognised the lead role the Commonwealth plays in promoting preventive health strategies and urged the Government to sustain and build its investment in preventive health.[19]

National co-ordination and leadership

2.14 Many submitters emphasised the importance of the Commonwealth's ongoing leadership role in the co-ordination of preventive health policy and programmes.[20] Evidence to the committee noted that the highest priority for states and territories tends to be acute healthcare. As such, the Commonwealth is best placed to lead and co-ordinate national initiatives on preventive health.[21] VicHealth noted that the Australian Government's recent successes with smoking and obesity had all been lead at a national level.

> In these instances, a coordinated approach at the national level included social marketing, policy and regulation and program delivery, and was reinforced by tailored and targeted activity by local and state government agencies, health agencies and non-government organisations … this leadership role need not just be financial investment in programs, but also includes providing a national coordination function for local, regional and state efforts, representing Australia at the international level and providing non-financial resources and support.[22]

2.15 VicHealth stated that as the lead preventive health body, it regularly communicated with ANPHA and other state bodies including Healthway in Western Australia. Continued communication and collaboration between states and the Commonwealth was reiterated as being important.[23] The role of Commonwealth and state agencies in stimulating and leading public debate on preventive health issues was also discussed.[24] Many submitters commended ANPHA on managing stakeholder

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18 Social Determinants of Health Alliance, *Submission 4*, p. 1.

19 Victorian Health Promotion Foundation (VicHealth), *Submission 10,* pp 1–3.

20 Ms Michele Herriot, Australian Health Promotion Association, *Proof Committee Hansard,* p. 1; Mr Michael Thorn, Foundation for Alcohol Research and Education, *Proof Committee Hansard,* p. 26; Jerril Rechter, Victorian Health Promotion Foundation (VicHealth), *Proof Committee Hansard,* 2 July 2014, p. 37.

21 Mr Adam Stankevicius, Consumers Health Forum of Australia, *Proof Committee Hansard,* p. 4.

22 Victorian Health Promotion Foundation (VicHealth), *Submission 10,* pp 1–3.

23 Ms Jerril Rechter, Victorian Health Promotion Foundation (VicHealth), *Proof Committee Hansard,* 2 July 2014, p. 39.

24 Ms Jerril Rechter, Victorian Health Promotion Foundation (VicHealth), *Proof Committee Hansard,* 2 July 2014, p. 39.

interests through consultative mechanisms including advisory groups and committees.[25]

2.16 It was acknowledged during the hearing that a number of public health awareness programs had been successfully conceived and executed by both state and Commonwealth prior to the establishment of ANPHA. These programs focused on a range of preventable diseases and conditions including road trauma,[26] use of tobacco[27] and HIV/AIDS.[28] Professor Moore explained the successful strategy used to reduce road trauma and how that might be used for other preventable diseases and conditions:

> … we actually can see … each of the interventions and the impact they have—the dropping of the speed limit, the introduction of alcohol breath testing and so forth. You can apply exactly the same thinking to things like obesity, because there was a personal responsibility absolutely fundamental in terms of how people drive, how you would train them and so forth. But a government responsibility was also recognised, and the concern that we have is that we will lose the element or shift that level of responsibility right over to the individual when in fact there is also a serious government responsibility. It is a combination of the two that is critical.[29]

2.17 FARE noted that some areas of preventive health policy, such as alcohol, are controversial with behavioural change being difficult to implement. Discussion of reduced alcohol consumption focused on unit pricing and sports sponsorship as the key levers that determine consumption. Submitters emphasised that an independent agency such as ANPHA may be better placed than a government department when implementing any initiative to regulate these levers.[30]

2.18 In evidence to the committee, the Department explained that it will maintain engagement with stakeholders through a series of specialist advisory and consultative groups. The Department explained:

> [T]he Department has a very strong engagement across all areas of prevention, with key stakeholders. That has not changed at all. There was one key group that related to disadvantaged groups, around tobacco consumption and the like. That was a separate advisory committee that was set up by ANPHA. We have taken on the responsibility, and we are continuing that committee, as well, in the Department.

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25 Department of Health, *Submission 1*, p. 1; Victorian Health Promotion Foundation (VicHealth), *Submission 10*, p. 10; Royal Australasian College of Physicians, *Submission 16*, p. 3.

26 Adjunct Professor Michael Moore, Public Health Association of Australia, *Proof Committee Hansard*, 2 July 2014, p. 8.

27 Ms Jerril Rechter, Victorian Health Promotion Foundation (VicHealth), *Proof Committee Hansard*, p. 37.

28 Mr Gordon Gregory, National Rural Health Alliance, *Proof Committee Hansard*, p. 16.

29 Adjunct Professor Michael Moore, Public Health Association of Australia, *Proof Committee Hansard*, 2 July 2014, p. 8.

30 Ms Meredythe Crane, Foundation for Alcohol Research and Education, *Proof Committee Hansard*, 2 July 2014, p. 28.

> But across the board we have a very strong engagement with all key prevention stakeholders, and that continues through a variety of mechanisms that we have.[31]

2.19 The committee notes generally the focus on outcomes in preventive health, rather than a specific delivery model.[32]

> What we are really interested in are outcomes, but when we see a situation where bureaucracies from states and territories are not coordinated well and there is not an independence to ensure that they are coordinated, then we see that there is an importance for some independence and also a specific focus.[33]

Scope of preventive health policy

2.20 Some submitters raised questions about the scope of current preventive health policy. The Australian Dental Association suggested that the focus of ANPHA has been too narrow and preventive health strategies should be broadened to consider oral health.[34]

> The government now has an opportunity to broaden the scope of current health prevention and promotion activities. Oral health messages can be linked to the initiatives that target obesity, tobacco and alcohol abuse, as they are all causative factors in caries, periodontal disease and oral cancers. Accordingly, oral health experts should be included on all reference groups in health promotion and prevention to ensure that the link between oral health and general health is maintained and reflected in all health messages.[35]

2.21 The Dietitian Association stated that preventive health should have a broader focus on food and nutrition.

> We certainly would like to see a broader appreciation of nutrition issues than just obesity. Clearly that is important. I have just been to a presentation where we heard that about 63 per cent of adults are overweight or obese—and the figure for children is 26 per cent. There is a broader spectrum of nutrition issues around vitamin D, iodine, folate and iron deficiencies, or anaemia, particularly in Aboriginal and Torres Strait Islander groups. The

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31 Mr Nathan Smyth, Department of Health, *Proof Committee Hansard*, 2 July 2014, p. 49.

32 Adjunct Professor Michael Moore, Public Health Association of Australia, *Proof Committee Hansard,* p. 7; Ms Jerril Rechter, Victorian Health Promotion Foundation (VicHealth), *Proof Committee Hansard,* 2 July 2014, p. 40; Ms Penny Shakespeare, Department of Health, *Proof Committee Hansard,* 2 July 2014, p. 64.

33 Adjunct Professor Michael Moore, Public Health Association of Australia, *Proof Committee Hansard,* p. 7.

34 Australian Dental Association Inc., *Submission 3*, p. 1.

35 Dr Carmello Bonanno, Australian Dental Association Inc., *Proof Committee Hansard*, p. 15.

> chronic disease burden is largely attributable to both nutrition and physical activity.[36]

2.22 Public Health Association of Australia and Australian Health Promotion Association indicated its preference for inclusion of a preventive health agency within a new Centre for Disease Control. This Centre would manage policy and program delivery for communicable diseases in addition to chronic and preventable diseases.[37]

2.23 Dr Jackie Street, a postdoctoral fellow at the University of Adelaide funded by ANPHA, raised the ANPHA's role in preventive health research:

> Researchers with a focus on preventive health have struggled in the past to obtain funding for their research. Researchers in this area often come to preventive health from another background and a previous career in another area. [ANPHA] provided an important role in translating the research findings into policy and practice.[38]

Transfer of ANPHA functions and responsibilities to the Department

2.24 All submitters emphasised that there should not be a reduction in the importance government places on preventive health strategies.

2.25 Submitters generally agreed that the Department has the capacity to carry on the work of ANPHA, however, must remain focused on outcomes in order to be successful. This has been demonstrated with the recent Health Star Rating System being successfully implemented by the Department.[39]

2.26 The Foundation for Alcohol Research and Education (FARE) observed that the Department must be pro-active rather than reactive with regard to policy and programme development. The Department should remain bold in prosecuting the arguments for controversial evidence-based policy and programmes in the preventive health sphere.[40]

2.27 One submitter called for greater accountability and transparency with regard to Commonwealth preventive health expenditure and outcomes citing the example of the annual *Closing the Gap Report* as a potential mechanism to ensure accountability.[41]

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36 Dietitians Association of Australia, *Submission 7,* p. 2; Ms Annette Byron, Dietitians Association of Australia, *Proof Committee Hansard,* p. 41.

37 Public Health Association of Australia and Australian Health Promotion Association, *Submission 8,* p. 14; Adjunct Professor Michael Moore, Public Health Association of Australia, *Proof Committee Hansard,* p. 1.

38 Consumers Health Forum of Australia, *Submission 15,* p. 1.

39 Adjunct Professor Michael Moore, Public Health Association of Australia, *Proof Committee Hansard,* 2 July 2014, p. 7.

40 Mr Michael Thorn, Foundation for Alcohol Research and Education, *Proof Committee Hansard,* p. 26.

41 Ms Liz Callaghan, Social Determinants of Health Alliance, *Proof Committee Hansard,* 2 July 2014, p. 8.

2.28 The Department stated that the emphasis on preventive health policy and programs will not change with the abolition of ANPHA, indicating:

> The Department is the lead agency for preventive health and this role did not change with the establishment of ANPHA. The Department's role in preventive health has been further reinforced and expanded in the 2014–15 budget. The Department remains committed to ensuring national preventive health efforts are well-managed, and is working with ANPHA to ensure resources and essential on-going work smoothly transition from ANPHA and are integrated into the Department's work in priority areas.[42]

2.29 At the hearing, the Department confirmed that the transfer of staff[43], functions, programs and files to the Department was now complete.[44]

Committee view

2.30 The committee notes the high level of importance that submitters place on preventive health initiatives in promoting improved health outcomes, reducing chronic disease and providing long term savings to the healthcare budget. The committee also notes submitters' desire that the Commonwealth Government continues to lead and foster a consultative approach towards the implementation of preventive health policy and programs.

2.31 The committee is satisfied that the transfer of ANPHA's roles and responsibilities to the Department should not result in any diminution of the commitment to preventive health programs and policies.

Recommendation 1

2.32 The committee recommends that the Australian National Preventive Health Agency (Abolition) Bill 2014 is passed.

42 Australian Government Department of Health, *Submission 12*, p. 2.

43 Mr Andrew Stuart, Department of Health, *Proof Committee Hansard*, p. 48.

44 Mr Nathan Smyth, Department of Health, *Proof Committee Hansard*, p. 48.

Chapter 3

Health Workforce Australia (Abolition) Bill 2014

Health Workforce Australia

3.1 Health Workforce Australia (HWA) was established by the *Health Workforce Australia Act 2009* as part of the National Partnership Agreement on Hospital and Health Workforce Reform. This agreement expired in June 2013.[1]

3.2 In late 2005, a Productivity Commission report on Australia's health workforce[2] noted the complexity of arrangements under which numerous bodies were involved at all levels in health workforce education and training.

3.3 HWA was established to create more effective, streamlined and integrated clinical training arrangements to:

(a) support workforce reform initiatives;

(b) support health workforce research and planning; and

(c) further new workforce models and reforms.[3]

Purpose and key provisions of the Bill

3.4 The Bill seeks to abolish Health Workforce Australia and transfer its functions and programmes to the Department of Health.

3.5 The key provisions of the Bill are as follows:

(a) part 1 contains amendments to the *Health Workforce Australia Act 2009* (HWA Act) that will introduce interim arrangements that facilitate the 'winding up' of HWA. The provisions include: removal of the requirement for HWA to act in accordance with the directions of the Australian Health Ministers' Conference; termination of current HWA Board appointments; and allocation of the Board's current functions to the Minister. The amendments in Part 1 would commence the day after Royal Assent;

(b) the *Health Workforce Australia Act 2009* is repealed (item 19 of Schedule 1);

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1 Senator John Faulkner, Minister for Defence, Second Reading Speech, *Senate Hansard*, 15 June 2009, p. 3101.

2 Productivity Commission (PC), Australia's health workforce, Research report, PC, Canberra, 22 December 2005.

3 COAG (2008), *National Partnership Agreement on Hospital and Health Workforce Reform*, http://www.ahwo.gov.au/documents/coag/national%20partnership%20agreement%20on%20hospital%20and%20health%20workforce%20reform.pdf , accessed 28 June 2014.

(c) the vesting of assets, liabilities and interests in land from Health Workforce Australia (HWA) to the Commonwealth without any conveyance, transfer or assignment (items 21 and 22 of Schedule 1);

(d) the transfer of pending proceedings, investigations, records and instruments (including contracts, undertakings, deeds or agreements) from HWA to the Commonwealth (items 25, 26, 27, 28 and 29 of Schedule 1); and

(e) no transfer of appointment, engagement or employment of an HWA officer to the Commonwealth (item 33 of Schedule 1).

Issues

3.6 Submitters to the inquiry generally recognised the comprehensive data collection efforts and reporting activities of HWA. The primary concerns of submitters focused upon the need to ensure that any proposed transfer of its functions and programmes to the Department did not undermine the continuation of this work.[4]

3.7 Many submitters were keen to understand the precise nature of the functions and programmes to be transferred to the Department:

> If the purpose of the Abolition Bill is to prevent duplicity in administrative functions, and not the abolishment of the functions and programmes of HWA, then it is vital that the breadth of work of HWA is fully understood and considered under any new arrangements.[5]

3.8 Several submitters emphasised that the Department should maintain HWA's cross-jurisdictional perspective and stakeholder engagement:[6]

> When amalgamating HWA's core functions into the Commonwealth Department of Health, an appropriate governance structure will be vital to ensure the new model does not lose the strengths of HWA's organisational structure as an independent, stand-alone body with a separate Board and public charter.[7]

4 For example: Australian and New Zealand College of Anaesthetists, *Submission 2*, p. 1; Community and Public Sector Union, *Submission 1*, pp 1–2; Exercise and Sports Science Australia, *Submission 5*, p. 1.

5 Australian Council of Pro-Vice-Chancellors and Deans, *Submission 12*, p. 2.

6 Consumers Health Forum of Australia, *Submission 13*, p. 6; Osteopathy Australia, *Submission 14*, p. 1.

7 Royal Australasian College of Physicians, *Submission 18*, p. 4.

3.9 Submissions identified a number of HWA's key projects that should continue in order to optimise the effectiveness of the Australian health system.[8] For example, the proposed *National Medical Training Advisory Network*[9] and *Health Workforce 2025—Oral Health.*[10]

Proposed savings—reducing duplication

3.10 Upon introduction of the Bill into Parliament, the Hon. Peter Dutton MP, Minister for Health (the Minister) stated that the proposed abolition of HWA and transfer of its functions and programmes to the Department will:

> …streamline the delivery of programs to build our health workforce and remove an unnecessary layer of administration and bureaucracy … The programs currently managed by HWA will continue, but aligning these with those already delivered through the [Department] will allow us to save valuable resources by reducing duplication in both service delivery and in the significant overheads required to run an agency.[11]

3.11 The Commonwealth Government is committed to providing national leadership while continuing to work with states and territories towards national workforce planning and reform.[12] The Government is proposing to achieve $142.0 million in savings from the abolition of HWA and changes to health workforce planning. Efficiencies will be achieved by the abolition of the agency and transfer of its functions to the Department. [13]

3.12 In its submission, the Department has noted that, contrary to the National Partnership Agreement on Hospital and Health Workforce Reform, the states and territories have never contributed their expected share of funding to the operations of HWA[14] (approximately $539.2 million from 2008–2013). [15] In contrast, the

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8 Community Affairs Legislation Committee, *Health Workforce Australia Bill 2009 [Provisions]*, June 2009, p. 10 (Department of Health and Ageing); Australian Council of Pro Vice-Chancellors and Deans of Health Sciences, *Submission 12*, p. 4; Australian Dental Association Inc., *Submission 4*, pp 1–2; Australian Primary Health Care Nurses Association, *Submission 6*, p. 1; Australian Physiotherapy Association, *Submission 15*, p. 1; National Rural Health Alliance, *Submission 21*, p. 2; Occupational Therapy Australia, *Submission 11*, p. 4; Faculty of Medicine, Nursing and Health Sciences, Flinders University, *Submission 17*, p. 1 (Simulated Learning Environment (SLE) created at the Centre for Remote Health in Alice Springs also provides continuing professional education of nursing and medical staff based in remote communities and the Alice Springs Hospital, also funding for SLEs in Greater Green Triangle region of Western Victoria and South-Eastern South Australia).

9 Australian and New Zealand College of Anaesthetists, *Submission 2*, p. 2.

10 Dr Carmello Bonanno, Australian Dental Association, *Proof Committee Hansard*, p. 15.

11 Second Reading Speech, *House Hansard*, 15 May 2014, p. 4.

12 Second Reading Speech, *House Hansard*, 15 May 2014, pp 4–5.

13 Australian Government 'Part 2: expense measures', Budget measures: Budget paper no. 2: 2014–15.

14 Australian Government Department of Health, *Submission 20*, p. 3; Ms Penny Shakespeare, Department of Health, *Proof Committee Hansard*, p. 50.

Commonwealth has remained the sole funder of HWA contributing $1.05 billion.[16] In evidence, the Department explained:

> This has presented challenges with HWA's governance arrangements, with HWA reporting to all Health Ministers and having a Board comprising of representatives of each jurisdiction, giving the Commonwealth government limited influence over the use of Commonwealth resources.[17]

3.13 The Review of Australian Government Health Workforce Programs (Mason Review)[18] stated that it is reasonable that the Australian Government would want more direct involvement in HWA, as the states have not contributed their share of operating funds, yet still retain a stake in governance. This governance arrangement has also led to 'uncertainty from the perspective of stakeholders' about the roles and responsibilities of HWA and the Department which need to be resolved.[19] The Mason review also stated that stakeholders perceived that HWA had 'an extremely onerous compliance based contracting model'.[20]

Importance of health workforce planning

Workforce capacity building and data collection

3.14 A number of submitters noted that HWA's data analysis and policy development work were the areas most valued by stakeholders.[21]

3.15 HWA's work on 'comprehensive and sophisticated health workforce data capture and analysis…to enable health workforce modelling and support planning'[22] was acknowledged. Submitters noted that, prior to the establishment of HWA, there was a 'paucity of data' on Australia's health workforce. Through monitoring workforce trends, collating data and building the evidence base on Australia's health workforce, HWA has contributed significantly to national planning for a sustainable

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15 Second Reading Speech, *Senate Hansard*, 15 June 2009, p. 3101.

16 Australian Government Department of Health, *Submission 20*, p. 2.

17 Australian Government Department of Health, *Submission 20*, p. 3.

18 J Mason, *Review of Australian Government health workforce programs, Department of Health and Ageing,* April 2013, accessed 23 May 2014, p. 329.

19 J Mason, *Review of Australian Government health workforce programs, Department of Health and Ageing,* April 2013, accessed 23 May 2014, p. 25.

20 J Mason, *Review of Australian Government health workforce programs, Department of Health and Ageing,* April 2013, accessed 23 May 2014, p. 330.

21 For example: Royal Australasian College of Physicians, *Submission 18*, p. 1, Catholic Health Australia, *Submission 3*, p. 1; University of Sydney, *Submission 19*, p. 2: See comments in *Submission 12*, p. 4 for a discussion on HWA's "Clinical Placement Survey" as an example of the sole source of data on student load and clinical placement activities. HWA's "Clinical Training Profiles" provide a national snapshot of student numbers, education pathways, and characteristics of clinical training and supervision requirements for clinical placements of a range of health professions.

22 University of Sydney, *Submission 19*, p. 2.

workforce. In turn, this information has 'instigated and informed clinical redesign and innovation improving efficiencies within the health system'.[23] Several submitters raised the reticence of various jurisdictions and professions to share workforce data prior to the establishment of HWA.

Health workforce distribution

3.16 Submissions identified the importance of continuing the work started by HWA to identify and implement reforms to improve the distribution of the health workforce in rural and remote communities.[24] The National Rural Health Alliance commented:

> The Bill's Explanatory Memorandum states that Australia has a '…*well distributed health workforce*, delivering frontline health services for all Australians'. Many people in rural and remote Australia would be surprised at this description, having poor access to many types of health professional and the services they provide.[25]

3.17 The *National Rural and Remote Health Workforce Innovation and Reform Strategy,* [26] the project on *Rural and Remote Generalist Allied Health Professions*[27], the feasibility study of a *National Framework for Rural Medical Generalist* programs[28] and the *General Practice Rural Incentives Program*[29] were all identified as important initiatives.

Clinical training[30]

3.18 Submissions identified clinical training funding for the non-government and private sectors as a valuable area of activity that should continue under the Department of Health's administration of health workforce planning.[31]

3.19 Flinders University noted that accommodation of students in rural and remote locations has always been an impediment to delivery of clinical training. HWA funding has allowed Flinders University to provide eight new residences and upgrade three existing residences to provide student accommodation in the Northern Territory.[32] Flinders University also noted that HWA's support for clinical training

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23 Exercise & Sports Science Australia (ESSA), *Submission 5*, p. 1; Also see: Australian Council of PVCs and Deans of Health Sciences, *Submission 12*, p. 4.

24 Exercise & Sports Science Australia (ESSA), *Submission 5*, pp 2–3; *Submission 21*, p. 2.

25 National Rural Health Alliance, *Submission 21*, p. 1; Mr Gordon Gregory, National Rural Health Alliance, *Proof Committee Hansard*, p. 16.

26 Health Services Union, *Submission 9,* pp 4–5.

27 National Rural Health Alliance, *Submission 21*, p. 2.

28 National Rural Health Alliance, *Submission 21*, p. 2.

29 Health Services Union, *Submission 9,* pp 4–5.

30 National Rural Health Alliance, *Submission 21*, p. 2.

31 Catholic Health Australia, *Submission 3*, p. 1.

32 Faculty of Medicine, Nursing and Health Sciences, Flinders University, *Submission 17*, p. 2.

initiatives has allowed the university to expand and expedite its training of students in a range of health related fields, particularly in rural and remote locations. [33]

National Medical Training Advisory Network

3.20 A number of submissions identified the recent establishment of the National Medical Training Advisory Network (NMTAN) as a highly valued component of HWA's current work program.[34] The NMTAN identified and sought to resolve looming bottlenecks in the training pipeline and its work is considered increasingly necessary: [35]

> Even though this is in the early stages of its work, this cross-professional expert group is fundamental to developing an effective strategy to meet the demands for and from our medical workforce into the medium and long-term future. It is also able to provide expert and detailed input to assist in the future refinement of the HW2030 modelling process.[36]

Nursing, allied health, and other health professional groups

3.21 HWA's approach in adopting a 'whole-of-workforce perspective' in reforming the sector was described as 'seminal' and the Department of Health was urged to maintain this momentum:

> …while much of their work has focused on the medical and nursing workforce, action has occurred across the spectrum of health professions. This has included a broad range of allied health professions and Aboriginal and Torres Strait Islander health workers. This whole-of-workforce approach is vital to build the capacity of the health workforce to meet the emerging health needs of the population, particularly in relation to the management of chronic illness. This broad focus on reform must continue.[37]

3.22 Osteopathy Australia encouraged the Department to continue investing in efficient workforce planning for allied health professionals because it accords with the Government's stated desire to 'reduce demand for unnecessary or overused services'.[38] For example, osteopaths see patients who are taking responsibility for their health by self-referring and paying fees out of their pocket without taxpayer subsidy.[39]

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33 *Submission 17*, pp 1–2.

34 For example: Australian and New Zealand College of Anaesthetists, *Submission 2*, p 2; Australian Medical Students' Association, *submission 10*, pp 2–3; Australian Medical Association, *submission 16*, pp 2–3.

35 Australian Medical Association, *Submission 16*, pp 1–2.

36 Royal Australasian College of Physicians, *Submission 18*, p. 2.

37 Australian Psychological Society, *Submission 7*, p. 1.

38 Osteopathy Australia, *Submission 14*, p. 3.

39 Osteopathy Australia, *Submission 14*, p. 3.

3.23 The committee noted HWA's role in facilitating novel workforce policy initiatives as a means of addressing skills shortages. Professor Wronski explained:

> The notion of generalism came out of medicine originally as a way of developing skill sets amongst rural medical practitioners so that they were comfortable working in areas of workforce shortage, and it spread into the allied health areas. For instance, you can look at the situation of a smaller town. Let's say you are only ever going to be able to afford one or two allied health personnel. Obviously you would want them to be card-carrying physios, [occupational therapists] or whatever else. What are the expanded skill sets that would enable that facility to provide a fair range of services, mobilising the most out of those personnel?[40]

3.24 The development and implementation of a primary health care nursing workforce plan should be prioritised in the work undertaken by the Department following the transfer of functions and programmes from HWA.[41]

Staffing issues and capacity

3.25 The issue of the relocation of HWA's functions from Adelaide and Melbourne to Canberra was raised.[42] The Department stated that 'ultimately, the Department is a policy department largely located in Canberra'.[43]

3.26 The Department confirmed the transitional arrangements for HWA staff:

> A number of staff [30–40] have taken redundancy payments and left the organisation. We have commenced an expression-of-interest process for staff who are interested in transferring to the department, which is largely complete. We are now waiting for the Australian Public Service Commission to confirm arrangements for the transfer of staff from HWA to the department. So there has been progress, but there have been no actual transfers from HWA to the department at this stage.[44]

3.27 The Australian Medical Association identified the types of skills the Department should look to retain or recruit including those with:

> an understanding of the health policy landscape and an understanding of the modelling techniques and assumptions that have been used by HWA in the past[45]

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40 Professor Ian Wronski, Universities Australia Health Professions Education Standing Group, *Proof Committee Hansard*, p. 23.

41 Australian Primary Health Care Nurses Association, *Submission 6*, p. 2.

42 Community and Public Sector Union, *Submission 1*, p. 1.

43 Mr Andrew Stuart, Department of Health, *Proof Committee Hansard*, p. 54.

44 Ms Penny Shakespeare, Department of Health, *Proof Committee Hansard*, pp 53–54.

45 Dr James Churchill, Australian Medical Association, *Proof Committee Hansard*, p. 13.

Communication and independence

3.28 Stakeholders expressed appreciation of HWA's strong focus on collaboration and engagement, and expressed the hope that this approach will continue with any transfer of responsibilities to the Department:[46]

> HWA has adopted a comprehensive consultative approach to all their activities and this intensive engagement with stakeholders will need to be continued by the Department in order to achieve effective and sustainable outcomes. This consultative approach must continue to be applied to the legacy projects that will be inherited by the Department as well as to newly commissioned projects.[47]

3.29 This broad consultative approach has been regarded as a key reason for the 'high uptake of implementation of HWA policy proposals' through findings and outcomes that are practical and relevant. [48]

3.30 The Australian Dental Association stated that an independent body such as HWA is not critical if the Department continues to consult with stakeholders:

> I am not sure independence is really that important an issue. As I said, the work they have done has been transparent and open and they have consulted well. As long as that process continues and is not lost, I think we would be pretty happy.[49]

3.31 Catholic Health Australia (CHA) claimed that the lack of 'specific requirements for HWA to consult and cooperate with both education and health providers on the provision of financial support for clinical training' has been a shortcoming. CHA advocated a new national agreement for action on health workforce as a replacement to HWA, with the role of the Department of Health clearly articulated.[50]

Transfer of HWA functions and responsibilities to the Department

3.32 Several submitters highlighted the HWA's capacity to communicate and collaborate with industry, different departments and jurisdictions. Submitters noted it is critical that the Department communicate and collaborate with industry, different department and jurisdictions to ensure that there is a unified and coherent approach to workforce planning.[51]

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46 For example: Occupation Therapy Australia, *Submission 11,* p. 5; *Submission 19*, p. 3; Australian and New Zealand College of Anaesthetists, *Submission 2*, p. 2.

47 Australian Psychological Society, *Submission 7*, p. 1.

48 Occupational Therapy Australia, *Submission 11,* p. 4.

49 Dr Carmello Bonanno, Australian Dental Association, *Proof Committee Hansard,* p. 18.

50 *Submission 3*, p. 1.

51 For example: Mr Allan Groth, Universities Australia Health Professions Education Standing Group, *Proof Committee Hansard*, p. 22; Mr Mark Farthing, HSU National, *Proof Committee Hansard*, p. 32.

3.33 Submitters said that prior to the establishment of HWA, there was a less-focused approach to workforce planning and emphasised the importance of the Commonwealth continuing to co-ordinate for training and health workforce planning.[52]

3.34 The Department noted the potential for 'duplication and confusion for stakeholders' in both agencies managing health workforce programs:

> These issues will be addressed by transferring HWA's programmes to the Department. There will be more clarity for stakeholders, consistent funding arrangements and the opportunity to align overlapping programmes.[53]

3.35 In response to concerns that innovation may be stifled and that the transition may hurt the progress made by HWA in strengthening the sector, the Department confirmed:

> There will continue to be work undertaken in the Department, and in state governments, to develop innovations and reforms to address health workforce challenges, and to support the implementation of these policies.
>
> The Government remains committed to effective health workforce training, productivity and innovation and will ensure that this work is delivered more efficiently through reducing corporate overheads, and eliminating duplication between HWA and the Department.[54]

3.36 The Department committed to 'continue to work with stakeholders, including the states and territories and the private sector'.

> The Department will continue to use established fora, such as the Australian Health Ministers' Advisory Council and the Health Workforce Principal Committee.[55]

3.37 The committee notes that as part of this commitment, the Department is conducting a review of all advisory committees to identify duplicate committees. The Department stated that those committees that represent stakeholders the Department does not already directly engage with will be retained.[56]

3.38 The Department confirmed that all Clinical Training Funding Agreements will be continued for the 2015 academic year.[57]

3.39 The Department acknowledged that staff of HWA have 'well developed skills in data analysis and modelling, programme delivery and evidence-based

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52 Professor Brendan Crotty, Universities Australia Health Professions Education Standing Group, *Proof Committee Hansard*, p. 22.

53 Australian Government Department of Health, *Submission 20*, p. 3.

54 Australian Government Department of Health, *Submission 20*, p. 3.

55 Australian Government Department of Health, *Submission 20*, p. 4.

56 Ms Penny Shakespeare, Department of Health, *Proof Committee Hansard*, p. 52.

57 Ms Penny Shakespeare, Department of Health, *Proof Committee Hansard*, p. 55.

strategic policy advice'. The Department advised the committee that 'many HWA staff will have the opportunity to join the Department' and that the Department was supporting the work HWA was doing to manage the transition process with its staff.[58]

Committee View

3.40 The committee acknowledges the positive submissions reflecting on HWA's role in leading and co-ordinating health workforce planning. The committee considers that it is important for the Department to maintain this lead role within health workforce planning and training. In addition, the amalgamation of this work with the Department will remove duplication and increase the ability of the Government to provide a more streamlined approach to the health workforce. Consultation and collaboration with all stakeholders must continue in order to sustain the unified and coherent framework established by HWA.

3.41 The committee is satisfied that the transfer of HWA's roles and responsibilities to the Department of Health should not interfere with on-going health workforce planning and programs.

Recommendation 2

3.42 The committee recommends that the Health Workforce Australia (Abolition) Bill 2014 is passed.

Senator Zed Seselja

Chair

58 Australian Government Department of Health, *Submission 20*, p. 4.

Australian Labor Party Senators' Dissenting Report

1.1 Labor Senators do not see merit in these bills and oppose them in their entirety without amendment.

1.2 The costs to Australia's healthcare system due to preventable disease continue to rise, and without coordinated action by government will continue to do so.

1.3 Labor established the Australian National Preventive Health Agency (ANPHA) to ensure the nation's effort to curb the rise in preventable illness was coordinated, properly resourced and a priority of the Australian government.

1.4 Health Workforce Australia (HWA) was established by Labor to ensure that for the first time since Federation an independent statutory agency existed to provide advice and ensure Australia's future health workforce needs were properly planned and distributed.

1.5 The best way of ensuring Australia's future health workforce is most properly distributed and appropriately resourced is through an independent agency tasked explicitly with that role.

1.6 Coalition Senators delayed the commencement of ANPHA and HWA and prevented even more achievements being realised because of these delays.

The bills are unnecessary and political in nature

1.7 The Coalition Government has failed to realise the role of ANPHA nor has it acknowledged its work to date in making the decision to abolish the Agency. In his second reading speech the Minister for Health stated that ANPHA was established to 'focus on the prevention of the harmful use of alcohol, on obesity and on tobacco'.

1.8 As noted by the Consumers Health Forum , this is a limited understanding of the role ANPHA was established to fulfil, and indeed it was established

> [To support] all Australians in reducing their risk of chronic disease by embedding health behaviours in the settings of their pre-schools, schools, workplaces and communities, by instituting programs across smoking, nutrition, alcohol, and physical activity (SNAP) risk factors which mobilise the resources of the private, public and non-government sectors.

1.9 ANPHA was established to:

(a) provide evidence based advice to federal, state and territory health Ministers;

(b) support the development of evidence and data on the state of preventive health in Australia and the effectiveness of preventative health interventions; and

(c) put in place national guidelines and standards to guide preventative health activities.

1.10 Labor Senators note that the Coalition Government has abandoned the *National Partnership Agreement on Preventive Health* and the associated $367 million in Commonwealth funding without establishing any policy rationale for having done so.

1.11 The abolition of ANPHA removes the independence with which governments receive advice on evidence based policy and the development of evidence to develop national guidelines and standards to develop and guide preventive health activities.

1.12 The Coalition Government is not properly resourcing the Department of Health to ensure that the functions of ANPHA and HWA can continue effectively.

1.13 Department of Health officials gave evidence that the Department has resourcing to employ approximately half the number employed at ANPHA.[1]

1.14 The health sector including most organisations directly affected by the abolition of HWA have almost universally expressed opposition to the decision and concern about the important role the agency has played being continued by the Department of Health.

1 *Proof Committee Hansard*, p. 44.

Australian National Preventive Health Agency (Abolition) Bill 2014 [Provisions]

The abolition of ANPHA will cost the health system more in the long run

1.15 The policy drivers for the establishment of ANPHA have not changed. As the Queensland Government's Department of Health noted 'ANPHA's vision – A healthy Australian society, where the promotion of health is embraced by every sector, valued by every individual, and includes everybody – remains relevant'.[2]

1.16 Over the past decade the incidence of almost all preventable illnesses has continued to increase. According to the ABS 2011–13 Australian Health Survey, nearly two-thirds of Australians aged 18 or over are now overweight or obese (63%—comprised of 35% overweight and 28% obese), compared with about 56% in 1995.[3]

1.17 Chronic disease continues to be the leading cause of death in Australia:

> Coronary heart disease was an associated cause of death for 51% of deaths due to diabetes, 28% of deaths due to chronic and unspecified kidney failure and 19% of deaths due to chronic obstructive pulmonary disease (COPD).
>
> Hypertensive disease was an associated cause of death for 35% of deaths due to diabetes, 28% of deaths due to cerebrovascular diseases (which include stroke) and 21% of deaths due to coronary heart disease.
>
> Kidney failure was an associated cause of death for 26% of deaths due to diabetes.[4]

1.18 Labor is concerned that taken with the Coalition Government's decision to abandon the $367 million *National Partnership Agreement on Preventive Health* the Commonwealth will have no role in funding or developing preventive health policy and that this will add an unnecessary burden and cost to the health system in the future due to even higher rates of chronic disease such as diabetes and heart disease.

1.19 Labor Senators are encouraged by the fact that smoking rates continue to decline but note this is only the result of increased disincentives to smoke and reforms introduced to remove tobacco companies' capacity to market their products through world leading plain packaging laws.

1.20 The Royal Australasian College of Physicians highlighted the potential ANPHA had to prioritise preventive health and the impact the failure to invest in preventive health will have on the health system:

> The RACP is concerned that the repeal of the Australian National Preventive Health Agency (ANPHA) sends a very negative signal to the

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2 *Submission 1*, pp 1–2.

3 Australian Institute of Health and Welfare, *Australia's health 2014*, Australian health series no. 14. Cat. No. AUS 178. Canberra, p. 76

4 Australian Institute of Health and Welfare, *Australia's health 2014*, Australian health series no. 14. Cat. No. AUS 178. Canberra.

> community about the value of preventive health, especially as it comes on top of the discontinuation of the National Partnership Agreement on Preventive Health. The abolition of ANPHA has the potential to reduce Australia's capacity to develop a national, strategic direction for preventive health and to inform a consistent approach to prevention across all levels of government, as there will no longer be that independent body working across jurisdictions.
>
> Long-term and well-planned preventive health measures are highly effective investments, and necessary to address many of the chronic health issues exacerbated by lifestyle related behaviours and choices. Chronic disease is rising in incidence in Australia and is placing increasing pressures on our healthcare system – both from a patient care and a cost perspective – and needs to be addressed.[5]

1.21 The Public Health Association of Australia pointed out the bill 'simply flies in the face of an agreement by all governments in Australia. It is a unilateral action by a single government to do away with an agreement reached between governments. It is one of a series of moves that undermine the actions that have been taken to promote preventive health in Australia'.[6]

1.22 The National Rural Health Alliance likewise pointed out:

> Preventive action costs relatively little but has been at the heart of Australia's status as one of the world's longest-lived and healthiest countries. Despite its undoubted benefit-cost ratio, only around three per cent of Australia's health dollar is currently spent on health promotion and illness prevention. It is to be hoped that the value of this three per cent will be monitored and that there will be a sustained effort to increase it…
>
> To be effective, health promotion efforts need to be sustained through time. The experience with skin cancer prevention campaigns, for example, has shown that benefits can take many years to come to fruition. Work to tackle issues such as high levels of alcohol consumption and smoking, diabetes and obesity should have the benefit of being sustained.[7]

Recommendation

1.23 Labor members of the committee recommend that the Australian National Preventive Health Agency (Abolition) Bill 2014 be opposed.

5 *Submission 16*, p. 1

6 *Submission 8*, p. 7.

7 *Submission 17*, p. 2.

Health Workforce Australia (Abolition) Bill 2014 [Provisions]

Abolishing Health Workforce Australia will undermine Australia's capacity to plan for future health workforce requirements

1.24 The policy drivers surrounding the establishment of Health Workforce Australia are as important today as they were when the Agency was established in 2009.

1.25 In 2004 COAG asked the Productivity Commission to investigate Australia's health workforce. In its report released in 2006 the Productivity Commission concluded a more responsive and sustainable health workforce was needed.[8]

1.26 Labor acted on these recommendations in 2009 and established HWA to ensure more streamlined and integrated clinical training arrangements were in place and to support health workforce reform initiatives, health workforce research, as well as new health workforce models and reforms.

1.27 This decision was made due to 'chronic shortages in general practice, various medical specialties, dentistry, nursing and certain allied health professions'.[9]

1.28 The abolition of Health Workforce Australia brings with it a $142 million reduction in funding for health workforce reform projects and health workforce planning. The reduced funding will mean much of the expertise and work HWA has been undertaking to date will come to an end.

1.29 The decision by the Coalition Government to abolish HWA was made without reference to the Standing Council on Health which had already endorsed HWA's Strategic Plan 2013–16.

1.30 The decision by the Coalition Government to abolish HWA will mean there is no independent body advising State, Territory and Commonwealth Health Ministers on the distribution of Australia's health workforce or on their state or territory's future health workforce requirements and distribution.

1.31 The lack of consultation and haste with which the decision to abolish HWA was made has left the Department without the resources or ability to absorb the clinical training programs undertaken by HWA to develop Australia's future doctors, nurses and allied health professionals. This includes a cut of $10.5 million to expand the capacity of the university sector to provide clinical placements to 22 different health professions. This will impact on Australians' access to the nation's health workforce.

1.32 The abolition of HWA also sees the loss of its work agenda agreed by the Australian Health Ministers Advisory Council including 'improving coordination of medical training by working with trainees, employers, educators and governments through a new National Medical Training Advisory Network; analysing state and

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8 Bills Digest No. 77, Health Workforce Australia (Abolition) Bill 2014, 2 June 2014, p. 2.

9 The Hon. Nicola Roxon MP, Minister for Health and Ageing, Second Reading Speech, *House Hansard,* 13 May 2009, p. 3615.

territory health workforce industrial arrangements to identify barriers and enablers to workforce reform; investigating the implications of increasing self-sufficiency in the medical workforce; streamlining clinical training funding through the development of nationally consistent approaches to clinical training placements in the public, non-government and private sectors and focusing work on the retention and productivity of nurses'.[10]

1.33 The work to improve the equity of access to general practitioners, medical specialists, nurses and allied health workers in rural and regional Australia will be undermined because of the decision to abolish HWA and the funding cuts to programs.

1.34 The work HWA has been undertaking since 2009 has almost universal support from the health sector.

1.35 The Australian Medical Association (AMA) noted in its submission:

> The AMA has strongly supported the medical workforce planning and coordination activities of Health Workforce Australia (HWA) since it was established in 2009. HWA has undertaken substantial long-term national workforce planning projections for the medical profession and established programs to expand the capacity of our health system to train the next generation including funding for additional clinical training capacity and simulation…
>
> Australia cannot afford to waste the significant investment it has made in boosting medical student numbers. For the community to benefit from this investment, there needs to be robust workforce planning to ensure that medical graduates can access quality training positions and that the future medical workforce is better matched to community need. This must be backed by well-informed policy advice and funding to expand our training capacity.
>
> After a long hiatus, we are now in a position where that information, advice and capacity enhancement is being delivered by HWA and we must not lose this momentum. Clearly, the NMTAN also has the potential to improve the available medical workforce data as well as the coordination and planning of the medical training pipeline. Its work is taking on an increasing urgency due to the shortage of vocational training posts highlighted earlier and the fact that the advertising of posts and applications for entry to vocational training in 2016 will occur in mid- 2015. This leaves only a year for substantial work to be done that can inform vocational training numbers and guide doctors' career choices.[11]

1.36 The Australian and New Zealand College of Anaesthetists (ANZCA) concur that the reasons for establishing HWA in 2009 are just as important today, concluding:

> These arguments for a unique entity to undertake this role still apply to this day.

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10 Bills Digest No. 77, Health Workforce Australia (Abolition) Bill 2014, 2 June 2014, p. 2.

11 *Submission 16*, pp 1–2.

ANZCA is concerned that subsuming these activities within the Department of Health may result in health workforce matters not receiving the high priority that they deserve. Such an outcome would be unacceptable to ANZCA. This is particularly so when the imperative to create a health workforce able to meet the current and future healthcare needs of all communities has never been greater.

During the four years that HWA has been in operation there has been a marked improvement in the understanding of workforce issues within the overall Australian healthcare environment. Meaningful data have been more freely available and shared within the sector, leading to greater capacity for policy makers and clinicians to have robust discussions about critical workforce issues.

It is vital that a national coordinated approach to the collection and analysis of workforce data continues. This must include iterative workforce model updating as new data come to hand. HWA has highly skilled staff working in this area and it is important that any proposed new workforce unit within the Department of Health is funded at a level that ensures personnel of this calibre can be employed. It is clear that failure to adequately plan for the transition of this key function could harm the capacity of the health sector to undertake workforce planning for years to come.

ANZCA has greatly appreciated the opportunity to engage with HWA during its brief history on a range of issues of strategic importance to the College in helping to meet the healthcare needs for Australia into the future. This was particularly so over the past year with respect to the proposal for a National Medical Training Advisory Network (NMTAN), and prior to this in relation to health workforce modelling for the medical workforce generally and anaesthesia and pain medicine specifically. The College has anticipated an ongoing role, providing input to future workforce modelling and policy initiatives.

Health Ministers agreed that HWA should establish the NMTAN in response to the findings of Health Workforce 2025, Doctors, Nurses and Midwives (HW2025) which found that:
Poor co-ordination of medical training was contributing to a lengthening of the time taken to produce independently practicing specialists, as well as projected oversupply in some areas and undersupply in others.

There was a reduction in the number of generalists due to a growing trend towards specialisation and sub-specialisation. There were lost opportunities to rectify the geographical maldistribution of the workforce. There was an over-reliance on overseas trained doctors.

ANZCA supports a coordinated national effort to bring together all relevant stakeholders to improve medical training and provide a more planned approach to medical workforce across the country. ANZCA recognises that NMTAN is an ambitious concept. However, we welcome this initiative as a

necessary mechanism to balance the needs of the community for quality healthcare with the training requirements of doctors to meet these needs.[12]

1.37 Universities Australia highlighted:

> [M]uch of the work undertaken by HWA had been identified by governments and agencies such as the Productivity Commission as inadequate prior to its formation … Health workforce planning and development is not just essential for ensuring an adequate and capable workforce, but helps to deliver cost effectiveness and containment. Workforce shortages typically result in service and wage cost blowouts without necessarily leading to productivity increases.
>
> It is critical that as a nation we do not undermine our capacity to meet future health care demand. Ensuring Australia has a highly skilled and distributed workforce to meet growing and changing population needs is and should remain a central strategy for effective health care provision while containing expenditure.
>
> The need to act on these issues is immediate. The abolition of HWA potentially diminishes our capacity to identify systemic issues and act coherently to deal with them.[13]

1.38 The Australian Medical Students Association (AMSA) similarly noted:

> HWA established the National Medical Training Advisory Network (NMTAN). It is the objective of NMTAN to provide advice to government on addressing training bottlenecks. The NMTAN is also aiming to produce a National Medical Training Plan. These objectives represent a significant step forward in health workforce planning, and contrast to the haphazard manner in which medical training has been addressed in the past, resulting in the bottlenecks we face today.
>
> AMSA has also engaged with other subsidiaries of Health Workforce Australia. The Future Health Leaders organisation is an HWA initiative. It provides a valuable forum for young people who will be involved in Australia's healthcare system in the future – allowing them to discuss important healthcare issues. We encourage the Committee to ensure this initiative is not lost during the transition to the Department of Health..
>
> Australia must retain its Australian-trained doctors. Health Workforce Australia has been instrumental in highlighting this fact, and in addressing barriers to achieving this goal. HWA was also set to make important contributions in addressing issues including the geographic workforce maldistribution, trends towards subspecialisation, and the use of overseas-trained doctors to fill workforce gaps. HWA brought together numerous stakeholders and created an independent space for them to collaborate in order to deliver the best health outcomes from Australia.

12 *Submission 2*, p 2

13 *Submission 22*, pp 1–7.

> AMSA is concerned that the disruption caused by moving Health Workforce Australia's functions to the Department of Health will come at a critical juncture in addressing Australia's health workforce needs. Beyond the predicted shortage in medical internships in 2014, there is only about one year for the broader postgraduate training bottleneck to be resolved before this too hits a crisis point. It is therefore important that any disruption does not impede upon the process being made by HWA and, in particular, by the NMTAN. AMSA would encourage the Committee to ensure this is not the case.[14]

1.39 The Royal Australasian College of Physicians (RACP) was similarly supportive of the role HWA has played and expressed 'concerns regarding the full implications of the Health Workforce Australia (Abolition) Bill 2014 (the Bill) and its effective transition to the Commonwealth Department of Health. RACP argued:

> The core functions currently performed by HWA are becoming more rather than less important. Driven by Australia's aging population, increasing levels of chronic disease and the emergence of new healthcare technologies, there will be a need for changing models of healthcare which in turn dictates changing workforce needs. Hence, there is a significant imperative for the timely collection and analysis of detailed and accurate health workforce data. This data needs to be able to be considered at a national, State and local level. HWA's health workforce data collection and analysis functions also need to be seen in the broader context of its role in facilitating and developing new models of care. The two functions are allied as the workforce data collected and analysed by HWA can and should also be used by State and Federal jurisdictions to drive workforce policy and coordinated development of new models of care. The continuation of these related functions needs to be assured following the abolition of HWA.[15]

14 *Submission 10*, pp 1–3.

15 *Submission 18*, p. 3.

Recommendation

1.40 Labor members of the committee recommend that the Health Workforce Australia (Abolition) Bill 2014 be opposed.

Senator Carol Brown **Senator Nova Peris OAM**

Senator Jan McLucas **Senator Claire Moore**

Additional Comments by the Australian Greens

Australian National Preventive Health Agency (Abolition) Bill 2014 [Provisions]

1.1 The Australian National Preventative Health Agency was established to focus on preventive health programs that specifically target lifestyle risk factors, such as obesity, alcohol and tobacco use. The Agency has successfully delivered national health prevention programs and played an important role in co-ordinating research into preventative health initiatives.

1.2 At a time when greater investment and accountability in health care and preventative health is critical, the Australian Greens are concerned that the abolition of ANPHA and question whether the Commonwealth Department of Health will be funded and capable of meeting the complex challenges of overseeing national preventative health research and initiatives. The Greens are also concerned that the Department of Health will not be able to expand the work of ANPHA to include oral health and diet.

1.3 The Australian Greens share the concerns expressed by the Consumers Health Forum of Australia and the Public Health Association of Australia that the bill is too narrowly focused on immediate cost savings and that the minimal savings the Government will reap from the abolition of ANPHA will be subsumed by the rise of presentations of otherwise preventable chronic illnesses to the health care system.

Senator Richard Di Natale

APPENDIX 1

Submissions and additional information received by the Committee

Submissions for the Australian National Preventive Health Agency (Abolition) Bill 2014

1. Department of Health Queensland
2. Foundation for Alcohol Research and Education (FARE)
3. Australian Dental Association Inc. (ADA)
4. Social Determinants of Health Alliance (SDOHA)
5. Australian Nursing and Midwifery Federation (ANMF)
6. Australian Primary Health Care Nurses Association (APNA)
7. Dieticians Association of Australia (DAA)
8. Public Health Association of Australia and Australian Health Promotion Association
9. HSU National (HSU)
10. Victorian Health Promotion Foundation (VicHealth)
11. Australian Physiotherapy Association (APA)
12. Australian Government Department of Health
13. Consumers Health Forum of Australia (CHF)
14. Osteopathy Australia
15. Ms Jackie Street
16. Royal Australasian College of Physicians (RACP)
17. National Rural Health Alliance (NRHA)

Submissions for the Health Workforce Australia (Abolition) Bill 2014

1. Community and Public Sector Union (CPSU)
2. Australian and New Zealand College of Anaesthetists (ANZCA)
3. Catholic Health Australia (CHA)
4. Australian Dental Association Inc. (ADA)
5. Exercise & Sports Science Australia (ESSA)
6. Australian Primary Health Care Nurses Association (APNA)
7. Australian Psychological Society (APS)
8. Dieticians Association of Australia (DAA)
9. Health Services Union (HSU)
10. Australian Medical Students' Association (AMSA)
11. Occupational Therapy Australia (OTA)
12. Australian Council of PVCs and Deans of Health Sciences (ACPDHS)
13. Consumers Health Forum of Australia (CHF)
14. Osteopathy Australia
15. Australian Physiotherapy Association (APA)
16. Australian Medical Association (AMA)
17. Flinders University
18. Royal Australasian College of Physicians (RACP)
19. University of Sydney
20. Australian Government Department of Health
21. National Rural Health Alliance (NRHA)
22. Universities Australia (UA)

Additional Information for the Health Workforce Australia (Abolition) Bill 2014

1. Australia's Health Workforce Series Dietitians in Focus, March 2014, from Dietitians Association of Australia, received 7 July 2014

Correspondence for the Health Workforce Australia (Abolition) Bill 2014

1. Correspondence from WA Occupational Therapy Association, received 11 July 2014

APPENDIX 2

Public hearings

Wednesday, 2 July 2014

Parliament House, Canberra

Witnesses

Social Determinants of Health Alliance
CALLAGHAN, Ms Liz, Director Strategic Policy
WALKER, Ms Melanie Jayne, Manager

Australian Health Promotion Association
HERRIOT, Ms Michele Ann, Vice President

Consumers Health Forum of Australia
MOORE, Mr Carter, Policy Officer
STANKEVICIUS, Mr Adam, Chief Executive Officer

Public Health Association of Australia
MOORE, Adjunct Professor Michael John, Chief Executive Officer

Australian Medical Association
CHURCHILL, Dr James, Chair, Australian Medical Association Council of Doctors in Training

Royal Australasian College of Physicians
LEEDER, Emeritus Professor Stephen, Public Health Fellow

National Rural Health Alliance
BADHAM, Ms Geri, Policy Officer
GREGORY, Mr Gordon, Executive Director
PHILLIPS, Mr Andrew, Policy Officer

Australian Dental Association Inc.
BONANNO, Dr Carmello, Federal Vice-President
IRVING, Mrs Eithne, Policy and Regulation Manager

Universities Australia Health Professions Education Standing Group
CROTTY, Professor Brendan, Member of the Executive Committee, Medical Deans Australia and New Zealand
GROTH, Mr Allan, Policy Director, Workforce Development, Universities Australia
WRONSKI, Professor Ian, Deputy Vice-Chancellor, James Cook University

Foundation for Alcohol Research and Education
CRANE, Ms Meredythe, Senior Policy Officer
THORN, Mr Michael, Chief Executive Officer

Australian Nursing and Midwifery Federation
BUTLER, Ms Annie, Assistant Federal Secretary
THOMAS, Ms Lee, Federal Secretary

HSU National
FARTHING, Mr Mark, National Project Officer

Victorian Health Promotion Foundation (VicHealth)
RECHTER, Ms Jerril, Chief Executive Officer

Dietitians Association of Australia
BYRON, Ms Annette, Senior Policy Officer

Department of Finance
GRANT, Mr John, First Assistant Secretary, Governance and Public Management Group

Department of Health
HOLDEN, Ms Fay, Acting First Assistant Secretary, Best Practice Regulation and Deregulation Division
SHAKESPEARE, Ms Penny, First Assistant Secretary, Health Workforce Division
SMYTH, Mr Nathan, First Assistant Secretary, Population Health Division
STUART, Mr Andrew, Deputy Secretary