

RESPONSE TO
DEPARTMENT OF EDUCATION, SCIENCE AND TRAINING

Review of the impact of the Higher Education Support Act 2003: clusters and pipeline arrangements

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The Peak Body Representing Allied Health in Australia

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Comprising: Allied Health Alliance WA, Audiological Society of Australia, Australasian Podiatry Council, Australian Association for Exercise and Sports Science, Australian Association of Social Workers, Australian Institute of Radiography, Australian Orthotic and Prosthetic Association, Australian Physiotherapy Association, Australian Psychological Society, Australian Sonographers Association, Dietitians Association of Australia, OT Australia, Society of Hospital Pharmacists of Australia, Speech Pathology Australia, The Orthoptic Association of Australia and incorporating AHPARR (AHPA Rural & Remote)

Introduction

Allied Health Professions Australia (AHPA) welcomes the recognition by Education Minister the Hon Julie Bishop MP and the Department of Education, Science and Training that the 'cluster' mechanism for funding clinical disciplines needs to be reviewed.

Allied Health Professions Australia is the national peak body for the major allied health professions, representing more than 50,000 health professionals. Current membership of AHPA comprises the peak professional associations for audiologists, dietitians, exercise physiologists, occupational therapists, orthoptists, orthotists and prosthetists, pharmacists, physiotherapists, podiatrists, psychologists, radiographers, radiation therapists, social workers, sonographers and speech pathologists.

In recent years, Allied Health Professions Australia (and its predecessor the Health Professions Council of Australia) has drawn attention to several urgent workforce issues, which are associated with problems in the provision of allied health clinical education, where funding difficulties are leading to course closures and workforce attrition.

It is now widely recognised that Australia faces an increasingly critical shortage of allied health professionals.

Since a major cause of this problem is inadequate funding for entry-level clinical education, the current review of the impact of the *Higher Education Support Act 2003* is very timely and welcome.

AHPA believes that the clinical component of most mainstream allied health entry-level courses – such as physiotherapy, occupational therapy, pharmacy, psychology, podiatry, social work, speech pathology, exercise science and rehabilitation, and others – is comparable to that of the other currently recognised clinical disciplines of medicine, dentistry and veterinary science. Therefore the Australian Government's contribution for these allied health students should be equivalent to that for students of medicine, dentistry and veterinary science.

The general case for change has been set out in several discussion papers and submissions, notably in submissions to the Productivity Commission in July and November 2005, in AHPA's pre-budget submission to the Australian Government in October 2006, and its report, 'Solving the Crisis in Clinical Education for Australia's Health Professions' (November 2006). These documents can be found on the AHPA's website, www.ahpa.com.au

Our responses to the six questions asked in the Department's discussion paper (December 2006) are set out in the following pages.

In summary:

- **AHPA urges the Australian Government to move allied health-related entry-level courses from clusters 5 and 6 to cluster 9 on the Commonwealth Course Contribution Schedule, so that students of these clinically-based disciplines are funded at the same level as students of dentistry, medicine and veterinary science.**
- **AHPA supports the submissions of its member organisations for other specific changes, notably that:**

- Undergraduate psychology, currently in cluster 5, should be funded at a level comparable to science, currently in cluster 8; post-graduate professional psychology courses should be funded comparably to medicine, currently in cluster 9
- Social work courses, currently in cluster 5, should be funded at the same level as nursing, currently in cluster 12.
- AHPA believes that a transparent formula needs to be adopted for grouping disciplines into funding clusters, and makes some suggestions on how such a formula might be structured.
- In relation to some allied health, the pipeline formula used to estimate course attrition rates is far too high and needs to be substantially reduced.

AHPA responses to Discussion Paper questions

1. Do the current funding clusters adequately reflect broad discipline relativities?

Allied Health Professions Australia believes that the current funding clusters do not adequately reflect the broad discipline relativities for allied health.

As crucial training programs for clinical disciplines, allied health courses should be in the same funding cluster as medicine and other clinical courses; yet they are currently grouped with non-clinical disciplines and so receive only half the funding provided for medical courses.

The Australian Government has made it clear through many of its programs that allied health professionals play an essential role in Australia's health services, and has underlined that commitment by extending Medicare to cover specified allied health services.

The National Health Workforce Strategic Framework¹ acknowledges national skill shortages in several allied health professions, and notes the key role of education and training in overcoming these shortages.

Allied Health Professions Australia believes that without additional higher education funding, the current funding crisis - particularly as it relates to clinical education - could lead to a crisis in the supply of allied health professionals.

Clinical education is fundamental to all health professions: but it is only specifically funded for doctors and nurses. Other mainstream professions – such as physiotherapy, occupational therapy, pharmacy, psychology (at post-graduate level), podiatry, radiography and radiation therapy, social work, speech pathology and others – have a mandatory requirement for clinical education, but no specific Commonwealth funding for it.

¹ The National Health Workforce Strategic framework can be found at:
http://www.health.nsw.gov.au/amwac/pdf/NHW_stratfwork_AHMC_2004.pdf

It is important to recognise that 'clinical education' is not something added-on and separate from 'education', but is an integral part of it. So funding for education intrinsically needs to cover costs associated with clinical education. The development of practitioner skills as well as clinical reasoning and decision-making, and the growth of theoretical knowledge, all need to occur in an integrated and interactive way. Many allied health students are required to complete up to 1,000 hours of supervised clinical practice as part of their entry-level training.

Under the Commonwealth Grants Scheme, Health is currently placed in cluster 6, along with computing and the built environment: this means that in 2007 health courses will get a government contribution (base level) of \$7,495 per student². Social work and psychology, in cluster 5, are funded at \$6,729 per student.

In contrast, medicine – in cluster 9 along with dentistry and veterinary science – will receive more than twice as much, at \$15,638 per student. Nursing, classified as a National Priority, attracts a government contribution of \$10,189 – about a third more than allied health courses.

AHPA urges the Australian Government to move allied health-related entry-level courses from cluster 6 to cluster 9 on the Commonwealth Course Contribution Schedule, so that students of these clinically-based disciplines are funded at the same level as students of dentistry, medicine and veterinary science.

AHPA supports the submissions of its member organisations for other specific changes, notably that:

- **Entry-level psychology, currently in cluster 5, should be funded at a level comparable to science, currently in cluster 8; post-graduate professional psychology courses should be funded comparably to medicine, currently in cluster 9.**
- **Social work courses, currently in cluster 5, should be funded at the same level as nursing, currently in cluster 12.**

The arguments for specific changes are set out in submissions to the HESA Review from the Australian Physiotherapy Association, The Australian Psychological Society Ltd and the Australian Association of Social Workers.

There is no logic in grouping Health in the same funding cluster with computing and the built environment. Students of the allied health professions cannot just be taught in a lecture theatre or through computer simulation. Only in actual clinical settings can students gain real time experience in clinical decision-making. Clinical practice requires rapid, efficient, high level clinical, moral and ethical decision-making almost impossible to simulate in classroom settings.³

² DEST: Review of the impact of the Higher Education Support Act 2003 – Discussion paper December 2006

³ References on the importance of clinical education include:

- McAllister, L., Lincoln, M., McLeod, S. & Maloney, D. (Eds.). (1997) Facilitating learning in clinical settings / edited by Lindy McAllister ... [et al.]. Cheltenham, UK: Stanley Thornes.
- Titchen, A. (1998a). A conceptual framework for facilitating learning in clinical practice. Occasional Paper No. 2, Centre for Professional Education Advancement. Sydney: The University of Sydney. Titchen, A. (1998b) Professional craft knowledge in patient-centred nursing and the facilitation of its development. Unpublished PhD thesis, Oxford University.
- McAllister, L. (1997). An adult learning framework for clinical education. In L. McAllister, M. Lincoln, S. McLeod, & D. Maloney (Eds.), Facilitating learning in clinical settings (pp. 1-26). Cheltenham, UK: Stanley Thornes.
- Lindy McAllister and Michelle Lincoln (2004) Clinical education in speech-language pathology / London : Whurr.

In 2003, the professions represented on Allied Health Professions Australia had more than 12,700 entry-level (undergraduate and Masters) students enrolled in 138 university courses around Australia. All of these courses include a requirement for extensive clinical experience of up to 1,500 hours.

The actual cost of educating an allied health professional is in fact much greater than the Australian Government contribution. Confidential estimates provided by universities put the true cost of educating each student at between \$15,000 and \$28,000 per annum.

In addition to Commonwealth Grant Scheme funding, the Australian Government provides multi-million dollar funding for the training of medical practitioners, both through universities and through GPET – General Practice Education and Training. But nowhere is there any specific funding for allied health clinical education.

Acquiring clinical experience is handled differently across disciplines and universities. Some rely on fieldwork placements in tertiary hospitals. Others, such as physiotherapy and psychology, extend into the community setting while some, such as podiatry and speech pathology, supplement this with their own on-site, operational clinic. Since over 70% of podiatrists work in the private sector, universities need to maintain costly on-site clinical training facilities which impact on their budget.

For many allied health professions, public hospitals provide the bulk of entry-level clinical education. Student supervision, which was once an accepted part of hospital clinical work, is increasingly being squeezed out of tight hospital budgets, causing major difficulties for universities. As a result, some allied health professional courses have closed and others are under great stress.

At present, allied health clinical education largely relies on the goodwill of senior practitioners and their employers, although some universities are paying considerable amounts to arrange clinical education. For instance, one Speech Pathology program has calculated that they receive approximately \$600,000 of in-kind clinical education support from external practitioners. Another Speech Pathology course has paid over \$100,000 in a single year towards paid placements – considered an unsustainable amount over the longer term.

Universities need to be funded at a level which enables them to provide hands-on clinical education for all their allied health students. Based on the current clusters, this would involve moving allied health courses from cluster 6 and locating them in cluster 9; moving postgraduate psychology programs from cluster 5 to cluster 9, and moving social work from cluster 5 to cluster 12.

2. Are individual disciplines placed in appropriate clusters? Are there any undesirable consequences of the placement of specific disciplines in particular clusters?

As discussed above, allied health professional entry-level courses have a mandatory requirement for clinical education and need to be funded at a level which covers these costs.

The main undesirable consequence of the current cluster arrangement is that there is grossly inadequate funding for allied health clinical education, and this is resulting in course closures, students being unable to graduate, and workforce reduction. Given the severe shortage of allied health professionals across Australia, these are highly undesirable outcomes.

The difficulty of finding clinical placements for entry-level allied health students is putting huge pressure on universities, hospitals, academic staff and students across Australia.

As an example, the Australian Physiotherapy Association (APA) states that 200 physiotherapy students at Australian universities could not graduate in 2006 because they could not get the clinical education they needed.⁴ The APA advises that a petition signed by nearly 1400 physiotherapy students – nearly half of the total number of physiotherapy students - urges the Australian Government to fund physiotherapy courses at the same level as medicine, so that clinical education can be properly funded.

In speech pathology, a new program in its second year of delivery operates on a loss budget for its total course. Income received from student and government contributions meets less than half of the total expenses (44%) required for teaching and clinical education units.

In recent years, podiatry courses have been closing at a time when the demand for podiatry services is high. In June 2003, Curtin University announced they would close the only podiatry program in the State due to cost constraints. In late 2004, the University of Western Sydney announced they would defer intake due to cost constraints; in both cases, the reason for closure was cited as cost of course delivery.

The problem of inadequate funding for allied health education was recognised in the Productivity Commission's recent report on Australia's health workforce⁵. The Commission observed that 'the current clinical training regime may not be sustainable over the longer term, due to lack of transparent and explicit funding'. It also noted comments by the Australian Council of Deans of Health Sciences that *'access to quality clinical teaching placements is likely to emerge as the major rate-limiting factor in an effort to ramp up professional training programs'*.

Funding is also needed to support allied health students undertaking placements far from their place of study – for instance, rural students undertaking a clinical placement in Melbourne, or metropolitan students undertaking a clinical placement at a country hospital. Such students not only have to pay for travel, accommodation and food, but may also lose income from any part-time employment they have at their normal place of residence. Current funding arrangements make no provision to support allied health students during such placements, which are an essential part of their education.

Funding difficulties in the higher education sector clearly have a flow-on effect on workforce shortages. Right around Australia there are significant shortages in the primary health care professional workforce.

⁴ See article in The Australian: Franklin M (2006): 'Boost for Medico Training', The Australian, September 1 2006.

⁵ Productivity Commission (2005): Australia's Health Workforce.
<http://www.pc.gov.au/study/healthworkforce/finalreport/healthworkforce.pdf>

The National Health Workforce Strategic Framework, issued in April 2004, highlights the national shortage of allied health professionals⁶, as does the current listing of Migration Occupations in Demand (MODL)⁷. This shortage is evident not just in rural and remote areas, where health professionals from many disciplines tend to be in short supply. In metropolitan hospitals, in private sector clinics and in community health services, difficulties in recruiting are being widely reported.

It is evident that workforce supply is affected in states and territories that do not offer entry-level university courses. Practitioners are more likely to practice where they train, therefore limiting supply of allied health professionals in states and territories where there are few or no training courses.

The rise in chronic disease, the emphasis on lifestyle prescriptions and the need for a whole of population approach are all increasing the demand for allied health services. Decisions about allied health professional courses need to be based on population needs and appropriate workforce planning. Although an increase in the allied health workforce is clearly essential for Australia's future, student intakes should not be increased unless adequate clinical education can be provided to all students.

Funding allied health courses at an equivalent level to medicine in the Commonwealth Grants Scheme, and thereby doubling funds available for allied health clinical education, would be a major step in addressing workforce shortages in the health sector.

3. Should the number of clusters change? What would be the advantages or disadvantages? If the number of clusters were to change, how should disciplines be grouped within those clusters?

Allied Health Professions Australia believes that the rationale for the current clusters is not clear. In particular, there is no logical basis for health to be clustered with computing and the built sciences, while the other clinical disciplines of medicine, dentistry and veterinary science are in a separate, much more highly funded cluster.

As indicated in the Discussion paper for this Review, the current clusters are based on the Relative Funding Model (RFM) which is now nearly 20 years old. The RFM was developed from historical education spending patterns which were then *'analyzed and adjusted for a combination of pragmatic and principled reasons'*⁸ to give a relative teaching cost matrix.

Clearly, in the health sector, things have changed significantly since the 1980's and current allied health professional course costs are not reflected in the RFM. Allied health professionals now play a crucial role in Australia's health system, alongside their medical and nursing colleagues; they require a depth of clinical knowledge and a breadth of skills scarcely envisaged 20 years ago.

AHPA strongly believes in the need for inter-disciplinary entry-level education, through shared common modules taught to students across health disciplines alongside discipline-specific teaching. This approach provides the basis for multidisciplinary teamwork between professionals upon their entry to the health workforce. Grouping allied health and medicine in the same funding cluster would

⁶ The National health Workforce Strategic framework can be found at: http://www.health.nsw.gov.au/amwac/pdf/NHW_stratfwork_AHMC_2004.pdf

⁷ The Migration Occupations in Demand list can be found at: <http://www.immi.gov.au/skilled/general-skilled-migration/skilled-occupations/occupations-in-demand.htm>

⁸ Quoted from http://www.griffith.edu.au/vc/ate/content_he_fund_rfm.html

further encourage development of inter-disciplinary education across the health sector.

AHPA suggests that in future clusters should be decided on the basis of a new and transparent formula covering a wide range of issues. Disciplines should be grouped into clusters based on their compliance with this transparent formula.

Issues relevant to a new cluster formula include:

- **Educational costs** – particularly those related to mandatory clinical education, laboratory costs, specialised teaching and course complexity
- **Workforce priorities** – recognising the need to encourage students to join disciplines where national workforce shortages and special needs have been identified
- **Public health priorities** – to help tackle identified public health issues, eg indigenous health, chronic disease, mental health, obesity
- **Research needs** – recognising that some disciplines have a strong involvement in costly research which may be of national or international significance
- **Public risk** – recognising that some professions, eg health, have more potential than others to affect people's lives, and that educational standards need to reflect this situation
- **National and global priorities** – such as the current need for more skilled climate change scientists and engineers.

Clearly these topics need to be worked through in more detail, following wide consultation. Since some relative weightings and priorities would change over time, the formula would need to be reviewed every few years.

Allied Health Professions Australia would welcome the opportunity to assist in developing a new funding formula and cluster system for higher education.

4. How have higher education providers used funding under specific measures, such as the additional funding for nursing units of study that was introduced in BAF to assist with the costs of supporting clinical training?

Allied Health Professions Australia believes that if a transparent formula for creating clusters is adopted, as set out above, there would be no need for additional funding measures such as the extra funding for nursing.

5. Should the current standard pipelines for most new Commonwealth supported places across most disciplines be kept? Does it unduly constrain providers in the provision of new places?

The current pipeline is based on a notional attrition rate of 25% a year. Allied Health Professions Australia believes that in relation to health this figure is far too high.

Attrition rates for allied health courses rarely go above 10%. Recent publications suggest that overall attrition from health disciplines is as low as nine per cent.⁹ The pipeline formula should be adjusted to this lower attrition rate.

⁹ McMillan J (2005): Course change and attrition from higher education. Australian Council for Educational Research
<http://www.acer.edu.au/research/projects/lsay/reports/lsay39.pdf>

6. If the current model were to be largely retained, should any further exceptions be made?

Allied Health Professions Australia believes a transparent formula for developing clusters, as set out in answer to question 3 above, would avoid the need for 'exceptions'. In general, if there is a need for an exception, it suggests that the original formula may be inadequate.

About AHPA

Allied Health Professions Australia (formerly the Health Professions Council of Australia) is the national peak body for major health professions other than medical practitioners and nurses. It works to represent the interests of the non-medical health professions sector, particularly to the Australian Government; and to provide a vehicle for liaison and discussion between the professions themselves.

Members of AHPA are national organisations representing specific professions, with membership across Australia in both urban and rural areas. Collectively, they represent more than 50,000 allied health professionals. Each organisation has internal systems and networks for liaising with their members right across Australia, who together provide a vast wealth of skills, experience and expertise.

Current membership of AHPA includes the peak professional associations for audiologists, dietitians, exercise physiologists, occupational therapists, orthoptists, orthotists and prosthetists, pharmacists, physiotherapists, podiatrists, psychologists, radiographers, radiation therapists, social workers, sonographers and speech pathologists.

More details about AHPA and its member organisations can be found at:
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