

Health Services Union



National Registration and Accreditation

Submission to the Health Working Group

Department of Prime Minister and Cabinet

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Introduction

The Health Services Union is the representative body for the largest breadth of health professions and health workers across Australia.

The HSU supports national consistency in standards and greater flexibility in the scope of roles to meet identified demand whilst ensuring appropriate professional standards and quality of care. The HSU is a central player in the development of new roles and adoption of mutual recognition of interstate workforce standards. We regularly work with governments, health services organisations and registration boards to deliver these outcomes.

As such, it is disappointing that genuine consultation was not undertaken by the Working Group with the HSU, the workforce, or the community earlier. It is our view that the reform elements proposed would have considered more critical issues, notably, how the reforms would impact on Australia's health workforce and health services, if this consultation had been undertaken.

We agree with the majority of stakeholders' views that the existing parameters or 'key elements' of the proposed reform are insufficient to provide full endorsement. There are too many issues which are outstanding and do not have an in principle or policy framework to guide the creation of beneficial outcomes.

In its current form there are no identifiable benefits to registrants, only risks. This balance needs to be addressed before registrants, and their representatives such as us, can support the proposed reform parameters.

This submission provides additions to the 'key elements' to be contained in the Inter-Governmental Agreement (IGA). The addition of these elements is to provide some level of protection to the health workforce and the community during the nationalisation of health professionals' standards.

‘Key Elements’ to be included in Inter-Governmental Agreement

Structure and Governance

1. The IGA needs to stipulate that:
 - 1.1. Representation on professional panels will be elected by the registrants.
 - 1.2. A lesser proportion of members can be appointed by Health Ministers provided they are guided by the principle of improving the balance of representation of key stakeholders or skills.

Ministerial Decisions

2. The size and composition of the board should be set by legislation.

Cross Professional Representation

3. Governance arrangements will be restructured to formalise incorporation of cross-professional representative organisations, including employee representatives and State and Federal Health and Community Industry Skills Councils.

Development of Accreditation & Registration Standards

4. That national accreditation and registration standards will not be formed from the lowest common denominator standards across the country.
5. That individual States will be able to modify the adoption of national standards to meet the needs identified by relevant State Agencies, (eg. Ombudsman, Coroners Court, Auditor General, Health Department, Health Services Commissioner, Administrative Appeals Tribunal)
6. That State Governments and Ministers will remain responsible and accountable for health services delivery, including the quality standards of health care providers.

Judicial Parameters & Procedural Fairness

7. Informal hearings are to remain private. Formal hearings will enable health professionals to have a right of representation.
8. Issues not related professional conduct (ie complaints for mediation and conciliation) will not be directed through registration disciplinary process.
9. Complaints and mediation agencies, eg. Health Services Commissioners, will refer complains which indicated ‘disciplinary or professional conduct’ issues to the ‘registration board’.

10. Fines will only be imposed for over-servicing - the introduction of any other fines will be subject to a full Regulatory Impact Statement process.
11. Complainants which are representatives of organisations or corporations with a financial or potential liability from third parties in relation to the disciplinary matter will disclose all interests.¹
12. Practitioners will have right of appeal of board and panel decisions by an independent tribunal and/or courts. The right of appeal will include merit based appeal.
13. An employed health professional will have a right to refer the matter to the Industrial Relations Commission on the basis that the complaint is employment related.
14. Maximum fine to be a weighted national average for 2005/6
15. Not increase in maximum fine by over 5% without full Impact Statement approved by Parliament
16. The revenue from fines will not be retained by scheme (conflict of interest)

Policy and Planning in Fee Setting

17. Transparent fee setting should be based on policy considerations and criteria which incorporate the following factors:
 - 17.1. The cost of registration relative to income
 - 17.2. Duplicating cost of registration with other regulatory costs – such as licensing by users of radioactive materials, compulsory education and training
 - 17.3. Registration fees not to be payable by employees in the public sector²
 - 17.4. The cost of registration for part time and low income employees
 - 17.5. The prohibitive cost of re-applying for registration, including courses and exams, after only short period of leave – eg. 1-5 years off to have a child
 - 17.6. The relative cost benefit to practice as a registered health practitioner or as another type of professional
 - 17.7. Cost of maintaining registration while working overseas/barrier to returning to Australia
18. That fee setting objectives and criteria will be included in the legislation and that an increase above 5% in any 3 year period will require full Regulatory Impact Statement procedures and approval independent of the Health Minister/s.

¹ This is required to prevent organisations who have contributed to adverse outcomes to shift their liability to individuals.

² The payment of registration fees for employees in the public sector will be directly funded by the commonwealth. There is the potential to offset or undertake cost sharing within the Federal State Funding Agreement.

Workforce Sustainability

19. That the national scheme will include a monitoring regime which explicitly and transparently monitors the migration patterns and income disparities between:

- Overseas trained skills sponsored health professionals
- Australian trained health professionals
- Overseas destination countries for emigrating Australian health professionals

Registration Boards Income and Assets

20. The \$19 million offered to the States from the Commonwealth to fund the reform (surplus to need), be diverted to strategies to encourage 'return to practice' and retention of health professionals in Australia.

21. The establishment of a trust from existing assets and surplus revenue of registration boards for compensation for representation at formal disciplinary hearings.

Structures and Governance

The proposed governance structure intends to give the Health Minister/s the power to nominate all the members of the Agency Board and Professionals Panels. The majority of these have the potential to be ‘consumer’ or other lay representatives.³ There is no proposal to put any other criteria around the skills or representation, including representation of working health professionals.

Health professionals have no indication of their future ability to access a fair system as a consequence of the dilution of their representation and increased politicisation of the proposed structure.

The representation of registrant membership needs to be guaranteed, to ensure the interests of all registrants are represented, public and private, low income and female. This can be achieved either by legislating their representation in the criteria for membership in the and/or by enabling registrants to elect representatives.

The system of electing representatives enables registrants to be involved in the regulation and development of standards of their profession. It provides an opportunity for people who are outside of the interests of professional or political ‘establishments’ to participate in representing the public interest.

Principles for the IGA

- **The IGA needs to stipulate that:**
 - **Representation of professional representatives will be elected by the registrants.**
 - **A lesser proportion of members can be appointed by Health Ministers guided by legislating principles of balancing of representation of key stakeholders or skills.**

³ However, it is not clarified whether ‘consumer’ includes the majority third party consumers, such as health insurers and occupational safety insurers.

Ministerial Decisions

Size of Board

The current proposal to enable Health Minister to determine the size and composition of the Agency and panels is inappropriate. In principle registration boards are representative boards, not handmaidens to sitting politicians. It is inappropriate for the Minister to determine the size of the board. This would give the Minister the ability to directly influence the balance of the board and their decisions. This would make the expense and bureaucracy of a governance structure redundant.

The proposal is antithetical to the principle of arms length governance which has traditionally and internationally determined health registration boards' statutory independence.

The HSU concurs with health boards' view that without any safeguards against ministerial abuse of power, professional standards and the quality of health care could be compromised for the sake of "workforce flexibility".⁴

The public protection of expert determination of safe practice standards is critical to public health. The health of Australians is too important for the national health professional standard setting parameters to be determined *carte blanche* by political appointees. The danger of this dynamic must be mitigated by strict legislative parameters for protecting the public interest through appropriate expertise and representation of health professionals.

Principle for IGA

- **The size and composition of the board should be set by legislation.**

⁴ Sarah L Middleton, Thomas D Pearce and Michael D Buist, The rights and interests of doctors and patients: does the new Victorian Health Professions Registration Act 2005 strike a fair balance? MJA 2007; 186 (4): 192-196

Cross Professional Representation

Chairs of Committees proposed sole function is to facilitate cross professional discussion on registration and accreditation.

This is unrealistic. The HSU has been integrally involved in the development of many new roles in the workforce and they arise, with negotiation, where the demand for them is evident. This demand can arise out of a range of factors, from demographic changes, high incidents of particular pathologies, organisational restructures etc.

The current Health and Community Services Industry Skills Councils comprising government, union and employer representatives, house the best coal face information about the roles, training, employment and career prospects for new classifications. The direct input of this representation needs to be maintained in any reformed structure.

Moreover, it is not clear that Chairs understand the scope of problems being experienced in the broad cross section of workplaces, across all sectors in which registered and unregistered workers are employed. Representative organisation with nation-wide, cross sectorial membership have access to timely, in-depth information about trends occurring across health sectors.

For example, the HSU has evidence of a dramatic rise in the number of people who feel their jobs are under threat if they do not perform or delegate tasks they believe would be dangerous to patients. Workers who are being increasingly pressured to undertake functions that they do not feel safe or qualified in performing are leaving themselves and their clients exposed. The greater 'employment flexibilities' introduced by the *Workplace Relations Act 1996* reforms are exacerbating this problem. Simple delegation rules clarifying, for example, the role of the health professional and the assistant, would substantially reduce the clinical risks and industrial conflicts across a range of health sectors. How this would be addressed by the proposed national structure, and how long it would take, are unfathomable.

The types of safeguards required to protect patients and staff need integral input of trade unions to protect the public interest. It is unlikely that, at the risk of their registration and/or job, registrants will notify registration boards of activities which are outside of their scope. Unions are therefore the only 'safe harbour' where people can raise critical health and safety issues. It should be clear therefore that unions have a distinct and important role to play in protecting the public interest.

Principle for the IGA

- **Governance Arrangements will be restructured to formalise incorporation of cross-professional representative organisations, including the HSU and State and Federal Health and Community Industry Skills Councils.**

Development & Adoption of Registration and Accreditation Standards

There are genuine concerns about the failure of the proposed framework to outline the process by which registration and accreditation standards will be developed and adopted by States. This raises real issues about the ability for States to be responsible and accountable for standards of health delivery within their jurisdiction.

In its current form the proposed structure appears overly bureaucratic with insufficient flexibility to incorporate the standard setting and monitoring governance structures of individual States. The ability for regional evidence-based decision making and ‘bottom up’ development of roles or resolution will be made more difficult. There is a real risk that the ‘lowest common denominator’ outcomes will be the only ones achievable under a nationalised, rather than co-federated system.

The flexibility of addressing local needs is at risk of being lost by a ‘national consistency’ objective and the increased bureaucracy. While it is highly seductive to assume that ‘national consistency’ will lead to parity in outcomes, the fact is health services and workforces in different States experience different problems and needs. See Appendix C. For example, high demand and low supply of some health professionals in one Territory, may lead to a reduction in standards nationally in order to deem people available as ‘qualified’ to act as a ‘registered practitioner’.

In tandem, it is equally likely that bureaucratic national structure will fail to give ‘high needs’ areas timely attention and response. This is evident in the relatively slow response of Universities, regulated nationally, to respond to the skills and employment needs of regions as rapidly as Vocational Education and Training Sector.

The National Training Package process creates national consistency in training parameters, but provides for individual States to adopt the subjects and roles which suit their circumstances. This enables each State to endorse the training and workforce roles is an

appropriate way for State's to meet needs identified through their own standard setting and monitoring frameworks. The governance frameworks which inform the safe parameters for health services' delivery standards at the State level include the:

- Ombudsman
- Coroners Court
- Auditor General
- Health Department
- Health Services Commissioner (or equivalent health complaints body)
- Administrative Appeals Tribunal (or equivalent administrative law review body)

A key question raised therefore is: How recommendations by the aforementioned State entities will be incorporated into the 'national standards'?

Additional critical questions include:

- **Will States and State Ministers be able to adapt 'nationally determined standards' to their own requirements? If so, how will this be achieved?**
- **Will State Ministers need a convoluted process to put additional safeguards around reduced national standards?**

The current arrangements nationally enable States, such as Victoria has already done, to 'mutually recognise' standards in other States. The differences between the States on any major scope of education or practice can be addressed by the State registration board. For example a Division 2 nurse, who has not been trained or endorsed to give medications in one State, can undertake additional training in the State they are moving to. In reality, if the higher practicing nurse in one State moves to another, they would still not be able to perform the 'out of scope' task. This is not because of registration arrangements, but because that State's service delivery arrangements & workforce configurations do not have the reporting and monitoring structure to ensure that it is safe. Currently States do have different workforce configurations. One model will not fit all requirements for planning and delivering health needs. The governance of the accreditation and registration arrangements needs to reflect this.

Critical questions regarding the reduced accountability of State governments for the health services they provide, and the operation of the ‘national scheme’ still need to be answered. They include:

- How will State Ministers be held accountable to their constituents for adverse outcomes across their respective health portfolios from the national standards? ⁵
- How *can* State Ministers/Governments be held accountable for any adverse impacts from a *nationally determined* reduction in standards?
- How will aggrieved parties seek redress from the Agency Board/State if the accreditation or registration process is found to have caused adverse outcomes?

Principles for the IGA

- **That national accreditation and registration standards will not be formed from the lowest common denominator standards across the country.**
- **That individual States will be able to modify the adoption of national standards to meet the needs identified by relevant State Agencies, (eg. Ombudsman, Coroners Court, Auditor General, Health Department, Health Services Commissioner, Administrative Appeals Tribunal)**
- **That State Governments and Ministers will remain responsible and accountable for health services delivery, including the quality standards of health care providers**

⁵ This includes State Ministers with responsibility for Aged, Acute, Community, Disability and related portfolios.

Judicial Parameters & Procedural Fairness

It is understood the proposal intends to dismantle the existing health professionals' registration boards and replace them with a national agency and scheme. The national scheme will establish State Registration Committees whose role will be to oversee complaints and disciplinary matters.⁶

We are concerned that the proposal outlines the political governance but not the principles or operational functions of the national scheme. This includes remaining silent on the judicial parameters and powers of the disciplinary functions of the scheme.

The enforcement of acceptable standards of professional and ethical conduct, essential to protect the public, is conducted through quasi-judicial disciplinary proceedings.

Under the proposed framework there is no mention of representation of working health professionals in the development or operation of these judicial functions. The fundamental role of disciplinary panels and hearings is to determine a person's suitability to work in their field. How disciplinary decisions will be determined, by whom, with what representation, costs, sanctions and right of appeal, are central questions to health professionals.

It is the fundamental responsibility of unions and governments to ensure working people have access to procedural fairness in the determination of issues affecting their working lives.

There are a broad range of mechanisms by which elements of procedural fairness in disciplinary procedures are achieved across the country and internationally. The difference in key elements, such as representation and rights of appeal, vary across States. This is demonstrated in Table 1. The current 'key elements' are silent on the governments' proposed parameters for the disciplinary and judicial treatment of health professionals, notwithstanding

⁶ Commonwealth consultation on National Registration and Accreditation, Slide 8, 13 March 2007

that this is a key function of registration boards. This is a very worrying signal given governments have clear conflicts of interest in the operation these arrangements. **As major funders and providers of health and judicial services, governments have a financial and political incentive to shift blame, liability and costs of any accusations or incidents onto individuals.**

Table 1 Hearings into serious unprofessional conduct⁷

	Victoria (HPRA)	QLD	NSW	ACT	NT	WA	TAS	SA
Independent body	Victorian Civil and Admin Tribunal	Health Pract Tribunal	Medical Tribunal	Health Prof Tribunal	Health Prof Review Tribunal	State Admin Tribunal	Medical Complaint Tribunal	Medical Profess Conduct Tribunal
Legal member included	No statutory guarantee	District Court Judge	District Court Judge	Magistrate	Legal practitioner	Judge, magistrate or legal practitioner	Legal practitioner	District Court Judge
Prof merit appeal	No	No	Yes	Yes	No	No	Yes	Yes
Complainant merit appeal	No	No	Yes	No	No	No	No	Yes

Each State also varies in the extent to which they interact with complaints handling bodies, administrative review bodies and courts. How these interactions will be dismantled, and the principles guiding their reform are critical to provide a guarantee of fairness for all stakeholders.

Key elements of procedural fairness and representation of working health professionals in the performance of disciplinary functions must be included in the IGA.

⁷ Sarah L Middleton, Thomas D Pearce and Michael D Buist, The rights and interests of doctors and patients: does the new Victorian Health Professions Registration Act 2005 strike a fair balance? MJA 2007; 186 (4): 192-196

Principles for the IGA:

- Informal hearings are to remain private. Formal hearings will enable health professionals to have a right of representation.
- Issues not related professional conduct (ie complaints for mediation and conciliation) will not be directed through registration disciplinary process.
- Complaints and mediation agencies, eg. Health Services Commissioners, will refer complains which indicated 'disciplinary or professional conduct' issues to the 'registration board'.
- Fines will only be imposed for fraudulent activities, eg. over-servicing. The introduction of any other fines will be subject to a full Regulatory Impact Statement process and agreed by Parliament.
- Complainants which are representatives of organisations or corporations with a financial or potential liability from third parties in relation to the disciplinary matter⁸
- Practitioners will have right of review of disciplinary board decisions by an independent tribunal or court. Appeals on the process and merit of decisions will be permissible.
- An employed health professional will have a right to refer the matter to the Industrial Relations Commission on the basis that the complaint is employment related.

⁸ This is required to prevent organisations who have contributed to adverse outcomes to shift their liability to individuals.

Fines

States also vary markedly in their approach to imposing fines, both through the registration boards or higher courts. Table 2, indicates the difference in maximum fines across the States for registration board' tribunals.

The proposed 'main elements' of the reform are opaque on operationalising national consistency in the determination of fines. The overriding legislation will not be able to remain silent on this matter. The potential impact on indemnity insurance costs for health professionals and consequently consumers needs to be fully evaluated.

These facts demand that explicit principles on the operation of fines are included in the Inter-Governmental Agreement.

It is noteworthy that fines are a fairly recent inclusion to registration board functions and they are not universally used. It is not clear that they are anything other than punitive and budgetary driven. There is no evidence that fines deter behaviours or are the most effective way of improving professional conduct.

Table 2 Maximum fine from Independent Disciplinary Tribunals

	VIC/HPRA	QLD	NSW	ACT	NT	WA	TAS	SA
Maximum fine	\$50 000	\$99 975	\$27 500	No fine	\$10 000	\$10 000	\$5,000	\$20 000

The IGA must contain principles on the use of fines to

- Maximum fine to be a weighted national average for 2005/6
- Not increase in maximum fine by over 5% without full Impact Statement consultation and approved by Parliament
- The revenue from fines will not be retained by the disciplinary body.(conflict of interest)

Policy and Planning in Fees Setting

The proposed framework for fee setting stipulates that the Agency Board will ‘set single set of national fees for each profession’ following ‘consultation with panels’⁹. This is an inadequate principle and process to guide fee setting.

There was an understandable objective of self-funding when boards were ‘profession specific self-regulating’ bodies. The nationalisation of health professionals’ standards under a federal scheme does not have the same self regulating objective or self funding imperative. The public benefit of health professionals paying for additional national regulation and infrastructure has not been determined.

It is suspicious that a public interest assessment has not been undertaken. Particularly because, over the past decade, under COAG’s own National Competition Policy (NCP), the public benefit of introducing a monopoly regulator would have demanded scrutiny. In fact, the COAG decision to nationalise health professional regulation, contradicts its own NCP legislative review findings which determined that the retention of the existing Health Registration Boards was in the public interest.

The policies regulating fee setting requires policy planning and independent oversight. A cost recovery objective is too base to guide the protection of the public through a national scheme for professional health practitioner standards. The monopoly role of the scheme and the principles of competitive neutrality, also demand independent oversight of fee setting.

Registration fees are essentially licence to practice fees. In principle, the cost of the license should be comparable to income. The relative cost to practice of registration fees differs markedly between health professionals, eg. a radiographer on \$40,000 per annum and a radiologist on \$400,000 per annum.

⁹ Commonwealth consultation on National Registration and Accreditation, Slide

Allied health professionals earn on average half the income of salaried medical officers and one eighth of a medical specialist. In many instances allied health professionals earn less than their nursing counterparts, notwithstanding having equivalent or superior education and equally taxing work environment.

Current health professionals' registration administration is inefficient and costly for health workers and consumers. This includes; fees for registration, restoration to register, late fees, extract from register, examination fees, review of credentials fees and more , including legislated 'mandatory professional education' etc. A summary of only some of the fees charged by registration boards indicates the potential plethora of fees required to work and their relative cost across different professions.

Table 3 Examples of Various Fees ¹⁰

Registration Board	No. Registered	Average Full Time Income \$ '000	Registration Fee	Restoration to register	Late app' fee	Extract register/certificate
Psychologist	5075	60	\$ 336	\$ 570 ¹¹	\$ 504	\$ 50
Physio	3974	52	\$ 150	\$ 160	\$ 40 ¹²	\$ 25
Optometrists	950	130	\$ 240	\$ 310	\$ 55	\$ 13
Podiatrist	780	52	\$ 330	\$ 430	\$ 100	\$ 10
Medical Drs	18,016	400 ¹³	\$ 330	\$ 515	\$130	\$ 60
Nurses	77,144	55	\$ 120	\$ 200	\$ 80	-
Osteopaths	322		\$ 500	\$ 500	\$ 552	\$50

Fees are a regulatory cost that contributes to the disincentive for health professionals to practice in Australia and in the health sector. The regulatory costs and the income benefits of working in Australia need to be investigated as a priority in the determination of the application of **all fees**.

¹⁰ Victorian Registration Boards 7/12 Annual Reports 2005/06

¹¹ The formula is 'renewal fee plus late fee plus 20% of renewal fee', Psychologists Registration Board, 2004/05

¹² additional renewal fee

¹³ This is an approximate average practice income from Medical Practitioners Registration Board website 2006.

Public Sector Workforce Strategies

The round robin nature of fees and the associated burden on public health expenditure needs to be acknowledged. Many organisations pay registration fees of their health professionals as an incentive to retain employees. Given many organisations pay the registration fees of their employees, it should be factored that it is an imposition on public health budget. To this extent, as well as to reflect the salary sacrifice of many people choosing to work in the public sector, employees from the public sector should be excluded from paying fees.

This is consistent with health sector workforce retention strategies to increase their capacity to match inducements offered to attract and retain staff. See Appendix A.

Principles in IGA

- Transparent fee setting should be based on policy considerations and criteria which incorporate the following factors:
 - The cost of registration relative to income
 - Duplicating cost of registration with other regulatory costs – such as licensing by users of radioactive materials, compulsory education and training
 - Registration fees not to be payable by employees in the public sector.
 - The payment of registration fees for employees in the public sector will be directly funded by the commonwealth. There is the potential to offset or undertake cost sharing within the Federal State Funding Agreement.
 - The cost of registration for part time and low income employees
 - The prohibitive cost of re-applying for registration, including courses and exams, after only short period of leave – eg. 1-5 years off to have a child
 - The relative cost benefit to practice as a registered health practitioner or as another type of professional as means of testing for reasonableness of fees.
 - Cost of maintaining registration while working overseas/barrier to returning to Australia.

That fee setting objectives and criteria will be included in the legislation and that an increase above 5% in any 3 year period will require full Regulatory Impact Statement procedures and approval independent of the Health Minister/s.

Workforce Sustainability

There is a high public policy priority of increasing the supply of health professionals in Australia and internationally. The federal government’s response to the exodus of health care professionals has been to facilitate employers’ ability to import workers from overseas, through the creation and expansion of skill sponsored migration programs, such as the 457 visa.

The proposed national scheme would give a federal government the ability to influence the accreditation and registration process to continue to facilitate the outflow of health professionals and replace them with ‘less expensive alternatives’. Whilst appealing to the shorter term interests of ‘the government of the day’, the longer term effect would be the continuation of the net loss of health workers to Australia.

The migration statistics show the extent of the problem. The latest available statistics in 2003-04 show that while 3,371 health professionals entered the country with the intention of settling here, almost 4,200 professionals left the country.¹⁴ Further evidence of the public policy priority of health workforce shortages is the proportion of health workers migrating to Australia on 457 Skill Shortages Visas. In 2003-04 the number health workers migrating to Australia was 2,687. **Chart 1 shows that the health and community services sector is the second largest industry of employment for the ‘skills shortage’ 457 Visas.**

Chart 1 Industry of employment of 457 visa holders and spouses



¹⁴ Department of Immigration and Multicultural and Indigenous Affairs (DIMIA), Input into Productivity Commission Health Workforce, Study Issues Paper, Migration of health workforce professionals

However, notwithstanding the attraction of health workers on 457 visas, there is still a net loss of people with health care skills from Australia. Moreover, evidence suggests that migrants arriving to work in the health sector have a lower skill base than those emigrating.¹⁵

Recent available evidence indicates that a significant number of 457 visa holders are paid below market rates, especially in the under 30 age group.¹⁶ The Department of Immigration and Multicultural and Indigenous Affairs, in a 2006 Research Report found that:

The work permit system (457) has not responded closely to prevailing labour market conditions and survey evidence indicates that companies prefer to use overseas labour which is highly mobile and may be purchased at bargain prices. For both countries, (UK & Australia) one implication is that the situation may lead to a reduction in firms' incentives to create talent pipelines.¹⁷

The implication from this evidence is that the Australia's shortage of health professionals could worsen exponentially in tandem with their income. Moreover, in addition to the budgetary incentives in lower wages for health professionals, the government has an incentive to reduce expenditure on education and training, as indicated above.

It is not being overly dramatic to say that health workers are already feeling insecure about the Commonwealth government's intention of driving down wages through their recent amendments to the *Workplace Relations Act 1996*.

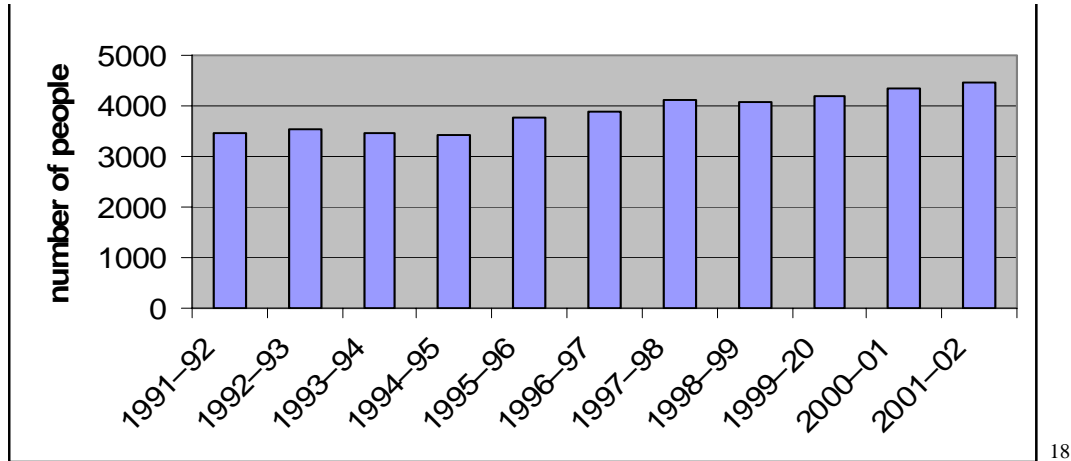
Without genuine measures to protect the interests of working health professionals within the National Scheme, workers can only assume it is an extension of the federal government's agenda to reduce the rights, representation and income of workers.

¹⁵ See DIMIA migration data on health workers migration. Australia tends to lose health professionals to industrialised countries and gain lesser qualified 'associate professionals' from developing countries.

¹⁶ DIMIA, Migration Report 2005/6 Evaluation of the General Skilled Migration Categories p270

¹⁷ Ibid.

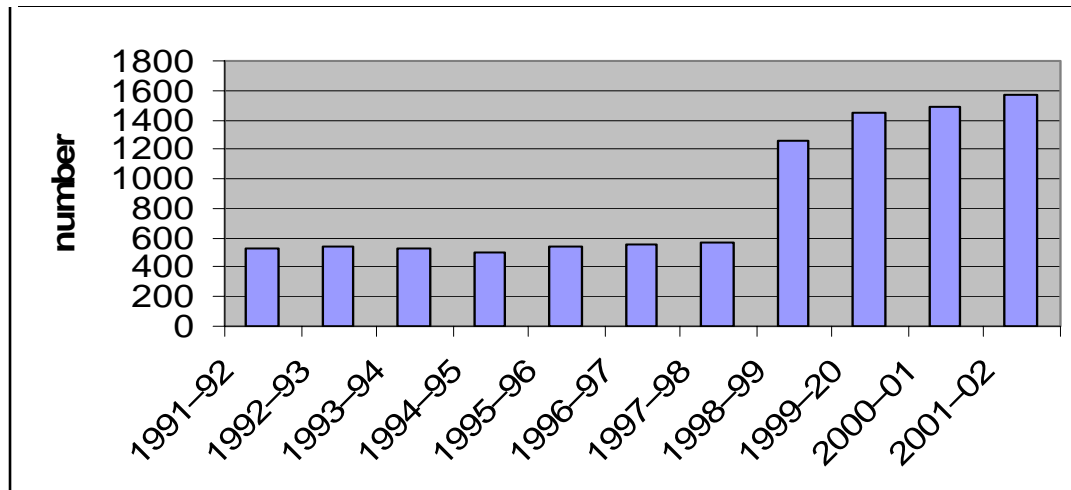
Chart 2 Long Term Departure of People with Health Care Skills



18

Chart 2 demonstrates the growing exodus of people with health skills from Australia for a long term period. The following chart, which totals the number of people with health skills leaving Australia permanently, shows the true extent of the problem. Additionally, the rate of attrition of health professionals to the major destination countries is not projected to decline under current and projected shortages.¹⁹

Chart 3 Permanent Departures of People with Health Care Skills



¹⁸ Source: DIMIA Movements Data Base.CEDA - Australia's Diaspora: Its Size, Nature and Policy Implications December 2003

¹⁹ British Parliament Health Select Committee Inquiry on 'Workforce needs and planning for the health service' Evidence from NHS Employers, March 2006

The rate of exodus of health workers from the country should be sufficient evidence of the need to consider issues important to health professionals as central to the reform agenda. There is more than anecdotal evidence that the net loss of health practitioners to Australia is partly due to the relative financial inducements.²⁰ That none of these factors has been raised in the national scheme does indicate a very poor appreciation by the Prime Minister's Health Working Group Officials, of the complexity of issues affecting the supply of health care professionals.

Principles for the IGA

That the national scheme will include a monitoring regime which explicitly and transparently monitors the migration patterns and income disparities between:

- **Overseas trained skills sponsored health professionals**
- **Australian trained health professionals**
- **Overseas destination countries for emigrating Australian health professionals**

²⁰ See Appendix A

Revenues and Assets of Registration Boards

The proposed reform is silent on the existing assets and revenues of registration boards, except that the Agency Board will assume the business functions. Given the size and significance of these funds, and the proposed objective of achieving efficiencies through the reforms, there needs to be more detailed consultation on registrants' assets and income.

There is little evidence that the current assets and operating revenues of registration boards would be required under a shared services model. In fact the high operating costs and level of assets across some registration boards strongly suggests efficiencies are available through even State-wide resource sharing.

However this assessment is not based on the relative functions performed or costs incurred by each board. Moreover, in each State, costs vary markedly depending on administrative and other cost sharing arrangements. The fees and costs of panels or independent hearings, payments to third parties etc, can vary widely. For example, recent reforms to Victorian health professionals' regulation provides for contributions from registration boards for hearings by bodies such as the Victorian Civil and Administrative Tribunal.

Notwithstanding the above, under a national shared administration model the federal government does not require the existing revenue and asset base. While functions can remain functionally independent, the co-location of administration with a federal government agency or department would be most efficient. The isolation of the bureaucratic structure from the policy and planning resources of government departments is not considered functional or efficient. Under a federal scheme, co-location within the Department of Health and Ageing or the Institute of Health and Welfare, and the sharing of resources and data, would be a more efficient option.

If the reform objectives are genuinely to improve national consistency of standards, isolating it outside of a government department is neither logical nor efficient.

Table 4 calculates approximately a quarter of the revenue which the national agency can expect to usurp under the current proposal.

Table 4 Registered Health Professionals Income, Fees and operating revenue of Registration Boards²¹

Registration Board	Numb Registered	Ave' Prof FT EFT Income	Registr-ation Fee	Board Annual Revenues	Board Expenses	Board's Cash Holdings
Psychologists	5075	\$ 60,000	\$ 336	\$ 1,841,532	\$1,506,540	\$ 1,975,255
Physio	3974	\$ 52,000	\$ 150	\$ 516, 563	331,639	\$ 1,467, 984
Optometrists	950	\$ 130,000	\$ 240	\$ 255,948	\$ 148,252	\$ 804,947
Podiatrist	780	\$ 52,000	\$ 330	\$ 256,212	\$ 166,109	\$512,333
Medical Drs	18,016	\$ 400,000 ²²	\$ 330	\$ 6,534,683	\$6,200,000	\$ 5,188, 540
Nurses	77,144	\$ 55,000	\$ 120	\$ 5,715,000	\$ 7, 075,000	\$ 5,365, 744
Osteopaths	322	-	\$ 500	\$ 185,682	\$ 93,000	\$ 462,482
Total				\$15,305,620		\$ 15,777,285

A conservative estimate of the operating revenue available from registration boards for a national scheme is over \$60,000,000 per annum. This is a very conservative estimate based on an assumption that the revenues from half of the largest registration boards in Victoria comprise 25% of total national revenues.

With an offer of from the Commonwealth of \$19 million dollars to the States to fund the reforms, the Commonwealth is likely to still gain a windfall of \$40-80 million per annum from the scheme.

Moreover, it is not clear what proportion of costs States will assume through the provision of State tribunals and courts etc. As such it is difficult to see how anyone except the

²¹ Victorian Health Professionals Annual Reports Income Statements 2004/5 or 2005/6

²² This is an approximate average practice income, AMA 2004.

commonwealth will benefit financially or economically from the arrangement if the commonwealth has made no commitment to delivering the functions more **productively**.

If COAG has resources available in 2006-07 for improving outcomes for health professionals and the communities they serve, they would be better spent directed towards identified high needs areas. The attraction and retention of the right health professionals in the right places could immediately assist people with treatment and rehabilitation. This is must be an immediate priority. The efficiencies achievable under a national scheme would more than offset the investment required for the establishment of national infrastructure for the registration and accreditation of health professionals.

Principles for the IGA

- **The \$19 million offered to the States from the Commonwealth to fund the bureaucratic reform, be diverted to strategies to encourage ‘return to practice’ and retention of health professionals in Australia..**

One estimate of the value of assets Health Professionals Registration Boards is over \$ 50 million. This has been the accumulation of health practitioners’ contribution to their self regulation. This revenue is not to be usurped by the Commonwealth government, but is entitled to remain available to registrants for the exercise of registration functions.

Principles for the IGA

- **The establishment of a trust for existing assets and surplus revenue of registration boards, for compensation for representation at formal disciplinary hearings.**

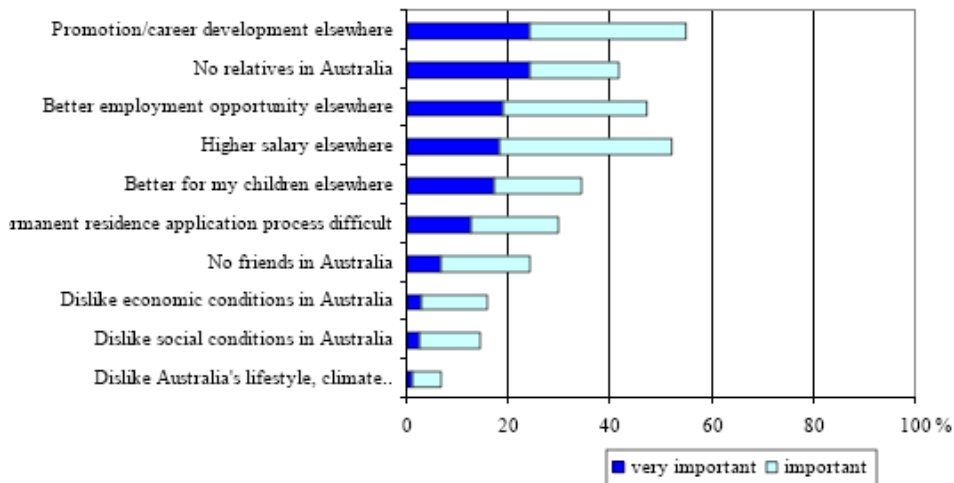
Contact Details

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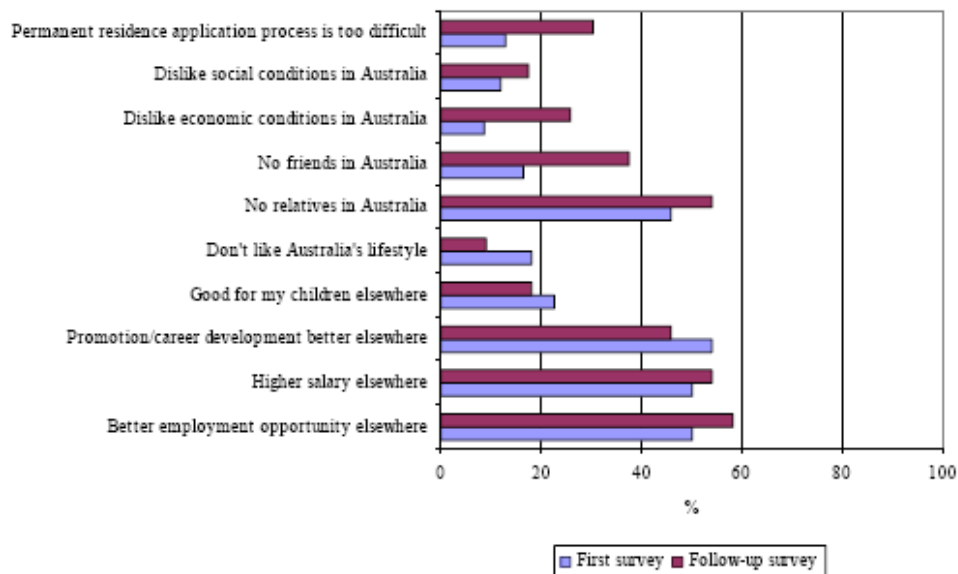
Appendix A: Relative Attractiveness of Overseas 'Terms of Employment'

Figure 18. Percentage of respondents indicating reason was important or very important in not wanting to live in Australia permanently.



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Figure 4. Percentage of respondents who stated that a particular reason was important or very important in their decision not to apply for permanent residence in Australia

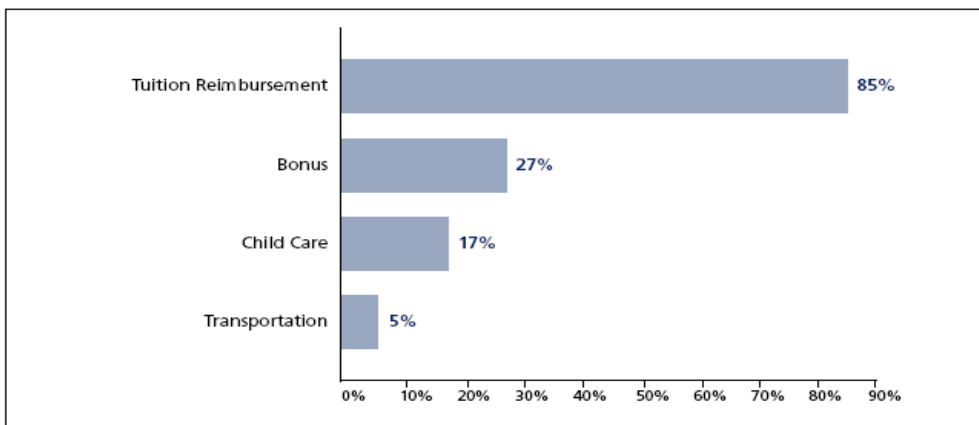


²³ Siew-Ean Khoo & Peter McDonald Graeme Hugo. Temporary Skilled Migrants' Employment and Residence Outcomes: Findings from the follow-up survey of 457 visa holders. Prepared for The Department of Immigration and Multicultural Affairs August 2006

The following diagram demonstrates the inducements that are offered to employees in the US, the second largest destination country for migrating health professionals. The diagram does not explicitly include registration fees but does indicate the range of non-salaried benefits which all employees are offered.

Percentage of USA hospitals offering recruitment and retention incentives, 2001

Figure 6: Percentage of USA hospitals offering recruitment and retention incentives, 2001



Source: American Hospital Association (2001).

Governments should also be aware that the majority of international recruitment companies and organisations seeking to recruit health professionals from Australia offer substantial inducements. Arrangements are currently available to Australian health professionals willing to work overseas include:²⁴

U.S. Recruitment Agency placements

- Up front costs of U.S Licensure
- Flexible contract options (12, 18, & 24 month contracts)
- Comprehensive NCLEX program and support
- Paid US licensure application
- Paid flights to take the NCLEX
- Paid accommodation during NCLEX trip
- Paid Flight to the U.S. to commence contract
- Assistance with Green Card fees
- Comprehensive Clinical Transition Program
- Generous pay rates
- Green Card sponsorship to include spouse and children under the age of 21
- Supportive employers who understand the needs of the international staff

²⁴ See any international health professionals recruitment agency website for employment in major destination countries UK, Ireland, Saudi Arabia and UAE, United States, Singapore, Malaysia.

Middle East Recruitment Agency placements

- 12 month to 2 year Contracts renewable
- Tax free income
- Accommodations Provided (Villa/House) & allowance to buy own furniture
- Education up to 3 children between 5 to 18 years of age (if on Married Contract)
- Travel airfares for self and family (if on Married Contract)
- Forty or forty five (40/45) days annual paid (calendar days) vacation
- Free Medical Care and emergency dental coverage
- End of Service Award - one month's pay for each year completed (up to first 3 years); one and a half months' pay for each year thereafter.
- Free airfare from your point of origin and return after completing your contract
- Service award at completion of contract -equal to an extra two weeks salary
- Annual vacation air tickets to point of origin (on contract renewal)
- Uniform provided and laundered
- Free bus transport to and from work

Work Schedule: 44 hours per week with rotating shifts

High Tax Free Salary: approx US\$3,782 per month

Canadian Recruitment Agency placements

- 12 month direct hire contract with the hospital
- Assistance with registration
- Assistance with visa application
- Generous relocation package, up to \$3,000 relocation assistance to cover cost incurred as well as comprehensive employee benefits packages

Appendix B: National Aged Care Workforce Strategy Components

Component 13.2: Financial Rewards and Recognition

Matters that need to be considered when formulating actions to highlight financial rewards and recognition include:

- the nature of terms and conditions;
- parity of wages and conditions with other sectors;
- approaches to national consistency and transferability of rewards and recognition;
- recognition for additional skills; and
- provision of scholarships.

Component 13.3: Non-Financial Rewards

Matters that need to be considered when highlighting non-financial rewards include:

- effectiveness of orientation and re-entry;
- access to continuing education;
- innovation in employment conditions that support flexible work practices and life/work balance;
- baselines for occupational health and safety;
- effectiveness of supervision;
- creation of challenges and opportunities;
- building of status and image; and
- a career pathway.

Component 14.1: A Multi-faceted Approach to Staff Retention

Matters that need to be considered when formulating actions to implement a multi-faceted approach to staff retention include:

- access to retraining;
- the nature of rewards – financial and non-financial;
- creation of career paths and progression;
- effectiveness of work environments with appropriate supervision, organisation and workloads, balance of clinical work against documentation;
- monitoring of reasons for leaving the aged care workforce; need for ongoing research;
- strategies for retention; and
- effective practices for mentoring and debriefing.

Strategies, policies and plans that need to be considered when formulating actions to implement this component include:

- National Strategy for an Ageing Australia;
- Health Workforce strategies;
- Indigenous Workforce Strategy;
- Community Based Aged Care and allied HACC workforce strategies;
- allied health strategies;
- CSHISC national strategic plan 2003-2008;
- Service Industries Workforce;
- National Strategy for VET 2004-2010 – Shaping our Future;
- nursing workforce strategies; and
- CALD strategies.

Appendix C

Differences of priority issues of registered health professionals across Australia.

Table 34: National and state skill shortage lists Australia - 2004

Skill shortages list – Professionals March 2004								
	Australia	NSW	Vic	Qld	SA	WA	Tas	NT ¹
HEALTH SPECIALISTS								
Dentists*	N	S*	R*	S		S*		S*
Pharmacist (hospital/retail)*	N	S	S*	S	S	R		D
Occupational therapist*	N	S*	S*	S	D	D*	S	R
Physiotherapist*	N	S*	S*	S	S	S*	S	S
Speech pathologist*	N	M	S*	S	R		S	D
Podiatrist*	N*	*	*	*	*	*	*	*
Diagnostic radiographer*	N	S*		S			S	S
Radiation therapist	N	S	S	S	S	S	S	
Nuclear medicine technologist	N	D		S		S	S	
Sonographer	N	S		S	S	S	S	S
Audiologist*			S	S				S
Social Worker		S	S				S	S

Notes: 1. Not all occupations assessed in all states; * = shortages may be restricted to specialist skills. Occupations marked with an asterisk have qualifying comments below.

N = National shortage M = Shortage in metropolitan areas S = State-wide shortage

R = Shortage in regional areas D = Recruitment difficulties

Dentists: NSW: shortages are especially in the public sector and regional / rural areas. WA: shortage is greatest in rural and in public health. NT: shortage is greatest in public sector.

Pharmacist: Victoria: shortages of pharmacists particularly acute in retail pharmacy, rural areas and hospitals. SA: shortage of pharmacists is particularly evident in the retail sector.

Occupational therapist: NSW: shortages especially for Occupational Therapists in senior roles and for specialists in mental health. Victoria: shortages in Occupational Therapists is particularly acute in aged care, paediatrics, disability/rehabilitation services and rural practice. Senior positions and those in regional and outer metropolitan regions are also particularly difficult to fill. Qld.: shortages are for experienced Occupational Therapists in specialisations such as mental health services and aged care. WA: recruitment difficulties are evident in aged care facilities.

Physiotherapist: NSW: shortages are especially in the public sector. Victoria: shortages of physiotherapists are particularly evident in aged care, women's health, working with children with disabilities, cardio-thoracic and rural areas. Qld.: shortage is most apparent for Physiotherapists experienced in specialisations such as gerontology and for locum work. SA: shortages are particularly evident in the aged care and public hospital sector. WA: shortage is greatest for paediatric physiotherapists and for physiotherapists in rural areas.