



SUBMISSION

REVIEW OF AUSTRALIAN HIGHER EDUCATION

BACKGROUND

Australian higher education is being reviewed as part of the strategies being applied by the Rudd Government to achieve economic and social reform.

A review panel comprising tertiary education sector and industry representation and chaired by Emeritus Professor Denise Bradley AC *“will examine the current state of the Australian higher education system against international best practice and assess whether the education system is capable of:*

- *contributing to the innovation and productivity gains required for long term economic development and growth; and,*
- *ensuring that there is a broad-based tertiary education system producing professionals for both national and local labour market needs.”*

It is intended that the Review Panel will provide advice on possible key objectives for higher education in Australia based on the following themes:

- **“Diverse, high performing institutions with a global focus**
Developing a diverse, globally focused and competitive higher education sector with quality, responsive institutions following clear, distinctive missions to provide higher education opportunities to students throughout Australia;
- **Productivity and participation**
Enhancing the role of the higher education sector in contributing to national productivity, increased participation in the labour market and responding to the needs of industry. This includes the responsiveness of the sector in altering the course mix in response to student and employer demand and an understanding of trends in the economy, demography and labour markets served by higher education;
- **Effective and efficient investment**
Improving funding arrangements for higher education institutions as they relate to teaching responsibilities, taking into account public and private benefits and contributions to inform the development of funding compacts between the Australian Government and institutions;

- ***Underpinning social inclusion through access and opportunity***
Supporting and widening access to higher education, including participation by students from a wide range of backgrounds;
- ***Enhanced quality and high standards***
Implementing arrangements to ensure that quality higher education is provided by public and private providers and that this is widely understood and recognised by clients of the higher education sector;
- ***A broad tertiary education and training sector***
Establishing the place of higher education in the broader tertiary education sector, especially in building an integrated relationship with vocational education and training.” (Department of Education, Employment and Workplace Relations).

These themes will form the framework for WA Health’s submission.

1. Diverse, high performing institutions with a global focus

Diversity has been promoted under the current competitive higher education model and has resulted in a wider distribution of health related courses. Within WA, competition has induced product differentiation, increasing variations in skills and a myriad of inconsistent minimum entry requirements to comparable health related courses. The mission statements of WA’s universities and other higher education providers include phrases relating to “international standards” and “...participating in international communities”, however, many are still promoting academia and research, along with flexibility in their literature. Geographically, universities have expanded their campuses and formed partnerships with vocational education and training (VET) providers to deliver health science courses to more rural and remote WA clients.

These various developments have added to the complexity of educational pathways within and between health disciplines and have in many instances, created a barrier to further education. A more collaborative and standardised approach to managing these arrangements is required particularly given the potential shift to national registration of the health professions.

Collaborative partnerships between higher education organisations and with WA Health are required on a number of levels to deal with a range of issues including the impact of projected workforce shortages, limited capacity to provide clinical placements and ensuring equitable access to education and training supply. Consideration should be given to greater use of community settings, simulated practice and - given the shift to multi-disciplinary service provision - interprofessional team based approaches. There is evidence that the universities are looking at international approaches to the delivery of health courses, including those being applied to interprofessional learning. However, they need to

be encouraged to formally adopt these processes and include international best practice in curriculum design and delivery. Greater collaboration with other higher education institutions and an increased focus on providing skills for the labour market are required to promote productivity and economic growth.

As WA becomes a destination for increasing numbers of potential and existing health workers, the higher education sector needs to become more responsive to the diverse cultural and educational needs of these people. A more global approach to the design and delivery of health studies needs to feed into more coherent and continuous educational pathways for both overseas and local clients.

2. Productivity and participation

Greater sensitivity to labour market trends, innovative curricula to develop team based health service delivery, and collaboration with other educational institutions in providing targeted health workforce skills will have a substantial effect on productivity and participation, and alleviating workforce shortages that loom as a result of predicted demographic trends.

Under the competitive model for higher education, as outlined in the “National Strategic Principles for Higher Education (DEST 2005), together with lower growth funding, universities have struggled to form clear, distinctive missions. Traditionally, Universities have adopted an academic focus and have viewed the provision of higher education as a social-economic tool rather than a source of labour supply. Subsequently, they have been forced to focus on maximising revenues and minimising costs in a competitive, “user pays” environment. As a result relatively “low areas of employment demand” are still not adequately catered for in skill development options. Many Health occupations fall within this category when compared to national market trends (eg radiation therapy and podiatry). In these instances WA Health has no choice other than to pay for course development and delivery with no guarantee that course graduates will opt to pursue employment within the public health sector.

In search of increased revenues, higher education has become more responsive to revenue driven market signals. Universities have opened themselves to charges of allowing educational standards to fall in pursuing fee paying enrolments and educating other countries’ workforces at the expense of our own. Australian higher education institutions are forced to find “niches” of fee paying students and are less able to offer courses of study to meet the needs of lower areas of workforce demand. These practices have had a negative impact on the health workforce and as a result lowered health service productivity.

The competing agendas of health and education sectors present a barrier to the responsiveness of the higher education sector to labour

market signals. The Health, education and training sectors are required to operate under the same umbrella of government policies. Every effort must be made to achieve maximum advantage from available government resources. These policies, however, put the health industry and education at odds.

An emphasis on collaborative strategies between health and education sectors would facilitate enhanced productivity and responsiveness to industry need. Towards this goal, current limitations in relation to data and information sharing between health and education sectors need to be addressed. The improved exchange of planning data between these sectors, such as projections for workforce requirements in specific professions and student enrolment and capacity, can improve health workforce productivity by highlighting predicted shortfalls and pressure points in both sectors.

A team-based approach to health service delivery has been shown to produce a higher quality of care and increased productivity (less hospital time per patient) in a number of clinical settings including stroke units and palliative care. Interprofessional learning principles should be applied to a range of health science courses in order to support the development of a team-based approach. The introduction of shared foundation units in health related courses would enable interdisciplinary teamwork in the health system and will also allow members of the clinical workforce to re-skill in different clinical disciplines more easily, resulting in increased employee satisfaction, retention and productivity, and reduced clinical workforce attrition to other sectors and/or management roles.

Clinical placement arrangements for health related courses offered by higher education are currently of concern in terms of preparing students for participation in the health workforce. While WA Health faces challenges in provision of clinical placement capacity, work is under way to formalise and streamline clinical placement mechanisms. Universities and VET providers place heavy demands on WA Health services in this area. Health related courses appear to be structured with common timeframes, requiring clinical placement capacity in peaks during a few months of the year. Collaboration and coordination between higher education and health sectors with regard to clinical placements is required to “smooth” the demand for clinical placements across the calendar year.

Higher education nationally accredited courses (according to the Australian Qualifications Framework (AQF) and competency standards) are expected to increase the number of educational pathways in and between higher education institutions, resulting in increased mobility of clients and increased participation in the health workforce. Collaboration between universities, VET providers, relevant government agencies (eg the WA Department of Education Services and WA Department of Education and Training) on the courses that are delivered, course

numbers and agreed national accreditation standards to increase articulation possibilities is essential. This is highlighted by a proposed Year 11 and 12 Health Studies course to be introduced into WA State High schools as part of the Western Australian Certificate of Education (WACE) in 2009. Graduates will have significantly different skills sets to enter higher education health sciences courses resulting in the need to reconsider course structures.

3. Effective and efficient investment

The capacity of the health industry to address current labour market shortages is hampered to some extent by the funding models that are currently applied to the delivery of higher education services.

The higher education sectors move to a funding cluster system in 2003 on the basis of increasing transparency and fairness in the funding of higher education student places has had a negative impact on the supply of courses for health disciplines and the clinical skill development opportunities that are available to students.

The pipeline funding model that is applied to the delivery of most Commonwealth supported places (medical places being an exception) assumes a student attrition rate of 25 percent whereas according to the universities the actual student attrition rate in many instances, is much lower (eg five percent). Under these arrangements the education provider (ie university) receives, for example funding for 50 new nursing places in the first year of study, 38 places in the second year of study and 29 places in the third year of study. These arrangements together with the variable funding rates applied to the clusters (eg the cluster amount for law, accounting, administration, economics and commerce is considerably lower than that applied to dentistry, medicine and veterinary science with agriculture receiving the most funding) act as a disincentive for the universities to cater for the educational requirements of health disciplines. These challenges are further heightened by the fact that while funding under these arrangements is based on notional commencing and continuing places, the universities are able to deviate from these funding patterns and apply business principles to the management of their annual funding. This results in the non supply of educational opportunities for some health professions which are essential in providing health services to the community but when compared to national workforce trends are low in terms of labour market demand.

The capping of nursing students fees due to nursing being designated a national priority, while beneficial in encouraging students into nursing careers and ultimately addressing nursing workforce shortages, are a disincentive for universities to run nursing courses. The flexibility in student fee structure that is afforded to the universities by Government does not apply. Under normal circumstances the universities are able to increase student fees by 25 percent to off set costs. Under current

funding arrangements the universities are not compensated for this loss of revenue. As a result they must either provide nursing education at a reduced cost or divert funding from other sources to cover these expenses. Neither option is attractive when applying business principles to the management of educational funding.

Further challenges exist in regard to clinical placements for all health disciplines. The universities currently receive an amount of \$1,065 per nursing student to offset the cost of clinical placements. However, while they are required by the Government to use this funding only for the purpose for which it is provided they are not required to pay these funds to hospitals or other clinical placement sites. Similar arrangements do not apply to other disciplines.

The fact that the universities receive some compensation for arranging clinical placements for nursing students is not the issue, the main concern is that the major players (ie hospitals, health service providers and educational institutions) are not penalised as part of these processes. It is essential that funding models and the conditions that are applied take into account the cost of all parties (ie the education provider and the hospital/health service providing the clinical placement).

4. Underpinning social inclusion through access and opportunity

Improving the health status of Aboriginal¹ people in Australia requires tackling their social disadvantage, strengthening primary health care and addressing many of the lifestyle factors that contribute to high rates of chronic disease and cause morbidity and premature death.

In March 2004 the report of the Health Reform Committee, *“A Healthy Future for Western Australians”* identified the benefit of an increase in the number of Aboriginal health professionals in improving health outcomes for Aboriginal people. The workforce in the public hospital and community health sector remains overwhelmingly non-Aboriginal even in regions where a significant proportion of the client base is Aboriginal. While the employment of more Aboriginal health service staff in regions with large numbers of people has been a government objective for many years, this has proven difficult to implement.

WA Health implemented a comprehensive reform program in response to the recommendations of the Health Review Committee including specific initiatives to increase the number of Aboriginal people within the health workforce. These initiatives, a brief synopsis of which is provided below, must be underpinned by suitable education and training pathways particularly those that link between the schools, VET and higher education sectors.

¹ The term “Aboriginal” has been used throughout this paper to refer to Aboriginal and Torres Strait Islander people.

- A key strategy to underpin the implementation of the WA Health Aboriginal Employment Framework is the establishment of a health education and training pathway which leads from secondary school through to the VET with emphasis on retention of core structures that can flow on to the higher education sector.
- The development of a number of new initiatives is occurring in partnership with the Western Department of Education. These programs are aimed at establishing VET programs which effectively link to education opportunities within the Curtin University of Technology and Murdoch University.

One pilot proposal aims to deliver a Certificate II in Aboriginal Primary Health Care to Year 10 students with the intent of linking this to other relevant Certificate programs which eventually result in Year 12 students graduating with a Certificate IV Aboriginal Primary Health Care. It is hoped that the high school participation rate of Aboriginal students will increase as a result of their involvement in this program and ultimately employment opportunities for course graduates in health related fields will be enhanced.

A second initiative in which the Marr Mooditj Aboriginal Health Training College is a partner, involves the piloting of the VET Diploma of Nursing (Enrolled/Division 2 Nursing) course as a work based skill development option preferably a traineeship. While there are a number of issues that need to be resolved to achieve this objective these are not considered insurmountable. The program as proposed will enhance the career path opportunities that are available to Aboriginal health workers and address current nursing workforce shortages and government policies on social inclusion.

- Scholarship programs have been established to encourage Aboriginal students to further their studies within health related fields of employment including Aboriginal health work, medicine, nursing and allied health. These programs are managed through the Office of Aboriginal Health and are available to undergraduate and postgraduate students.

It is intended that similar initiatives to those above be developed and implemented for other community groups from similar socio economic backgrounds. As stated previously these programs will only be successful with the support of the education and training sectors particularly the higher education sector.

As well as employing the above strategies to address issues with these community groups, the broader educational needs of rural communities should also be taken into consideration. A number of initiatives should be considered to minimise barriers to accessing health training and education opportunities in regional areas. Rurally-located students should be actively recruited and provided with additional financial

assistance and support to meet entry requirements as appropriate. Rural locations can provide unique learning opportunities for metropolitan-based and international students, however clinical placements in these settings need to be adequately resourced and students provided with sufficient orientation to deal with the operational and diverse cultural characteristics of rural health settings. The introduction of rural education centres has gone some way to making courses more accessible to existing and potential health professionals in regional areas. However, a challenge exists in providing education and training opportunities for staff at small sites that may not be able to leave the clinical setting to attend training.

5. Enhanced quality and high standards

Health-related higher education which is of a high standard and relevant to industry need is reliant on excellent communication and collaboration between health and higher education sectors and the development of innovative educational strategies. Provision of clear educational pathways and outcomes will assist clients to understand and engage with higher education.

5.1. Clinical placements

Research is currently being undertaken by the Health Education and Training Taskforce (HETT) (endorsed by the Western Australian (WA) Minister for Health and Minister for Education and Training) to determine the current status in regard to demand for clinical placements in health related higher education courses in WA, and the capacity of WA Health to meet these requirements. This research will support the ongoing improvement of existing (and development of innovative) arrangements regarding clinical placements by better aligning the supply of clinical placement opportunities within WA Health to the requirements of education and training providers (vocational education and training institutions being included within these processes) and ultimately improving quality educational outcomes.

Courses which are able to provide access to a variety of high quality clinical placements may be more attractive to prospective students (clients). They may also be likely to produce graduates who are better equipped for – and therefore more productive in – the health workforce in both clinical and research roles.

Preliminary analysis of the research being undertaken by the HETT suggests that the timing of clinical placements is one of the factors relating to their shortage. That is, the demand for clinical placements appears to be noticeably higher towards the end of each of the university semesters (May/June and October/November). Arrangements that encourage a more even distribution of clinical placements across the calendar year may

alleviate the current and projected shortfall in placements. Innovative alternatives to clinical placements, such as simulated learning facilities, may also prove to be advantageous.

Promotion of these positive elements of course delivery to potential clients of the higher education sector will help to ensure that they are widely understood and recognised.

5.2. Collaborative planning - data and information sharing arrangements

A key objective of HETT is the development of collaborative workforce planning tools. Workforce shortages loom across the spectrum of health professions as a result of an aging, diminishing health workforce coupled with an aging population. Current limitations and issues relating to data collection and management need to be addressed. The development of improved data and information sharing arrangements between health and education sectors will assist both sectors to plan most effectively for future health workforce and education demand and supply.

5.3. Educational pathways

The current lack of clarity regarding educational pathways in the higher education sector has been identified as a hindrance in the movement of students within the VET sector and between the VET and University sector. This not only has the potential to limit options for existing students, but also may serve as a disincentive to potential students. Pathways within and between VET and university sectors may not be easily accessed or comprehended by clients of the higher education sector, and the employment outcomes and opportunities provided by courses may not be readily apparent. Addressing these limitations may make courses more accessible and attractive to potential clients.

For many health workers in a clinical setting, the only feasible career progression is away from clinical work and towards management. This increases pressure on an already dwindling clinical workforce. Providing more flexible routes for retraining for existing health employees may also assist with the satisfaction and retention of the clinical workforce, thereby minimising the cost of recruiting new employees and improving the productivity of existing employees.

As described above, increasing the number of Aboriginal professionals has been identified as key to improving health outcomes for Aboriginal people. Improved access to training and education through enhanced educational pathways specifically for Aboriginal people and other disadvantaged groups, including

immigrants are expected to benefit both employment and health outcomes for these groups.

6. A broad tertiary education and training sector

Over recent years the prevailing philosophy in health care has shifted. It is no longer based on a philosophy of acute care or an intervention model but rather a holistic approach to individual care. This shift in philosophy has signalled a need to move away from discipline specific professions to team-based service delivery in community settings. These reforms require workforce attitudinal shifts and due to world labour market trends, more effective linkages with the course structures that are available through the higher education sector and those that are provided through the vocational education and training (VET) sector.

The Australian Qualifications Framework (AQF) (previously the Australian Skills Framework (ASF)) provides the structural basis for linking the course options that offered within the VET and the higher education sectors. The AQF or ASF as was the case underpinned the major reforms that occurred within the Australian training sector in the 1990's. It provided the means to align skill development pathways with formal work structures, normally a career path or industrial classification.

The AQF if applied effectively can provide the linkages that are required to improve access to mainstream employment in Health and job re-design. It can and in some instances, does provide an alternative pathway to university. However, the application of competition policy and as a consequence, the competing nature of educational institutions and differences in course structures tends to make this rather "a bumpy road" for the user.

Competency based course structures are applied to VET course structures whereas they are not applied within the higher education sector. The criteria that is applied to the articulation of students from the VET to the higher education sector differs between universities and disciplines. In many instances these arrangements are seen as a disincentive rather than an advantage.

Recent changes in the delivery structures of educational institutions have merged the boundaries that were originally applied by the AQF (ie VET course structures being linked to the AQF at levels one to six and higher education programs at level seven and above). VET institutions are now able to deliver technical based degree programs (ie AQF 7 course options) whereas the Certificate and Diploma options which form the major delivery component of VET institutions are able to be delivered by higher education institutions. However, while these arrangements support some of the job changes/workforce requirements of the health sector they tend to be aimed at increasing the scope of delivery of the institution concerned rather than an articulated skill development pathway from one sector to the other.

The application of a competency based skill development pathway including recognition of prior learning or recognition of current competencies which commences within the VET and continues into and through higher education course options has benefits for health in attracting and retaining staff. It has the capacity to provide the basis for performance management, career advancement and multi-skilling of the workforce – an essential consideration in addressing labour market shortages.

CONCLUSION

Given current labour market trends and the need for greater focus on economic and social reform it is considered essential that greater attention be given to aligning the products and services provided by all components of the Australian education and training system. The changes that may be made to the Australian higher education sector should not occur on the basis of a “stand alone” entity but an integral part of a much larger system.

International trends and practices, new job design, changing service delivery models and the funding models that underpin the delivery of educational services must be taken into account within these processes if Government is to ensure the tertiary education system is capable of meeting both local and national workforce needs.