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The Peak Body Representing Allied Health in Australia

SOLVING THE CRISIS IN CLINICAL EDUCATION FOR AUSTRALIA'S HEALTH PROFESSIONS

A discussion paper from the
Health Professions Council of Australia

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Comprising:

Audiological Society of Australia, Australasian Podiatry Council, Australian Association of Social Workers, Australian Institute of Radiography, Australian Orthotic and Prosthetic Association, Australian Physiotherapy Association, Australian Psychological Society, Dietitians Association of Australia, OT AUSTRALIA, Speech Pathology Australia, [Society of Hospital Pharmacists of Australia](#), The Orthoptic Association of Australia and incorporating ARRAHT (Australian Rural & Remote Allied Health Taskforce)

CONTENTS

Overview	3
Summary of Recommendations	4
About the HPCA	5
The Crisis in Clinical Education – comments from the coalface.....	6
The Health Professions - essential but in short supply	8
Clinical experience is an integral part of entry-level health professional education	9
Worsening difficulties with Clinical Education	10
Some Innovative Responses	11
Clinical Education - directions for change	13
National Health Workforce Strategic Framework	13
Proposed changes to the Health Budget.....	14
Proposed changes to the Education Budget.....	14

SOLVING THE CRISIS IN CLINICAL EDUCATION FOR AUSTRALIA'S HEALTH PROFESSIONS

Overview

Clinical education – the face to face encounter with a real-life patient or client – is integral to the training of all health professionals. Without it, academic knowledge cannot be translated into actual healing. And without it, students cannot tell whether they have chosen the right profession, or whether the reality is different from their hopes and dreams.

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, podiatry and others – have a mandatory requirement for clinical education, but no funding for it.

Across Australia, the difficulty of finding clinical placements for entry-level students is putting huge pressure on universities, hospitals, academic staff and students. It is creating friction where there should be co-operation; and it is leading to course closures and workforce attrition at a time when chronic workforce shortages are apparent in many health professions.

The first step in solving this problem is recognising that it exists. To fully understand the complexity of funding and other issues which bring it about, additional workforce data is urgently needed.

The Federal 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 recently underlined that commitment by extending Medicare to cover specified allied health services.

The National Health Workforce Strategic Framework acknowledges national skill shortages in several allied health professions, and notes the key role of education and training in overcoming these shortages. Clinical education is a key element in successfully meeting this challenge.

Summary of Recommendations

The Health Professions Council of Australia, which represents the major non-doctor non-nurse health professions, believes there is a range of possible solutions to the current crisis in clinical education. The HPCA would like to work with Federal and State Governments to find the best way forward, and offers this paper as a contribution to understanding the problem and finding solutions.

- Funding for the clinical education of allied health professionals needs to be specifically recognised in measures developed to implement the National Health Workforce Strategic Framework. Clinical education should be specifically considered in relation to strategies associated with Guiding Principles 1 and 4.
- Comprehensive workforce data on the allied health professions, including projections of future supply and demand, is urgently needed.
- The Health Professions Council of Australia urges State and Federal Health Ministers to ensure that clinical supervision is a fully recognised and funded activity in hospitals and other public health facilities.
- Targeted support needs to be provided for allied health students undertaking clinical education away from home, to cover additional accommodation and living expenses.
- Because of severe national workforce shortages in the major non-doctor non-nurse health professions, the Health Professions Council of Australia urges the Federal Government to list Health as a National Priority on the Commonwealth Course Contribution Schedule, along with Nursing and Education.
- The Health Professions Council of Australia urges the Federal Government to move 'Health' from cluster 6 to cluster 9 on the Commonwealth Course Contribution Schedule, so that students of the allied health professions are funded at the same level as students of dentistry and medicine. As a minimum, Health should be funded at the same level as Nursing.

About the HPCA

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 Federal Government; and to provide a vehicle for liaison and discussion between the professions themselves.

Members of the HPCA are national organisations representing specific professions, with membership across Australia in both urban and rural areas. Collectively, they represent about 50,000 health professionals. Each has internal systems and networks for liaising with their members, ensuring that the HPCA has input from health professionals right across Australia who together provide a vast wealth of skills, experience and opinion.

Current membership of the HPCA represents the following professions:

- Audiologists
- Dietitians
- Occupational Therapists
- Orthoptists
- Orthotists and Prosthetists
- Pharmacists
- Physiotherapists
- Podiatrists,
- Psychologists
- Radiographers
- Radiation Therapists
- Social Workers
- Speech Pathologists.

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

www.hpca.com.au

The Crisis in Clinical Education – comments from the coalface

(These comments come from clinicians, academics, students and others associated with HPCA member organisations.)

Getting harder ...

“Day in and day out it is getting harder to provide the quantity and quality of clinical education to students they and society expect them to have.”

“As funding for public teaching hospitals has decreased, it has become more and more difficult (and now in some cases impossible) for the hospitals hosting placement students to meet placement costs. Clinical staff in hospitals are so stretched that it is difficult for departments to find supervisors for students, let alone staff to plan and evaluate placements.”

...but it's essential

“Only in real clinical settings can students gain real time experience in clinical decision making. The dynamic complexity of the clinical environment requires clinical reasoning that cannot be replicated in academic settings.”

No funding...

“There is no allocation for the provision of clinical education (for health professionals) in the current higher education funding model. The base allocation for medical students contains a component for clinical education but there is no such entitlement (for health professionals) even though their clinical education costs about the same.”

“Clinicians and workplaces need to be offered incentives to have students. As I don't have money to give our clinicians I have a number of incentives to offer them... They can attend, free of charge, faculty workshops... We also provide them with electronic access to the university library and its extensive databases (and) on-line professional supervision...”

“Our academic staff members offer consultancy services, short professional courses and off campus teaching to raise enough money to fund what the School considers essential clinical tutorial sessions for our students. This detracts their time away from other activities such as research, which the University gives high priority to.”

Students are a drain ...

“Teaching hospitals (who we have relied on heavily in the past) feel that students are an added burden in an already squeezed work day,”

“There is an attitude from above in the health department that has filtered down to managers which basically says that students are a drain on resources and not our responsibility, so don't feel you have to!”

“Students require considerable time and support to their learning from their supervisor while on placement. Increasingly employers are expressing reluctance to take on students for placement because of these costs in time and resources and client throughput.”

“Very few allied health awards recognise clinicians who work with students, and also certainly don't recognise clinicians who have done additional study/training in clinical education. Addressing this issue would be helpful.”

“I feel the Department of Health does not recognise the contribution senior students make to the public health system.”

Working with hospitals and fieldwork centres ...

"There is no guaranteed responsibility taken by hospitals to contribute to the education of allied health students, and no formal sanctioning of shared access to placements – if (another university) pays a fee our students will not be accepted."

"We perceive that at times field work centres promote a perception of competition (rather than co-operation) between universities for their available fieldwork places.."

"Currently we are having regular meetings between academics and clinical heads of departments to try and sustain fieldwork requirements, particularly with the inclusion of entry level Masters students ...However, solutions at this level are not sustainable in the long term."

"One of our hospitals has a grade 3 student unit supervisor position; this person takes about 20 students a year on placement. She has now gone on maternity leave and that position has been filled with a new graduate (grade 1) who is unable to supervise placements. 20 adult placements gone per year! A disaster for us!"

"Pharmacy has a post-graduate, unregistered training year as a requirement of Pharmacy Boards. Public hospitals would like to take more of these 'interns', but funding is limited in most places. Training more pharmacists in public hospitals is a very important 'workforce tactic' as on average internationally only about 15% of pharmacists work in hospitals. If they have never had experience in hospitals, this is a limiting factor in future recruitment (they feel intimidated)."

"Recently two major teaching hospitals in Melbourne have withdrawn their placement offers due to increased pressure and workload..."

Impact on students...

"Although there are numerous offers for rural placements, students are reluctant to go due to the cost of travel and accommodation."

"Whilst on a rural placement students either have to forego their employment or drive long distances back to the city each weekend to continue their part-time employment in order not to lose their part-time work opportunities."

"I have recently returned from a five-week placement in Bundaberg. I was one of two students who was offered accommodation in the nurses quarters thus had the luxury of not having to find and finance alternate accommodation like the other three students. My expenses for my rural placement included: groceries, transport around Bundaberg and transport between Bundaberg and Brisbane. With the combined loss of income (having to take time off work) this rural experience resulted in the loss of most of my savings...When I returned to Brisbane a few weeks ago I was informed that my job was no longer available due to the fact that they obviously had to employ someone during the time I was away."

The Health Professions - essential but in short supply

Australia has at least 90,000 health professionals; together with doctors and nurses, they provide the essential skills on which Australia's health system is based. Best practice management of certain conditions is unachievable without the specific contribution of university-trained, autonomous allied health professionals.

There are significant shortages in the primary care health professional workforce right around Australia. It 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.

The National Health Workforce Strategic Framework, issued in April this year, highlights the national shortage of health professionals. Of the 14 non-information and communications technology professions on the Australian Government Department of Employment and Workplace Relations national skill shortage list, 12 are health professions. The allied health professions listed are:

- physiotherapy;
- pharmacy (hospital/retail);
- occupational therapy;
- speech pathology;
- diagnostic radiography;
- radiation therapy;
- sonography; and
- nuclear medicine technology.

Other professions facing shortages include audiology. The Audiological Society of Australia reports a shortage of audiologists in all sectors and in all States in Australia. Employers are actively recruiting audiologists from overseas; but despite the demand universities are unable to significantly increase their student intake numbers because of the difficulty in providing adequate and appropriate clinical placements.

In order to plan for the future, there is an urgent need for comprehensive workforce studies of key health professions other than doctors and nurses. There is an urgent need to understand in detail the extent, causes and impact of health professional workforce shortages; and to project and plan for future needs, in the light of the changing health services environment.

Clinical experience is an integral part of entry-level health professional education

All health professions regard hands-on clinical experience as an integral part of entry-level education. 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.¹

In 2003, the professions represented on the Health Professions Council of Australia had more than 12,700 entry-level (undergraduate and Masters) students enrolled in 138 university courses around Australia. All of these courses include extensive clinical experience – up to 1,000 hours for physiotherapy, podiatry, psychology occupational therapy, orthoptics and social work, 800-900 hours for speech pathology and radiography, 700 hours for students of orthotics and prosthetics, and of nutrition and dietetics.

Acquiring clinical experience is handled differently across disciplines and universities. Some rely on fieldwork placements in tertiary hospitals. Others, such as physiotherapy, extend into the community setting while some, such as podiatry, 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.

Allied health professions are usually entered through undergraduate courses; however, some can only be accessed through post-graduate studies. Audiology is a 2-year Masters program offered at 5 universities across Australia. Students must complete a comprehensive academic program, plus 200 hours of face-to-face clinical work under the supervision of a qualified audiologist. New graduates must then complete a 12-month Graduate Clinical Internship, working under the supervision of a qualified audiologist.

The pharmacy profession also uses internship to provide clinical training. Pharmacy students must complete a post-graduate, unregistered training year as a requirement of Pharmacy Boards. Students find their own places in private sector or hospitals: they receive a salary, but need supervision and have no rights of independent practice. Public hospitals would like to take more of these post-graduate unregistered pharmacy 'interns', but funding to cover salaries is limited in most places.

¹ References on the importance of clinical education include:

- McAllister, L, Lincoln, S. McLeod, & D. Maloney (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.

Worsening difficulties with Clinical Education

Universities and health professions are finding it increasingly difficult to organise clinical placements for their students. Unlike medicine or nursing, there is no allied health clinical education funding in either the Health or the Education budgets. As student numbers increase, so problems in arranging clinical education become more acute.

Clinical education requires intensive supervision and staff-student ratios which are significantly smaller than for academic programs. The current DEST funding model does not recognise the diverse nature of clinical placements in allied health; nor does it provide direct funding for them.

The health system is also providing inadequate support. 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. In some cases, courses have closed as a result, and others are under great stress.

For example, WA's Curtin University recently announced closure of its podiatry program - the only one in the State - for financial reasons (in particular the cost of clinical tuition). La Trobe University is currently proposing to phase out its undergraduate occupational therapy course, giving as a major reason, the difficulties in obtaining fieldwork placements when the planned Monash occupational therapy program commences.

Contributing factors associated with diminishing access include:-

- Little or no allocated budget for teaching of allied health in health sector (despite allocation for teaching in overall health budgets)
- Limited budgetary flexibility in education sector
- Rising cost of professional indemnity insurance and increasing risk of litigation which further emphasise the need for rigorous supervision of students
- Cost of adherence to legislative standards (eg: infection control).

There is a decline in the number of placements being offered coupled with increased student numbers. Some professions report increased bureaucratic requirements - for example students might need to have a criminal record check, sign a prohibited employment declaration and present evidence of their immunisation status.

Equally serious are reports of a pervasive attitude and unsubstantiated belief among health system managers that students are a drain on resources and there is no obligation to take them. This seems a particularly short-sighted approach, given the widespread concern about recruitment and retention issues.

A recent Western Australian Government report notes that, *'There is a lack of clarity and co-ordination about funding sources and their intended uses between the universities, Department of Health and health services in regard to clinical placements.'*² The report goes on to recommend that, *'The education sector and the health industry must accept joint ownership of funding responsibility for health professional clinical placements. The Department of Health should facilitate the establishment of a partnership between the education sector and service providers with the aim of finding a sustainable solution to funding of clinical training.'*³

In New South Wales, a discussion paper on clinical education has been prepared by the Faculty of Health Studies, University of Sydney, following the NSW Premier's Round Table on

² Education and Health Standing Committee Report No. 6 (2004) 'The Role and Interaction of Health Professionals in the Western Australian Public Health System'. Finding 16.

³ Ibid. Recommendation 18.

Medical Workforce held in April 2004. It is intended as a starting point for discussion of the issues and possible initiatives related to clinical education in the allied health sector.

Professions which have traditionally relied on hospital placements have in some cases arranged private placements. However, these can be difficult (for instance, indemnity issues coupled with reluctance to ask private patients to allow students to attend/participate in consultations) and do not provide the range of exposure available in hospitals.

Competition between universities for placements has been reported by some professions, including Podiatry. For instance, metropolitan placements available to La Trobe University have reportedly been reduced because placements have been made available to students from Charles Sturt University and the University of Western Sydney. This is expected to be an ongoing issue for La Trobe University as Victoria has a greater number of Public sector podiatrists than any other State. As one academic notes,

“In addition being a small profession, the demand for placements falls on the same kind people. How long these podiatrists can put up with volunteering their time and resources to students is to be seen. I predict a few withdrawals from placements due to burn out ...”

Universities which provide on-site Podiatry clinical practice tend to face quite high running costs. This reflects not only the high costs of consumables, materials and equipment, but also the cost of paid supervisory staff, insurance and adherence to strict infection control guidelines and occupational health and safety legislative guidelines. Low staff to student ratios are required when invasive and potentially harmful procedures are undertaken.

The Society of Hospital Pharmacists of Australia believes that more training places for pharmacy interns should be funded, as well as funding for clinical supervisors to train them (say on a 1-10 basis).

A common problem is fluctuating offers for clinical placements. A service might offer a placement one time, but not another (even though they might have a department with a large staff),

Further difficulties arise in respect of rural placements. There are dramatic shortages of accommodation suitable to students in a number of states and there are insufficient government subsidies to offset the considerable costs associated with relocating for clinical placements. Unfunded costs are associated both with rural placements for urban students, and metropolitan placements for students in rural and remote areas.

Some Innovative Responses

Universities adopt many strategies designed to improve liaison with clinical placement providers and where possible lock in the placements they need. In spite of this, the Schools can spend months trying to organise sufficient suitable placements, and may still not be fully successful. Even when placements are arranged, facilities do not see the agreements as binding, and will at times pull their clinical education staff from placements to fill staff shortages in other areas.

In Occupational Therapy, Deakin University has developed an innovative model of fieldwork education, designed to meet challenges in securing fieldwork places, clinicians' concerns about lack of resources and support, and World Federation of Occupational Therapy standards. In exchange for the support of a Deakin University Fieldwork Supervisor, fieldwork centres are required to agree to fixed, predetermined numbers of students. There has been a positive response to this new model, but even so, there are still issues to be dealt with.

At the University of Sydney (USyd), the School of Occupational and Leisure Sciences has recently rearranged the organisation of communication between USyd fieldwork staff and practitioners. The aim is to improve the School's relationship with fieldwork supervisors in response to increasing demands in providing adequate and sufficient fieldwork education opportunities.

This regional approach is also being used by the School of Physiotherapy at USyd to support their clinical placements. Five geographical areas have been identified, (corresponding roughly to metropolitan area health boards). These have steering committees which work to provide the best possible communication and engagement between the School and clinical placement providers.

In Western Australia, Curtin University's Podiatry School has this year begun to offer national and international placements to students during the non-semester times. This has involved 'vetting' each place for its suitability, which is time consuming and costly, but it provides experiences for students that are otherwise difficult to obtain. As one podiatrist noted, *"WA's public podiatry sector is scant to say the least. We hear constantly about the need to improve services for the indigenous population, the increasing number of elderly people and those in rural areas, yet little is done to coordinate an effective drive to deal with these issues. The Department (at Curtin) is closing and as it stands at present the nearest training facility will be in Adelaide. I doubt many from the Eastern States would consider moving to WA to address the increasing need for podiatry services, and so the situation will deteriorate."*

Within the audiology profession, university programs have responded to the difficulties in finding clinical placements by implementing a wide range of initiatives. These include on-campus clinical services particularly focused on clinical experiences for students in the early stages of their programs when they need intensive one-on-one at-elbow supervision. All university programs in audiology have established such clinics; but they cannot offer students the full range of clinical experience required. To access as many external placements as possible universities have undertaken extensive curriculum revision, adapting their academic programs to clinical education requirements. For example, the University of Western Australia has recently changed its academic program to intensive block mode, so that students can be available for clinical placements for about 35 weeks of the year.

There are also some useful innovations underway in speech pathology clinical education. The NSW Speech Pathology Consortium between Charles Sturt, Macquarie, Newcastle and Sydney Universities manages the requesting and allocation of placements across all facilities in NSW, and collaboratively runs clinical education workshops across the state to support and generate additional placements. Some universities have also created speech pathology student units, which are funded entirely by the host facility (usually a hospital) or are co-funded between the host facility and the university.

These various initiatives, however, are not enough to deal with the growing crisis in clinical education.

Clinical Education – Directions for change

The Health Professions Council of Australia believes there is a range of possible solutions to the current crisis in clinical education. The HPCA would like to work with Federal and State Governments to find the best ways forward.

National Health Workforce Strategic Framework

A number of the Guiding Principles and Strategies in the National Health Workforce Strategic Framework are relevant to clinical education.

The first strategy under Guiding Principle No.1 suggests that Australia should:

- *'Align education and training supply with projected workforce requirements and health service needs, to achieve long term national self sufficiency of supply'.*

The HPCA believes that solving problems associated with clinical education is integral to aligning education with workforce requirements and health service needs. Clinical education should be specifically considered when measures to implement this strategy are being developed.

Strategies under Guiding Principle No.4 include the need to:

- *'Identify a formal mechanism for the effective engagement of the health and education and training sectors such as the establishment of a National Health and Education Training Council'*
- *'Align education and training programs with health service needs' and*
- *Continue to develop new and innovative ways to deliver health education and training, with facilitates accelerated entry to the workforce and flexible delivery of clinical training.'*

These strategies imply the need for more comprehensive workforce data, better coordination between the health and education sectors, and new problem-solving approaches – strategies which the HPCA fully supports.

However, there needs to be caution in relation to the comment on page 12 of the Framework document:

'...the delivery of that learning is shifting increasingly towards computer-based and web-based platforms...there is an expectation that virtual learning platforms and processes will expand further.'

Much can be learnt on computers, but some things need real patients. Only in real clinical settings can students gain real-time experience in clinical reasoning and clinical decision-making. Only by dealing with real patients can students find out if they are in fact suited to the profession they have chosen. To avoid future workforce attrition, it is important that this realisation is achieved as early as possible.

Recommendations:

- Funding for the clinical education of allied health professionals needs to be specifically recognised in measures developed to implement the National Health Workforce Strategic Framework. Clinical education should be specifically considered in relation to strategies associated with Guiding Principles 1 and 4.
- Comprehensive workforce data on the allied health professions, including projections of future supply and demand, is urgently needed.

Proposed changes to the Health Budget

In contrast to Medicine and Nursing, there is little or no direct support through the health system for clinical education within the health professions. As noted above, students of many key health disciplines are required to complete up to 1,000 hours of clinical education as part of their undergraduate course; and some disciplines require a post-graduate 'intern' year before the students are qualified to practice alone.

Universities are facing major difficulties in providing clinical education for health students, since there is no recognised funding for it either in the education or health budgets.

In contrast, the Federal Government contributes to funding the training of doctors through GPET – General Practice Education and Training. In 2003, GPET spent \$54 million on GP training; HPCA understands that this is of the order of \$150,000 per trainee. The Government also provides considerable support for nursing, including giving it National Priority status in the new Tertiary Education funding arrangements, and providing a range of scholarships and education support provisions.

The Health Professions Council of Australia believes that the Australian Health Ministers Conference needs to ensure that clinical education for health professionals is adequately supported, as it is for nursing and medicine. Within the health sector, clinical supervision of students needs to be reinstated as a legitimate, significant and properly funded activity, based on the recognition that support for Australia's future health workforce is critically important. Clinicians who undertake this work needed to be properly trained, adequately funded and given full management support.

Additional support is also needed for students on clinical placements. Grants or other funding mechanisms are needed to offset the costs incurred in living away from home during clinical placements, including disruption to the part time employment many students need in order to meet their education expenses.

Recommendations:

- The Health Professions Council of Australia urges State and Federal Health Ministers to ensure that clinical supervision is a fully recognised and funded activity in hospitals and other public health facilities.
- Targeted support needs to be provided for allied health students undertaking clinical education away from home, to cover additional accommodation and living expenses.

Proposed changes to the Education Budget

The New Commonwealth Grants Scheme replaces the traditional block funding for universities, with institutions receiving FTSU-funding per student to an agreed (and previously negotiated) number. Each university then sets its own student contribution levels within the ranges set by the Commonwealth. The result is that, for each agreed place in a particular course, the government makes a contribution and the university can charge an additional fee of the student, up to an agreed maximum level.

As the Table below shows, Health is currently placed in cluster 6, along with Computing and the Built Environment: this means that Health courses get a Commonwealth contribution of about \$7, 292 per FTSU student. Medicine – in cluster 9 along with Dentistry and Veterinary Science – receives more than twice as much, at \$15,422 per student. Nursing, classified as a National Priority, attracts a government contribution of \$9,733 – about a third more than Health.

The Health Professions Council of Australia believes that the clinical component of mainstream Health Professional courses is comparable to that of Medicine, and that therefore

the Commonwealth Government contribution per student should be equivalent to that of Medicine.

At the very least, it should be the same as for Nursing.

Table A: Commonwealth Course Contribution Schedule 2005 ^(a)

Cluster	Discipline	Estimated Commonwealth Course Contribution ^(b)
1	Law	\$1,509
2	Accounting, Administration, Economics, Commerce	\$2,481
3	Humanities	\$4,180
4	Mathematics, Statistics	\$4,937
5	Behavioural Science, Social Studies	\$6,636
6	Computing, Built Environment, Health	\$7,392
7	Foreign Languages, Visual and Performing Arts	\$9,091
8	Engineering, Science, Surveying	\$12,303
9	Dentistry, Medicine, Veterinary Science	\$15,422
10	Agriculture	\$16,394
National Priority	Education	\$7,278
National Priority	Nursing	\$9,733

(a) Figures are for Equivalent Full-time Students undertaking units in indicated discipline. The Commonwealth course contributions are for institutions that receive the 2.5 per cent increase in Commonwealth contributions through compliance with the National Governance Protocols and workplace relations policies.

(b) The Commonwealth contribution towards course costs represents the base amount provided to institutions for students in a particular discipline. The total Commonwealth funding that supports individual students is much greater than this and includes other funding provided for operating and research purposes.

The HPCA recognises that, since the Federal Government has only recently reviewed its funding arrangements with universities, changes to the Cluster system are unlikely to occur in the near future. However, the HPCA believes that the location of Health in a classification different to Medicine is an anomaly which should be recognised and addressed as soon as possible.

Recommendations:

- Because of severe national workforce shortages in the major non-doctor non-nurse health professions, the Health Professions Council of Australia urges the Federal Government to list Health as a National Priority on the Commonwealth Course Contribution Schedule, along with Nursing and Education.
- The Health Professions Council of Australia urges the Federal Government to move 'Health' from cluster 6 to cluster 9 on the Commonwealth Course Contribution Schedule, so that students of the health professions are funded at the same level as students of dentistry and medicine. As a minimum, Health should be funded at the same level as Nursing.

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