INTERPROFESSIONAL EDUCATION AND TRAINING IN AUSTRALIA

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Background

Health professional training is carried out by most Universities in Australia at degree level while the vocational training of a range of assistants and other health workers is the responsibility of the Technical and Further Education sector (TAFE) . Students in Australia pay some fees – although most students have some Commonwealth Government support – the so called 'student' contribution can be deferred as a loan which is paid back to the Government once the student is earning a certain income. Universities also take full fee paying students both from Australia and increasingly (over the last few years) from overseas. The government has kept a cap on Commonwealth supported places in Medicine but significant numbers of overseas medical and nursing students enrol in Universities around the country . The number of students enrolled in Australian universities in health professional programs (1996- 2009) are shown in fig 1

FIELD	1996	2000	2004	2007	2009	% CHANGE 2007-2009	% CHANGE 1996-2009	
DENTAL SCIENCE	98	124	227	331	387	17%	295%	
MEDICINE	963	1117	1505	2304	2772	20%	188%	
MEDICAL SCIENCE	41	171	1072	966	1003	4%	2346%	
NURSING (basic)	762	839	1623	4546	6124	35%	704%	
NURSING (post basic)	545	2336	3109	2090	2566	23%	371%	
PHYSIOTHERAPY	79	173	239	370	365	-1%	362%	
PSYCHOLOGY	136	335	1258	1354	1757	30%	424%	

Fig 1 . Source Hawthorne ,Langley and To (2011) 1

Medical education is based on the in Australia is based on the British model although over half of the medical schools have developed Graduate entry programs and several are now exploring altering the exit degree to a MD . With its range of medical programs from 5 year School entry to 7 year graduate entry MBBS (MD) PhD programs there is a richness of programs that is not found elsewhere on the globe (2). Nursing programs were traditionally Hospital based but moved to

Universities in the 1980s and have now expanded to include a range of postgraduate programs including nurse practitioner and specialty areas .Allied health programs have also increased rapidly and are very popular in attracting high performing students . The health employment environment in Australia with a mix of public and private provision of care has created to a market led development of health professional training with little coordination and national planning. Over 60 % of surgical separations now occur in the private sector and 40% of Australians have private health cover and yet it has only been in the last few years that Private Hospitals have started to play a role in teaching .The uncapped fee for service payment system which operates in private practice and for general practitioners is funded by taxation revenue although increasingly gap payments are required by medical providers . No one seems willing to challenge this fiscally irresponsible situation since the ability for doctors to set their fees is actually enshrined in the Australian Constitution . These issues of renumeration – particularly in medicine -are beginning to influence career choice and certainly encourage the establishment of private medical schools and fee paying places .

Current Situation in Australia

The importance of inter professional team based practice is now well accepted as a key element of management of chronic disease and improving safety and quality in health care delivery (3,4). Most universities will have an inter professional learning (IPL) agenda which will oversight these activities across a faculty . Not all universities have medical schools so there are particular challenges for those entities without medicine although collaboration between Schools and Universities is common particularly around the rural sector . The establishment of a network of Rural Clinical Schools some 15 years ago has made delivery of IPL much easier in those geographical areas where the health "silos ' are not as rigid and cooperation between a smaller number of professionals is easier to organise.

In terms of incentives for IPL it should be noted that (at least for medical students) the Australian Medical Council (AMC)- the body which accredits Medical Schools in Australia and New Zealand has developed a new standard (3.2.9) which states that "the effectiveness and safety of health care delivery can be greatly enhanced by the coordinated contributions of professionals from different backgrounds working together as a team . Medical students should have opportunities to appreciate the roles and function of all health care providers and to learn how to work effectively is a health care team ". While this could be very important in driving the IPl agenda clear outcomes that need to be achieved have to be clarified . It will be interesting to see if other health professional registration Boards develop similar standards .

Much of the activity in IPL in Australia was driven by a project funded by the Australian Learning and Teaching Council to the University of Technology Sydney and the University of Sydney (2009)(5) This project built on work carried out in a number of Australian state health jurisdictions and developed four key areas for development

- Informing and resourcing curriculum development
- Embedding IPP (interprofessional practice) as a core component of health professional practice standards and where appropriate , in registration and accreditation processes

- Establishing and implementing a program of research to support and inform development ;and
- Establishing and implementing an IPE/IPL/IPP knowledge management system

This project continues to develop and expand (6)

Impact and Effect

Just what has actually been implemented around the country is less clear and it is time to ensure that some structure is put in place to ensure that this work is acknowledged . Much has been written about the importance of team work in assisting General Practitioners and nurses and allied health practitioners working together (7). Much of this work has focussed on rural practice (8)and there is no doubt that the Rural clinical Schools which were set up in the 1990s have been more effective at driving the IPL agenda . Taggart et al (2009)(9) demonstrated the importance of developing team skills through educational programs to improve team care in chronic disease and showed the importance of strong leadership as a determinant of success of the project. Mudge et al (2006) (10)showed that patient centred multidisciplinary team care could reduce bed stay and in hospital mortality in an acute general medical service within a tertiary referral hospital .

So if we accept that team care is important particularly (but not exclusively) for chronic disease how do we embed it in the training health professionals . How many Universities really have clear outcome criteria that they require students to achieve from IPL and how many have a requirement that this is an essential part of the assessment to be achieved to progress in the course ?

One success story has been the development of the Health Fusion Health Care Team Challenge that was modelled on the University of British Columbia program but has now been developed as a national competition in Australia. This involve health science students competing against other multidisciplinary teams to gain “exposure to , immersion in and mastery of inter professional practice “ by developing case management plan in their teams (11) This program has now been adopted as an annual event and seems enthusiastically supported by the students

Future Trends

There would seem to be an opportunity to review the IPL agenda in Australia in the light of an increased focus recently by Governments on health workforce . A new National agency (Health Workforce Australia) has been established with a budget of some $1.4 billion over 3 years to ‘ create a sustainable health workforce “ and national registration of health professionals is occurring through the Australian Health Professionals Registration Authority . Both these groups are expressing interest in issues such as IPP and hence in the training agenda of IPL

HWA has also embarked on an ambitious agenda of developing simulated learning environments (SLE s) and this is an area that should be explored for IPL . Part of the agenda is look at how SLEs might expand clinical placement opportunities and the issue of doing more of health professional training in primary care settings rather than in (inappropriate) tertiary referral hospitals needs to be evaluated carefully . SLEs may allow this to happen

more efficiently by providing learning resources to point of educational delivery . While SLEs are an educational 'technology ' ,blending them with clinical experience is likely to enhance the traditional learning paradigm of "see one (simulate -100) do one , teach one " . However this is an active research agenda .

IPP and IPL are clearly felt to be important in enhancing patient outcomes – what we need is an active research agenda to see where they can really help , and at what cost . Can they actually save money . The advent of SLEs is another area of research . But the research agenda aside we need to be 'smarter / tougher ' in how we process the results of our research – if we really do show things work – how do we implement them – and that takes leadership and moving outside the traditional silos so well entrenched in health care

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