

Document for Consultation

Australian Institute of Health Policy Studies (AIHPS)
National Health Policy Roundtable – 6th April 2006

Workforce for the Australian Healthcare System in the 21st Century

Executive Summary

The 4th AIHPS National Health Policy Roundtable was held on April 6 2006 in Brisbane. There were four presentations responding to the recommendations made by the Productivity Commission Report into the state of the Australian healthcare workforce (www.aihps.org). Since its release on January 19th 2006, the Productivity Commission's report on "Australia's Health Workforce"¹, there has been much debate and discussion about how the health system and its outcomes might be improved by addressing key workforce challenges; for example, by changes in current practices and policies in relation to accreditation and registration and/or by simply employing more doctors and nurses to combat current shortages in the workforce.

We hear in the mass media every day of reactive responses to the current and looming problems in the health system and its very complex, diverse workforce. Government has announced increases in the number of nurses and doctors to be trained and there are already a number of initiatives underway to involve nurse practitioners in providing a broader array of health services. However, the key question is whether such strategies, either by themselves or in concert with other strategies, really provide long-term solutions?

There were four presenters at the Roundtable (www.aihps.org):

- **Dr Anne-Louise Carlton** spoke on the topic of Models for National Registration of the health professions;
- **Mrs Elizabeth Kennedy** spoke on the topic of Does the national registration arrangement for lawyers hold any lessons for the health profession?
- **Prof. Evan Willis** spoke on the topic of Professional autonomy, globalisation and the State: international perspectives on professional labour market reform; and
- **Dr Stephen Duckett** spoke on the topic of the next steps in workforce reform.

The point was made many times at the Roundtable in response to each of the presentations that there needs to be long term and proactive – and not reactive – responses that address specific needs, issues and problems. We also need to be realistic about what is possible given the complexities of the current and changing health system as well as the higher education system and the myriad of other influences that affect both of these systems and what they can deliver. Too often, assumptions are made about what is known and what might be done, without necessarily having the evidence base to inform what can be realistically done and what the outcomes might be.

Given the current workforce environment and the changes proposed by the Productivity Commission to COAG, merely reforming accreditation and registration process and systems is clearly not going to solve workforce shortages and problems. The key question is, what problems are we trying to fix? While overall, the Australian health care system performs pretty well compared with other comparable health systems in other countries, there are undoubtedly, increasing pressures and sustainability issues that will adversely affect the long term health of the current system.

There is a need for new ideas, approaches and thinking which is 'outside the box'. There is little doubt that involving nurses and health professionals in a broader array of service delivery functions is one very important step for addressing the current and future shortage in the supply of "qualified" doctors in Australia.

The issues

Five broad areas/issues were identified in a background research document prepared for the Roundtable event⁵:

- Barriers to the mobility of practitioners
- Inconsistencies in legislative requirements across states and territories
- Ensuring effectiveness, quality assurance and consumer protection
- Peer review models of regulation
- Facilitating a flexible and sustainable health workforce.

The Productivity Commission's report identified a range of systemic problems that impeded efficiency, responsiveness and sustainability of the current health workforce arrangements in Australia¹:

- fragmented roles and responsibilities, with health workforce policy 'compartmentalised' by profession, even in circumstances when an integrated 'cross-profession' approach is clearly called for;
- inadequate co-ordination mechanisms, inflexible and inconsistent regulation with a lack of collaborative policy efforts to improve co-ordination across the various parts of the system;
- inflexible and inconsistent regulation that is subject to considerable influence from the professional groups concerned, and widely perceived as inhibiting changes to scopes of practice and the development of new competencies that could help to better meet changing health care needs;
- perverse funding and payments incentives that may result in patients seeking treatment from a doctor, when (unsubsidised) treatment from another health professional may be more appropriate and limited incentives for medical practitioners to delegate less complex service provision to other suitable skilled but more cost-effective, health professionals; and
- entrenched workforce behaviours that are heavily influenced by 'custom and practice'.

The Commission's report proposed reforms that will impact on scopes of practice, and job design more broadly, whilst maintaining safety and quality in practice; improve and coordinate a more responsive education and training regime for the current and future health workforce; accredit courses and institutions and register health professionals in nationally consolidated and coherent frameworks; and provide the financial incentives to support access to safe and high quality care in a manner that promotes innovation in health workplaces^{1,5}

A less fragmented and better coordinated registration system is expected to provide the levers required to improve workforce deployment, generate efficiencies and promote consumer protection.

Discussion at the Roundtable focused on the issues facing the current Australian healthcare workforce and what are the short and long term plans that need to be put in place following the Productivity Commission's workforce report and its recommendations for reform.

What is achievable right now? In the short term, it was identified that through the Productivity Commission's findings, the rules for national accreditation and registration will need to be amended for a long-term change, but this will not fix the identifiable short-term issues.

Who is in charge of making these changes, besides COAG? One suggestion has been that a statutory body is required to tackle specific issues for the long term, but not in relation to disciplinary issues. There also is a need to have a process involving external bodies, i.e. the employers, the employees, the health consumer to be involved in providing their views/feedback into the process. There needs to be a consultation process, but the best way forward at a national level.

There needs to be separation. Most groups have shown support for the change to national registration, but there needs to be a separation of disciplinary functions from the registration function and for disciplinary processes to incorporate a peer process, as has been established in the national accreditation and registration scheme for the legal profession.

Last, there needs to be a reflection of the different kinds and needs of workforce i.e. ATSI Health workforce, Mental Health workforce, Nurse practitioners, rural/remote practitioners etc.

Bureaucratic challenges

There are many challenges in the role of bureaucrats including demarcation and the impact of healthcare on the consumer. How do we make health policy and its implementation work and to be designed better for consumers? The easy answer is to engage consumers better, but this in itself is a challenge, as has been presented in the previous Roundtable in 2005 www.aihps.org There needs to be more transparency in the decisions made by policy makers, more public reporting and to make this more consumer-friendly and to promote national debate. The current barriers are not legislative, but political, too many viewpoints and pressure on the decision makers who are trying to appease all parties.

Is it just a quick fix by implementing new rules? Would it be easier to have re-registration in the health system? In comparison, Australia has less registration regulations than other Western countries (US, UK), which have re-registration every other year.

There is an opportunity for the bureaucratic system to make change, but for them to understand the differing needs of the workforce. Better systems for Indigenous Health, improvements in understanding of the roles in specific health issues i.e. Mental Health, Men's/Women's Health etc. There needs to be projects set up that can commit to improving health overall and to stop pilot projects, which have proven in the long run to have little or no effect on the overall improvement in the health system.

Not only is this a question of politics, but there is also the effect of disciplinary processes that occur within governing and statutory bodies. Articles such as "Watchdogs Breakfast: failings in the system"² and the issues in northern Queensland⁴ are just some of the tell-tale signs that some of the necessary registration systems are breaking down. It can be noted however, that these two particular cases are related to the medical profession, but the same can be true for other regulated health professions⁵. One could argue that the current registration boards are doing an excellent job, under difficult circumstances and constant change, but can these "slips" in system regulation become a cause for alarm?

In changing registration and accreditation practices for the legal profession, legal services boards now have support panels and it is up to the legal services boarding each State to discipline lawyers. The changes to the legal services field has supported the need for self-regulation, the need for greater transparency, to design a system that assist law firms to not be anti-competitive and to create a level playing field.

One other issue of concern overall, was that of fraud and problems arising from self-regulation. The problem of health professionals being de-registered and then continuing to practise as an unregistered alternative health care provider e.g. "counsellor" was noted to be of concern.

Barriers to change

There are a plethora of barriers to addressing the various challenges, but for the purpose of this summary paper, we shall look at only three:

- Existing professional interests
- Policy/Legislative barriers
- Communication

The current Australia workforce is caught up with many external professional groups and interests i.e. MBS, industrial relations/coverage and job security. With present issues, there is a need to disentangle economic interests.

Policy barriers, including ineffective implementation are another barrier. How policy is interpreted by different sectors/health professionals is also a recurring problem. There is inconsistency in legislative requirements across the states and territories. Another issue is the external bodies that

also have to deal with legislative change, health funds being one of them, where they have to deal with over 90 pieces of legislation as they are required to cover all levels and kinds of healthcare, including alternative medicines.

Communication is the key for change, but how? It is a constant that there needs to be more transparency in what is communicated and that the right communications are sent. However, there is also the need for better communication between the educators, the health providers and the bureaucrats. So how can communication be improved?

There needs to be better communication between schools/educators/trainees and government/registration boards/regulatory authorities. At this point in time, there seems to be an ever widening gap between these two collective groups on the requirements of training, the costs involved and changes in policy requirements. Following this, communication between the health care providers and the consumer can be improved as there is the existent naivety of the consumer to healthcare and its systems. It is not a matter of transparency in this case, but information that removes the bureaucratic “jargon”.

Also governments need to be more transparent in reporting actual data/information on the current situation in the health system i.e. waiting lists

Training

There is a need for further high level training of most health professional groups. This training needs to be lifelong and not just for first-year students in medical school. There needs to be commitment from the larger support group for training before any accelerated programs can be implemented.

A tailored or core set of competencies need to be implemented throughout Australia and make the training of future health professionals the same and this is an area that the academic community needs to take the lead on and provide feedback to COAG directly. The VET sector, through TAFE training is a good example of lifelong learning, where skills and information is updated by experience. Following this, there needs to be a shift to a competency based system, not academic, where students are provided with practical training from their first day.

Another area that needs to be taken into account is credentialing. This needs to be “divorced” from the overall privileging process and experience.

The overseas experience

The healthcare systems in New Zealand, Canada, the United States and the United Kingdom are in the same position as in Australia, with high profile failures in the peer review systems. With workforce shortages, increases in insurance costs, the lack of health insurance overall it seems that the whole of Western society is dealing with a global health crisis.

To understand the overseas experience there is a need to put the international health systems into context and who regulates the system. In the United States, the health system is a culmination of federal Medicare, state Medicaid, private health systems (FP and NFP), which might be local, regional or national and local hospitals, but not run by one individual statutory authority/body. In Canada, the health workforce is governed at the provincial level i.e. Ontario – Health Professions Regulated Advisory Council (1991). In New Zealand, the Health Practitioners Competency Assurance Act (2003), and the United Kingdom, the National Health Service Reform and Health Care Professions Act (2002) and similarly the UK Health Professions Order (2002)⁶. A scoping exercise, undertaken on behalf of the Council for the Health Regulation of Health Professionals (CRHP) by Judith Allsop (2004) reflects on regaining trust in medicine through professional and state strategies:

In the UK context, government relations with the medical profession are no longer unilaterally supportive as the focus of government policy has shifted towards improving the quality and effectiveness of health care and reducing variations, as well as controlling costs. The market reforms of Conservative

governments, followed by a range of Labour government measures to raise standards have increased accountability for individual performance through the introduction of clinical governance, target-setting, practice guidelines and protocols, audit and inspection ⁷.

Through this exercise, the various functions of regulatory bodies/councils has shown that regulatory bodies are not moving with health policy and legislative changes made by governments, but it does not directly identify that this is directly linked to lack of participation, but and more of an issue based around trust.

However, there have been significant inroads made by each federal government in terms of assurance and responsibility for and of their individual health systems. These have been reflected in competing trends in allied health i.e. the deregulation of the dentistry system in New Zealand and an increased use of dental nurses.

Conclusions

So what can we gain from prospective changes to the health workforce, through the recommendations of the Productivity Commission through to the many hundreds of submissions, articles and papers that have arisen not only since January 19th, but over recent years. It is too easy to blame the system, the politics and the policies, but clearly the time has come when some major changes and initiatives are required.

The sick will always be with us, and with most workforce sectors, there is no compunction for doctors and other health professionals to remain in the public health system, particularly when the financial rewards are greater elsewhere. More complex still, there needs to be improved realignment of the health system to better meet the needs of both health consumers and health professionals. It is also important to consider health workforce issues within the broader context of Australia's health outcomes at both a population-level as well as in terms of those population sub-groups where major health disparities still exist. Prevention and health promotion are very important in this broader context.

There is recognition of the importance of policy and its influence on change. How important is the health professional influence on policy change and is it conducive to positive changes in the health system? One could say that the dominance of the medical profession of the healthcare system diminished fifty years ago, but groups such as the AMA, Nursing and Medical colleges still have a large influence and say in how things move and change. Jenny Lewis (2006) states that "medical expertise is a potent embedded resource connecting actors through ties of association, making it difficult for actors with other resources and different knowledge to be considered influential" ⁸.

These issues need much more debates and discussion at all levels, however, there is also a need for identifying a way forward and next steps.

Recommendations to COAG

Following discussion in smaller groups, a number of core recommendations to COAG were proposed. Of the many key recommendations, seven broad headings were identified as important to consider in relation to a change of thinking and approach in this whole area:

1. Training/Education

- a. Recruitment and retention issues and challenges
- b. Reform of the education system that might achieve more integration and resource support for education and training from the health system and not just from DEST
- c. Reforming undergraduate health training – specialisation and streams – consideration of VET sector training
- d. Postgraduate competency training (in smaller packets)
- e. Skills escalators for progression i.e. short courses, practical skills training
- f. Use of more peer teaching, e.g., involvement of practitioners and physicians in education – more work experience, not just theory
- g. Development and implementation of more transdisciplinary curriculum working between VET, higher education, industry and other sectors to provide wider scope and practical examples of “real-life” training
- h. Accelerated training and development of more flexible training and career development pathways, increase access to allied health and other sectors for variation

2. Policy and structural change

- a. Changing hospital “culture” and roles and scope of hospital and healthcare staff
- b. Looking at different models i.e. legal and industrial to inform processes that have worked
- c. Move back to prevention management in health rather than curative models
- d. Different approaches to healthcare – keep patients out of hospitals i.e. complimentary medicines/alternative therapy options, increase general or nurse practitioners in medical centres
- e. Recognise existing innovation and encourage future growth in this area i.e. increase nursing staff, nursing practitioner programs/training etc.

3. Financing

- a. Alignment and reform of financing incentives
- b. Look at different models that work and reform funding schemes
- c. Look at different non-government funded models such as health savings accounts (US), voucher systems (Singapore) etc
- d. Look into two tier funding arrangements
- e. Change Medicare scheme to include a wider range of health professionals – give the consumer the option to choose their health care (preventive models)

4. Greater engagement with consumers

- a. Need to understand the consumer system and what is involved – involve consumer representatives/community more frequently, and not just at the policy decision stage
- b. Consumer protection/quality assurance processes: improve the quality, or have a centralised department specifically looking at consumer protection
- c. Public domain reporting greater transparency of information
- d. Need for genuine community consultation and National commitment to consultative processes – involve the community throughout all stages of the policy making

5. National Registration/Regulation processes

- a. Reduce rigidity and increase blurring between professions – must be recognised as an autonomous, but individual group of health professions making up a whole
- b. Produce new regulatory groups/institutions
 - i. Short term support
 - ii. Long term protection

- c. Decentralise process of registration and regulation of health workforce, in this case doctor registration
- d. Better assessment and portability mechanisms, particularly of registration/accreditation between states
- e. New national database of medical/healthcare practitioners/professions – could remove existence of current regulatory problems and checking of health workforce as they move across the country/or from overseas.

6. Industrial issues

- a. Awards allow for new roles in reform – involve Industrial reform legislation and policies across health workforce?
- b. Contract reforms – long or short-term contracts – consistency in length of contracts and implement review before renewing.

References

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