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Health Workforce Study
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Dear Commissioners Woods and Owens

The College of Health Sciences at the University of Sydney notes that the Productivity Commission is seeking 'relevant information and analysis' from participants to assist in the preparation of the Health Workforce Issues Paper.

> We wish to underline the importance of policies for the education and training of the health workforce so that it can meet the changing needs, especially those associated with serious and continuous illness, that accompany increasing numbers of older people among whom these conditions are concentrated. This requires critical appraisal of the current educational arrangements for undergraduate, postgraduate and continuing education of health professionals, together with a strong commitment to the definition of the competences that we predict will be needed by patients and carers in managing these illnesses, and by populations seeking to avoid and minimise them through prevention.

The College of Health Sciences is well placed to assist the Productivity Commission in this task. The College comprises the Faculties of Dentistry, Medicine (including its School of Public Health and this Institute), Nursing, Pharmacy and Health Sciences (including all the Allied Health Professions). The Pro-Vice Chancellor, Professor Don Nutbeam, has asked the Australian Health Policy Institute to coordinate the work of the Faculties in developing a submission to the Commission.

I have consulted with the deans of all Faculties. In their initial responses they emphasise that the model of health care needs to be considered alongside our consideration of the workers needed and how we produce them. At present, patients with complex health issues are typically managed in the same way as patients with discrete problems – by a succession of individuals addressing specific problems, often without relative priorities or proper recognition of the interactions. As the population ages the proportion of patients with multiple or complex health care needs will increase. Each patient needs to be managed by a form of case manager who is able to coordinate a team of multi-/ inter-disciplinary care providers and establish a care plan by consultation and then ensure it is delivered. These managers can be more generalist health care workers because they will not actually be providing service delivery, just managing it.

Our training programs for health care workers of all disciplines, especially among the emerging and new health sciences and less so among established groups such as the medical profession, have

progressed in status and as a consequence are now generally populated by students with high capabilities and aspirations. Many modern graduates have aspirations that are poorly matched to the workplace realities when they arrive. They find it hard to put into practice what they have been taught and many leave as a result. The mismatch can be partially improved by changes in the educational programs, but needs to be addressed also in the workplace. Best practice is being taught but not implemented in the workplace due largely to workplace pressures and shortages.

The upward drift in status of many health professions has led to practitioners in many disciplines who are ill-suited or inclined to carry out many of the more routine and lower level work actually required in the workplace.

The scope of work needing to be done has in many cases stretched beyond the realistic range that an individual can encompass. The nursing workforce has addressed this by having different levels of training with matching expectations and responsibilities and lessons from nursing need to be explored for their applicability in the other health professions.

In summary, there is a need to first define the type of health care model we wish to put in place to serve the Australian community's needs for the next couple of decades. This will likely result in a broader spectrum of workers, operating in teams, with workers delivering the services and leaders devising care plans for the management team to implement.

A two-pronged approach to the health care needs of the future is required. One prong defines the model of care. The second identifies the type of workers needed to make it work. We can then design the training programs to produce them. This is not dumbing down the health workforce: rather, it is recognizing that we have raised our expectations of traditional practitioners and broadened the scope of work we expect from them beyond reason. A more graded and inclusive workforce may suit our needs better for the future.

Deans of the Faculties also identify the following issues as important to the future health workforce:

<u>Dentistry</u>

- There is an inquiry being conducted in NSW into dentistry currently and previous studies by Professor John Spencer from the Australian Research Centre for Population Oral Health at the University of Adelaide (http://www.arcpoh.adelaide.edu.au/index.html) have also reviewed the dental workforce. The *Healthy Mouths Healthy Lives* report defines workforce issues as an overarching area in dentistry that needs to be addressed[i].

- More commitment is required to act on the research that has previously and is currently being conducted and on the recommendations made in previous reports. The situation will worsen if nothing is done.

<u>Health Sciences</u>

Currently, one of the most serious human resource problems in health care is the inability to retain experienced health care professionals. Whilst the research on reasons for staying and prematurely exiting the workplace is piecemeal and typically focuses on only one health care professional group, there appear to be critical factors associated with negative employment experiences in allied health. Factors associated with exiting include out of date pay structures, the lack of a clear and equitable career track, and the lack of senior positions that retain an element of clinical work.

The introduction of professional and graduate entry programs in allied health by some universities in Australia (eg the University of Sydney) provides a window of opportunity to re-examine job grading structures and associated work roles and responsibilities within the health industry. If these workplace

issues are not addressed, retention of experienced staff could become an even greater problem than currently is the case. Accordingly, there may be a greater need to more aggressively seek out solutions to make the workplace attractive and welcoming.

Below are a series of questions about changing the way we educate health professionals and changing the work structures that they currently experience:

- Will a generic undergraduate degree help potential professional entry students think more carefully about a career in allied health and what career? Will students be more knowledgeable about their future working conditions than they currently are? Thus, will recruitment become more efficient and effective? Will this help with current retention problems?

- What might be the general implications for recruiting and retaining allied health professionals with the proposed **extended** training? Will this increase the frustrations currently experienced by allied health professionals (poor fit between their high expectations of what they will do as graduates and the reality of the workplace), OR will allied health professionals become a more powerful, autonomous, articulate group who will reduce the effects of the dominant group - the medical profession - and accordingly derive more satisfaction from their working lives? OR some other case scenario? How can we plan for this?

- By changing the educational requirements for a career in allied health (extended training), could the skill mix or degree of collaboration during training across allied health groups be loosened up and extended? Could there be a greater recognition of the common workplace problems faced by allied health professional groups which is addressed during training? Students will be 'older and more mature' with extended training. Will they be more receptive to a collaborative/work together/teamwork approach? Could the training of allied health professionals be more similar to that of the UK (eg University of Portsmouth)?

- Will there need to be a hierarchical system-eg PT assistant etc, akin to nursing? How will a lack of hands-on patient care be accepted by allied health professionals? Career motivation of allied health professionals has been identified as 'a need to help others', 'helping others is rewarding'. If assistants are to be employed will this be another frustration experienced by allied health professionals? Who will train the assistants?

- There is now an urgent need for comprehensive and relevant findings with clear policy implications concerning what factors determine the attractiveness or otherwise of public/private sectors as a place of work for allied health professionals.

- Most allied health disciplines, if challenged, could define a starting subset of skills that could be gained in say a 2 year program, that would equip workers to be part of a team and able to deliver a significant part of routine health care needs. The higher level graduates would deliver the higher level care, supervise and be part of the inter-disciplinary teams developing care plans.

Medicine

The following factors will impact on the medical workforce:

- Graduate entry programs.

- Feminisation of the medical workforce.

- Shorter more varied careers of health practitioners, all leading to less direct patient service per graduate.

- Growth of biotechnology and other career paths for medics.

- Increasing burden of chronic disease leading to more need for disease management and muti-disciplinary team approaches.

- Growth of private sector increasing fee-for servicing and over-servicing.

- Hot and cold spots for service as a consequence of a free market and mobility of practitioners and wealthy patients.

- Growth of medical tourism.

- Role substitution.

- Newly emerging disciplines.

- Inhibitory role of trade "guilds" in restricting supply of specialists.

- Increased regulatory barriers to international exchange of practitioners.

- The chronic disease and ageing epidemic in our region.

- The indemnity crisis forcing people to retire from high risk practice early and driving up costs therefore driving down accessibility.

- The ability of IT to reduce some consultations and reduce duplicate investigations.

- Increased doctor shopping through on-line medical information.

- The development of commercial disease management corporate offerings.

- The increasing cost of pharmaceutical development pushing up prices for new drugs to the $1000's per year range instead of $100's.

- The loss of smaller hospitals and the development of the super hospital servicing 1million people instead of 250,000 as the demand for acute 24/7 MI angioplasty and acute stroke unit care increases. This will drive greater sub-specialisation so that more doctors are needed on larger rosters.

- The increased unwillingness of primary care to provide its own after-hours cover.

- Hospitals using super-expensive equipment 24/7 leading to changing work practices and work life balances (at the cost of increased salaries or shorter working lives or both).

- The desire for a no-risk health care service driving the need for over-servicing and defensive practice.

<u>Nursing and Midwifery</u>

- An important international issue is the reluctance of nurses to stay employed in the direct health care industry where patient care occurs. Nurses will not work in health in the current arrangements.

- There is a supply issue if we are realistic about capabilities for successful practice. Given the entry scores at some universities and internal research conducted by the Faculty in 2000-1 on entry attributes (and how these correlate with progression through their studies and making it into the workforce), there is a high probability of poor performance among some of these graduates. This remains a significant issue while health departments have a supply-side approach to workforce policy in nursing.

- There are no national or state polices about the need for or preparation of specialist nurses. This has been the case for years and the last work done on this area was Professor Lynette Russell's national report that is now a decade old.

- The nursing workforce is generally treated as homogenous - a different spin on supply dominant policies. There is a rapid and progressive dismantling of the responsibility/capability boundaries between ENs and RNs, yet within the RN workforce we are seeing a bottleneck at the upper end of the capability spectrum. This leads to frustration in the slow evolution of the nurse practitioner (NP) group who face opposition from the AMA and individual institutions. Confusion and fear continues to plague this area. The doctors seem to regard the NPs as a direct threat, but the model being pursued here, like the UK (and unlike the US) is an extension of nursing, not a turf war with medicine, particularly the GPs. What people keep ignoring is that nurses want to do nursing not doctoring.

- An important issue for RNs is the continuing industrial and employment context in which they work. They are managed under and remunerated with 19th century practices, over-monitored and under-remunerated, not necessarily in the monetary sense but in terms of access to study leave, support to attend conferences and other activities that feed directly back into improved service.

- The intensification of nursing work is not taken into account, yet increasing throughput etc. is dependent upon greater productivity by nurses. There is some US work on this that is troubling and it shows the RNs simply wear out from overwork.

- There are few maintenance programs or incentives to keep nurses in the workforce. An important issue on this front is simply respect in the workplace.

- Despite the emphasis on evidence based practice, there is no really serious attempt across the system to get this working, though there are excellent examples in areas where particular individuals are driving it.

- The politicisation of nursing (and health care) is out of control with direct interference at a departmental level when matters are best dealt with at the local level. Much of the anxiety stems from the media focus on nursing issues.

- Attention needs to be shifted from obsolete models about the nature, preparation, employment, remuneration and deployment of nurses to a focus on planning for the future health system. Most attention should be on RNs because this is the group feeling eroded from underneath by ENs and blocked administratively, industrially and in relation to career advancement in nursing. The literature suggests that the good RNs who leave, do so with reluctance and regret and most will not return.

<u>Pharmacy</u>

• The (international) shortage of pharmacists in the workforce is well documented. In Australia, this has been mostly felt in rural practice (both private and public sector) and in public sector hospitals in both metropolitan and rural areas. In metropolitan hospitals in Sydney, the vacancy rate has been continuously at or around 20% for over 5 years.

• Private sector-community pharmacy: The role of community pharmacy in the provision of primary health care has been studied extensively by the University of Sydney Faculty of Pharmacy and others. A number of the services (Homes Medicines Review, Disease State Management programs in diabetes, asthma, mental health) have been developed and evaluated through research by this group.
As the population ages, the need for cost effective primary health care services will increase, however the opportunities for pharmacy to deliver such services will be diminished if workforce constraints continue or worsen.

• Public sector-hospitals: The impact of pharmacy services in tertiary health care services has become increasingly important. Pharmacists have a leadership role in multidisciplinary services focusing on patient (and specifically, medication) safety, quality, clinical governance and cost containment. Senior pharmacists and medical colleagues, through Drug Committees, manage drug use in hospitals through evidence based medicine policy and guideline implementation. The operational arm of Drug Committees, in terms of implementation of the principles of the Quality Use of Medicines, is the clinical pharmacy service. There are research data on the impact of Drug Committees, drug use evaluation and clinical audit programs on drug use and outcomes. Influencing prescriber behaviour – to adopt an evidence based approach, as well as influencing the patient's behaviour (ie that they actually do take appropriate medication) are key roles for pharmacists in these settings. The development of policies and approaches to managing high cost medications in the public health sector is also part of the hospital pharmacy service role. The impact of the pharmacy service is therefore both on individual patient management as well as hospital or Area/ state policy for use of medication in a given clinical area. It is also recognized that medication management in hospitals does influence drug use in the wider community.

• NSW Health has to date not had a strong relationship with the Faculty of Pharmacy, University of Sydney. Issues such as (current and future) pharmacy roles in this sector, workforce recruitment and retention, as well as training of pharmacy undergraduates and graduates in public hospitals have not been negotiated during expansion of the University of Sydney degree programs. As a key provider of students and graduates to this 'employer', the University and NSW Health and other stakeholders need to be at the negotiating table.

• In a response to workforce needs, new schools of pharmacy have been opened in recent years (CSU 1998, Newcastle 2004, Canberra 2004). The alternative providers have put pressure on the capacity of the existing workforce to train our future workforce. We do not have a sustainable program for clinical training of these future pharmacists.

<u>Conclusion</u>

The College of Health Sciences would like to work with the Productivity Commission to:

- clarify the competences needed to meet the health needs of the population with more serious and continuing illness;
- explore which, among existing health service professions, those competences could be practically and politically distributed;
- note if there are any competences currently not met within existing health service professions (management quite likely);
- explore the implications for the health service if we are seriously to address these needs.

The College of Health Sciences looks forward to working with the Productivity Commission on the Health Workforce Study and making a further submission in July 2005.

Sincerely

Stephen Leeder

19 May 2005

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[i] National Advisory Committee on Oral Health. Healthy mouths healthy lives: Australia's national oral health plan 2004–2013. Adelaide: Government of South Australia on behalf of the Australian Health Ministers Conference, 2004.