PB/em

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Dear Mr Woods

It was good to see you last week.

Here is my final submission to the commission. I would be very happy to have further discussions with you at any time and look forward to meeting you when I am next in Canberra.

Yours sincerely

PROFESSOR PETER BROOKS
EXECUTIVE DEAN

Enclosure

SUBMISSION TO THE PRODUCTIVITY COMMISSION –
HEALTH WORKFORCE STUDY

From: Professor Peter Brooks, Executive Dean, MD, FRACP, FRCP *Edin*, FAFRM, FAFPHM, MD *Lund* (Hon Causa)
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I make this submission as the Executive Dean of Health Sciences at The University of Queensland. I have had over 35 years experience with the health system in Australia as a rheumatologist and general physician working in Tertiary Referral Centres and in private practice, as a teacher and researcher and as a health administrator. In my current role at The University of Queensland I am responsible for the training of a broad range of health professionals - doctors, dentists, allied health professionals, nurses, pharmacists, public health professionals and human movement specialists. The Faculty of Health Sciences at The University of Queensland is one of the largest in the country and has adopted a significant platform for inter-professional learning over the last five years.

The issues paper produced by the Productivity Commission clearly outlines the reasons for the health workforce shortage and recognises that this is a global issue and not confined only to Australia. This globalisation of the health workforce will be an important issue to be considered as solutions to the health workforce challenge are discussed. The issues paper rightly points out that this is not just a problem with 'numbers' but also with job satisfaction and it is interesting to note box 4 (page 21) draws out some of the examples of health worker disenchantment and this clearly needs to be addressed when solutions are being considered.

Chapter 3 outlines the tensions in the current arrangements for health funding and organisation in Australia and particularly points out the fragmentation of roles and responsibilities between the Australian and State and Territory Governments. While this division of responsibility continues, behaviours such as cost shifting, which have developed as an art-form in Australia, are likely to continue. Another major issue again identified in the background paper is that of the lack of formal between Health and Education Departments at both a Federal and State level.

In terms of the responsibility for health worker training, there are two important areas that the Commission needs to investigate. These are the fact that State Governments take little or no responsibility for the funding of clinical training places at an undergraduate level within their institutions. Sadly there is no real acknowledgement that they have a responsibility to help train the health workforce of the future. It might be argued that they cover the salaries of the trainee registrars (within the specialties) but they do not acknowledge their responsibility for undergraduate clinical placements or for the training of general practitioners. It would be interesting to further investigate some of the models of clinical training payment from overseas – for example in the United Kingdom there has been a long tradition of health authorities purchasing training places for health professionals from local Universities.

Another area that requires review is that of private sector involvement in health workforce training. The private health sector is the major beneficiary of the health workforce and yet invests very little in training. It is not uncommon for a young specialist to spend 15 years training, primarily in the public system (at significant cost) and then move entirely to the private system when he or she receives their specialist qualification. It would not seem unreasonable to consider some way of requiring all specialists to continue to spend some period of time (a fractional appointment – as low as two sessions per week would be sufficient) working in the public sector (and being paid appropriately) even though the majority of their work time may be in private practice.

There is still a tendency to see "medicine" and the medical workforce as driving the agenda. While this attitude persists there will be no real advance. The health workforce has to be looked at as a whole - appropriately co-ordinated and the full range of health practitioners (existing and "new") considered in any restructuring.

"There is currently just over 11% of the total workforce of Australia engaged to some degree in the health industry". Given the ageing population and the projected significant increase in requirements for health services built on an ever demanding (for health services) population as a whole, it has been suggested that this percentage of the workforce will need to increase to around 20% by 2025 if we are to maintain the services to the population that we currently find acceptable. It would be impossible to provide these services (or this increase) using doctors (or even nurses) alone. There needs to be a significant (and urgent) reorganisation of the health workforce and role extension of existing health workers would go somewhere to assisting this. A fundamental question that all health workers need to ask (but particularly the medical profession) is "what should I do that cannot be done by anyone else?" and "what can I stop doing and have performed by some other appropriately trained health worker?"

Health Workforce Extension

Within the existing health workforce there could be significant role extension –

- Pharmacists involved in some routine prescribing (particularly with repeat prescription or medication monitoring);
- Radiographers reading x-rays (some 30% of all x-rays performed in the United Kingdom are currently read by radiographers and there are a number of papers showing that appropriately trained radiographers can read x-rays as well as radiologists);
- Pathology technicians being involved in routine histopathology screening and possibly some diagnostic work (technicians currently carry out routine screening for cervical pathology and this could easily be extended to cover some diagnostic work);
- Nurse practitioners being involved in chronic care (limited prescribing and some procedures);
- Physiotherapists performing triage of musculoskeletal injuries in the Accident and Emergency Departments;
- The development of technical skills – colonoscopy, minor surgery etc being performed by nurse practitioners or other individuals;
- Anaesthetic technicians being employed to assist anesthesiologists (this occurs commonly in the United States where anaesthetic technicians can be involved in pain management, routine anaesthesiology and often allow anaesthetists to run up to four theatres at any one time).

A key element to role extension of health workers is that it should be seen as a "liberation" for those groups of workers being "substituted for". For example, routine x-ray reading by radiographers allows radiologists to spend more time on the much more important and interesting investigational work – carrying out angiography etc.

The nurse practitioner movement has been developing for a few years but they are still not well accepted by the medical profession, although this is changing rapidly. This is seen particularly so in the rural sector where nurse practitioners can be extraordinarily helpful in providing healthcare to isolated rural communities. Nurse practitioners and practice nurses are probably better accepted in general practice and there is some data to suggest that those practices who employ these nurses are, in fact, far more effective and are more profitable.

Consideration also needs to be given to the development of a range of new health practitioners – physician assistants and others. In the United States there are some 60,000 physician assistants who grew out of the "medics" returning from the Vietnam War. These professionals are trained in some 130 training programs across the United States – the majority being associated with Medical Schools or Health Science Faculties. The importance of having Physician Assistant Training Schools within a Health Science Faculty is an important one as it helps to promote inter-professional learning and the concept that they are all very much a part of the health care team. The physician assistants programs in the United States are usually conducted over a 26 month period and involve training in basic sciences as well as in clinical aspects. Postgraduate programs and continuing education are gaining in popularity and the physician assistants in the United States take on a range of activities from primary care to involvement with a number of specialties from cardiothoracic surgery, critical care, gerontology, management of chronic disease, orthopaedics, sports medicine and a range of others.

There is also an opportunity to review the development of a range of other "assistants" – physiotherapy assistants, occupational therapy assistants etc. These workers could take over some of the routine work carried out by more highly skilled professionals. They could (like the enrolled nurses) be trained within the VET sector and would provide good links between the Universities and the VET sector in health workforce training and expansion. Again, there are opportunities of linking the training of these assistants with the training of other health professionals to provide that team concept of management.

The development of any new health practitioner would need to be linked to a number of other issues-

- Development of clear career pathways and registration for these practitioners;
- Development of continuing education programs;
- Development of articulation programs with other health practitioners;
- Issues of remuneration, professional indemnity etc would also need to be addressed.

Specialisation in Generalisation

The expansion of the health workforce needs to be considered in the context of specialisation versus generalisation. The current health workforce (particularly medicine) is becoming much more specialised and this will continue to be driven by the pervasive economic incentives which remunerate procedures rather than the clinical (considered) opinion. The issue of remuneration is an important one since there is reasonable evidence to suggest that young doctors are thinking of higher remuneration specialties (often procedural) where they can make good money and also organise their lives somewhat better. In this context it would be useful to revisit the "Relative Values Study". This study was conducted some years ago but was never acted on by Government. Provision of the funding of medical practice, and particularly the balance between the cognitive opinion and procedures, would act as a powerful incentive/disincentive to continue

super-specialisation. There is little doubt that this is driving the health workforce agenda in the United States and contributing somewhat to the enormous costs (15% plus) of GDP. There is also reasonable data to suggest that these financial issues are also starting to drive the health workforce agenda in this country as well.

For example, the remuneration for cataract surgery seems to fly in the face of normal supply and demand. Here is a procedure that can now be undertaken relatively quickly (30 minutes at a maximum), has a very significantly growing market (most of us will require cataract extraction if we live long enough) and yet the cost of this procedure has gone up very significantly over the last few years. This is but one example of a technology where it may be possible to train non-physicians to perform tasks. Professor Fred Hollows actually showed this some 15 years ago and transported these ideas to the developing world where they seem to have been very successful.

There are many situations where specialists take over much work that could be carried out just as well by a general practitioner. Take for example my own specialty rheumatology where patients suffering from osteoarthritis will be reviewed each year. Similar things happen with chronic cardiovascular disease hypertension etc, where a specialist having once seen a patient requires follow-up at 12 monthly intervals which could be just as easily (and certainly more cheaply) carried out by a general practitioner or perhaps even a nurse practitioner. Here again, it may be important to consider whether changes in the remuneration for these chronic (but not life threatening) conditions should be remunerated at a specialist rate (even when seen by a specialist).

The issue of creating a generally trained workforce is a particularly important one when considering chronic disease and the elderly. Multiple pathologies are now commonplace and it is not cost effective to have to have every individual seeing five or six different specialists, all of whom will be remunerated at a consultant rate.

Length of Training

The length of training of health professionals is an important issue that also needs to be reviewed. With the development of graduate entry medical programs many students have a reasonable idea of what specialty they wish to pursue before they have completed their medical program. Would it be possible for example, to build flexibility into the undergraduate program and allow it to articulate much better with postgraduate programs. Currently one of the issues acting against this is that medical education is under the control of at least three separate groups – Universities until graduation, the State Health Departments through the Postgraduate Medical Foundations responsible for Years 1 and 2 and then the learned Colleges picking up training after that. Currently there are no incentive for any of those groups to work together. The College programs also need to become much more flexible and could perhaps look at a significant reduction in training – particularly if specific technologies are to be learned. We need to ask whether it is rational to continue to spend 10 to 15 years training a super-specialist who may well be carrying out one particular operation or investigation (arthroscopy, colonoscopy etc). Perhaps some shorter period of training could be designed with limited credentialing and practice payment to cover those particular competencies. If this were done some specialists may well be able to be trained much more rapidly and able to practice in the community before they are 30 rather than some five to 10 years later.

The issue of health workforce curriculum change will have to be driven by groups that comprise all of the major participants and this is very unlikely to occur if left entirely to individual groups such as the Royal Colleges.

For example, I have recently established a small consortium of five Universities who are developing training programs in the following areas:-

- Online basic sciences program;
- Development of a training program for career medical officers;
- A program to teach radiographers to read routine x-rays; and
- A program to teach pathology technicians to be involved in histopathology section preparation, review and reporting.

Co-ordination between Health and Education Groups

There is a need to establish a formal co-ordination group between the health and education sectors at both State and Federal Governments. This group could help to co-ordinate and drive health education reform by cutting across State and Federal legislative barriers and promoting links between major education providers (Universities, VET sector, rural colleges and schools). The issue of health education in schools is a very important one from a public health perspective – it is here where health behaviours could be taught at an early age, hopefully with a significant effect on issues such as early adult obesity.

The Competitive Environment

One of the real challenges to changing the health system is that of managing a competitive environment. There are a number of areas (such as aged care) where competition between a number of providers may well be useful and third party payers may be quite happy to develop a range of different funding mechanisms with different provision of service. On the other hand there does need to be a public good aspect to healthcare financing – particularly, for example, in the area of high technology provision where inappropriate competition between providers may not be cost effective.

Review of Pharmaceutical Benefits Scheme (PBS) and the Health Insurance Commission (HIC) Remuneration

It is of some concern to note that the HIC has now moved out of the Health area of responsibility and seems to be seen purely as an administrative structure. There are significant items currently funded through the HIC or PBS where there is little evidence for efficacy. There is a genuine need to provide an evidence base into this remuneration package. Over a period of time all items on the HIC or PBS should be reviewed – in many cases there will be good evidence of their efficacy, but where there is little then it would be possible for the HIC to continue remuneration but only on condition that patients were entered into a clinical study to try to develop that evidence base. If at the end of the day the procedure was still shown to be inefficacious then the Government would have the option to review that and make a decision on the "politics" rather than the science, if it so desired.

Tele-Health

The area of tele-health is one that really needs to expanded across Australia. Australia has assumed a leadership role in tele-health in a number of areas – tele-psychiatry, tele-radiology and tele-paediatrics – where tertiary services can be delivered at a distance. For example, in tele-paediatrics, studies from the Centre for Online Health, at the Royal Children's Hospital Brisbane

and The University of Queensland have clearly demonstrated benefits in reducing the number of paediatric patients referred to Brisbane for a variety of disorders. This has not only been cost effective but has also significantly enhanced quality of life of these patients, meaning that these children do not have to be taken out of their own home caring environment and away from their young friends. Programs that monitor children with burns at home, rather than having to bring them into hospital, and assistance with palliative care in children, keeping them in the home environment for much longer periods of time, have also been developed. Tele-health will be assisted by a much broader recognition of item numbers and a very active educational campaign for health workers to use these systems. Issues such as item numbers for remuneration, infrastructure to support such activities and appropriate training programs to maximise use of these technologies would and need to be considered.

In Hospital Work Place Organisation

It would also be timely for the Productivity Commission to explore the work that junior doctors do – particularly in the first two years after graduation. It is reported that there is still significant non-medical tasks that are having to be performed by young doctors at a clerical and organisational level which could just as well (and perhaps even better) be provided by other workers. This is a very important issue to look at relatively quickly given the dramatic reduction in the hours that young doctors are allowed to work (safe hours clauses) and the significant feminisation of the health workforce which has led to a significant reduction in the lifetime hours worked of some 30%.

Organisational aspects particularly within age of public hospitals needs to be reviewed. Is it rational, for example, to continue the traditional division (and control) of beds into medical and surgical when most patients are treated in a problem based environment – cardiovascular disease, gastroenterology etc. It is much more common now for patients admitted to hospital with relatively serious conditions to be seen by physicians, surgeons, radiologists and a range of other specialists and having a "problem-based" distribution and control of beds is likely to enhance through-put and maximise output. A number of hospitals and disciplines have adopted this approach with such groupings as a heart/lung/vascular institute comprising cardiologists, cardiothoracic surgeons, thoracic physicians etc or a gastroenterology service comprising gastroenterologists and gut surgeons.

Let me reiterate that what we are seeing is a world shortage of health workers and if society really wishes to address such things as waiting lists and rapid access to good quality care this will not be served by focusing on numbers alone. Australia has a significant opportunity at this point in time to make some radical changes in the way that health training is carried out, the range of health practitioners who are trained and available to provide service and the method by which those services are remunerated. These new innovations in health care need to be appropriately evaluated both from clinical outcomes and cost effectiveness. I look forward to the outcome of your deliberation and hope that you will be recommending "real" change.