Submission from the Australian Health Policy Institute to the Productivity Commission's Health Workforce Study
July 2005

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Introduction

The Australian Health Policy Institute was established by the College of Health Sciences at the University of Sydney to provide a high-level capability for authoritative, independent, non-partisan analysis of major health policy questions which confront Australian and international health systems. The Institute collaborates with government and non-government organisations on a range of research projects, conducts a seminar program to promote debate on policy issues and provides an educational capacity in health policy in the College's teaching programs.

This submission is based on a series of in depth interviews conducted by researchers at the Australian Health Policy Institute in June and July 2005 with key stakeholders from across the Australian health system. We conducted 17 interviews and respondents included consumers, representatives of consumer groups, journalists, government representatives, representatives of vocational training bodies, academics and representatives of professional bodies.

The interviews were conducted by telephone and in person and ranged in length from 25 to 75 minutes. We asked a series of broad questions designed to elicit responses about the current and future needs of the health workforce and how the education of health care workers may be improved in order to meet these needs.

The points of view offered in the interviews varied and demonstrate a health system very much divided as to its current and future needs and the possible solutions to these needs.

This submission provides an outline of the most recurring themes raised during the interviews. All themes discussed below were raised as significant by at least a quarter of our participants and therefore represent some of the more pressing needs which must be addressed as a facet of the reform of the health workforce. This report is broken into two sections. The report discusses both themes relating to the health workforce in general and the current education of the health workforce.

We have included pertinent quotes from the interviews in boxes throughout the submission in order to illustrate the points raised.

The views contained within this report do not necessarily represent the views held by the Australian Health Policy Institute but merely represent the synthesis of the points raised in interviews concerning the future of the health workforce.

Workforce flexibility and role substitution

Fourteen of those interviewed independently brought up issues of workforce flexibility and role substitution as significant issues for the future of the health workforce. The current health workforce is seen to be unable to meet the demands brought about by demographic change (such as an ageing population), rural and regional shortages and new technologies because current job roles are too rigid.

The health workforce is structured around professional silos which have jurisdiction over particular roles and are deemed to be inflexible and approach any encroachment on their jurisdiction with hostility.

> "…there's the silos that exist in health and these silos develop at an undergraduate level and even from year twelve….these narrow foci are already too developed by the time practitioners enter the workforce and are hard to break down."

Twelve of those interviewed believed that professional silos restricted the effective operation of the workforce.

The respondents variously stated that the existence of these silos meant that:

- Professions were too inward looking and therefore got in the way of the building of multidisciplinary health care teams;
- The treatment of patients with needs which stretched across professional boundaries was impeded; and
- Role substitution could not take place.

Only two respondents believed that the dominance of professional silos was beneficial to the operation of the workforce because of the way they maintained a certain standard of treatment and education.

The respondents were firmly divided as to the merits of role substitution (by role substitution we refer, for example, to the allocation of tasks normally undertaken by a doctor to a nurse or other worker, e.g. nurse practitioners or lesser trained generic health workers) with seven respondents in favour of role substitution and seven against.

> "Demarcation of work practices is really unhelpful and unsustainable (for example nurses only do this and doctors only do this). Nurse practitioners are working in rural areas but this only happens because they can't get enough doctors and is not seen as best practice by medicos. It is seen as competing with what doctors do so is not taken up widely in cities although it is a good model."

Role substitution was seen to be a positive step for the following reasons:

- It frees up doctors to deal with patients presenting with more 'serious' health concerns;

- The existence of a generic health worker whose expertise crossed professional boundaries would be helpful in rural and regional areas;
- It could help alleviate shortages in particular areas such as dentistry or mental health;
- The use of a generic health worker would make for a more flexible health workforce because these workers could easily be retrained through short training programs run through the vocational sector when a need for a particular skill arose;
- More limited levels of training would be needed to train a worker whose skills lay only in conducting a limited range of routine procedures (such as pap smears, immunisations) in comparison to doctors; and
- At the moment doctors are carrying out tasks for which they are overqualified when someone with many years less training could carry out the task.

> "We need to use the person with the least amount of preparation but can still do the job rather than the person with the most amount of educational preparation. You only need a certain level of competency for most jobs and you shouldn't engage people over qualified when it is not necessary."

- It is already successfully used within the UK context; and
- Shorter training courses offered outside the university system would attract a broader sector of the population to work in health care – such as middle aged workers – and thereby engage with new possibilities for expanding the health workforce.

> "There are new groups that are moving into the health workforce, so we need to look at engaging with people throughout their lifetime and letting people know that there are pathways into the health workforce other than straight from school."

Role substitution is seen as a negative step for the following reasons:

- It is deemed to risk safety and quality because those taking on these roles would not be trained to the same extent as doctors;
- In the case of nurse practitioners taking on doctors' roles this is seen as inappropriate because nurses are in such short supply as it is that they should not be taking on new roles;
- Role substitution is not best practice but only takes place because of a lack of funds or workforce shortages;
- Role substitution is pushed onto poorer, voiceless and more isolated sectors of the population (such as the public system, in nursing homes and rural and remote areas) and therefore creates a two-tiered health system;
- It undermines and devalues existing professions; and
- It is an easy, knee-jerk reaction to a crisis situation (such as the Dr Patel case in Queensland) and what is needed instead is long-term planning.

> "A lack of funds will mean that state governments will be more attracted to employing a three or four year trained health care worker or even lower than this – a certificate worker- doing some of the hack work."

Two of the respondents who were largely against role substitution believed that in extreme circumstances role substitution was appropriate only when a doctor was available to supervise task allocation and when roles were very clearly delineated.

> "In order to meet the demand that will be made by the lack of doctors until the new cohort come through in 2010 we can look to physician extenders who will be able to do tasks for doctors under their direction. Their role would not subsume doctors but complement them and [they would] be under the doctor's direction."

While many of the respondents engaged with the issues around role substitution and believed that this was one of the most prominent issues affecting the future of the health workforce most of them did not demonstrate a complex understanding of these issues. This misunderstanding of the issues is a significant barrier to any future progress toward a clear understanding of how role substitution may (or may not) occur in an Australian context.

Teamwork

> "The issue of teamwork is not addressed enough. Currently training is more and more specialised and the team is not working together enough from a patient's point of view when a patient has diverse needs. There needs to be joint training across faculties in order to make this happen."

Six of the respondents raised a lack of teamwork amongst health workers as a problem. This problem was thought to be tied to the way that health workers are largely educated within professional silos and that they therefore have difficulty dealing with others outside these silos. This is of particular concern when patients have a complex condition which does not fit easily within a specialization.
The following solutions to this problem were put forward by interviewees:

- Teamwork needs to be consciously built into the education of the health workforce at all levels;
- Education for teamwork can be delivered through effective mentoring of young doctors; and
- A common multidisciplinary undergraduate education of all health workers would engender inter-professional communication and understanding and therefore lead to better teamwork (see discussion below).

Common multidisciplinary education

The idea of a common multidisciplinary education at an undergraduate level for all university trained members of the health workforce has recently been put forward as a solution to some of the problems faced by the health workforce. Amongst those interviewed in our study strong and widely divergent views were held about the merits of this idea.

"…these silos develop at an undergraduate level…and there needs to be more of a multidisciplinary undergraduate focus so that some of these barriers are broken down."

Such an education would:

- Counter problems connected to a lack of interdisciplinary understanding amongst health care workers; and
- Breed a cohort of health practitioners who are more able to work and problem-solve together as a cooperative team across professional boundaries.

The problems associated with such an approach were seen to be:

- The pushing of any training for practice into the later stages of education;
- A 'dumbing down' of medical education to the lowest common denominator; and
- The potential for this approach to be capitalised upon by those wishing to cut funding.

"A common undergraduate course will not guarantee a multidisciplinary approach and it is up to the settings where health care takes place to institute these multidisciplinary practices."

Rural needs

"Major workforce shortages are the significant issue, across every discipline. Rural and remote will be affected worse of all."

Nine of those interviewed drew attention to the specific problems associated with the operation of the health system in rural, regional and remote areas. These areas were seen to be at a significant disadvantage in the provision of appropriate standards of health care in relation to that offered in metropolitan areas. The following specific points were raised:

- There are significant shortages in all areas of the rural health workforce;
- Only very limited bulk billing services are available in regional and rural areas;
- Two respondents noted that rural practitioners felt burdened by offering placements for medical students who had no intention of going on to work in rural practice;
- Rural communities are not happy with doctors who only work in their community for a short time and then go back to the city;
- Doctors are poorly treated in rural and regional hospitals and medical centers by administrators whose main focus is on budgetary concerns and not on staff and

patient care. This causes doctors to leave these settings and they are replaced by overseas trained doctors who are often exploited by their managers; and
- Rural and regional patients are seen by less qualified practitioners (for example psychologists instead of psychiatrists, or nurses instead of doctors) and this leads to the development of a two tiered system where there is a higher set of standards for the cities compared to the bush.

> "You need to attract staff to the bush through paying them more. Nurse practitioners are not the answer to the bush problems and neither is workforce conscription where you will have a less than enthusiastic person in the role. You need to think in terms of carrots and not sticks."

Solutions to concerns regarding rural health services were seen to be:
- More funding for rural training facilities so that they can train health workers to go back and work in rural areas. (One respondent said that 70% of rurally trained students go back and work in rural areas);
- Three respondents stated that stronger incentives for people to work in rural areas and better pay would be simple solutions;
- The need to further trial nurse practitioners and generic health workers in the place of doctors in order to carry out routine medical procedures (this was only supported by half of the respondents and the other half were against this as it made rural practice sub-standard in comparison to that offered in metropolitan areas);
- Telemedicine and remote supervision by doctors of nurse practitioners in doctor-type roles would be appropriate for rural and remote areas where there are significant shortages; and
- An end to compulsory rural practice education as part of medical degrees in order to lessen the burden on rural doctors. Rural practice education should only be for those who have a genuine interest in rural practice.

> "Every GP registrar has to do a year in the rural areas before they are allowed to get the specialist qualification in general practice. This places a tremendous strain on rural practitioners who are lumped with an unwilling conscript."

Ageing population

Ten of those interviewed believed that the ageing of the population would significantly impact on the future operation of the health workforce. The ageing of the population is viewed as having multiple impacts on the health workforce, these being:
- An ageing of the health workforce itself which means that there will be gaps in workforces which currently have a large proportion of older workers (such as nursing);
- A growth in the need for particular specialisations who will increasingly be called on to treat age-related medical conditions. This is a problem for gerontology

which is already an area of workforce shortage due to its lower remuneration in comparison to other specializations;

> “In terms of geriatrics the only thing that will work will be to pay them more.”

- Generational change within the health workforce which would mean changes to the way individual health workers related to the demands of the system (this will be discussed further below under the section ‘workforce change’);
- The growth in aged care facilities and a lack of appropriate or qualified staff to staff them;
- A greater degree of age-related palliative care being conducted in the community which will impact on community health services;
- Greater strain on dementia care facilities; and
- Greater strain on dentists as more people move into old age retaining their original teeth.

> “Over the coming years…there will be a big retirement of the baby boomer generation and there are not enough new dentists to cover this. This means there will also be a drop in the total number of dentists. There is an increasing ageing population and because of advances in dentistry it will be an ageing population who are keeping their own teeth [leading to] a greater need for dentists amongst the elderly population.”

Litigation

> “Litigation is going to continue to have an impact more and more in Australia. For example there will be less and less natural births and more caesareans. Doctors will make decisions not to treat patients because they are obese, or drinking or smoking.”

The heightened trend within society for litigation for medical malpractice was viewed by five of the respondents as having a significant impact on the choices made by health workers as to which areas they wanted to work and which patients they wanted to treat. Specifically it was noted that the potential for litigation meant that:

- Doctors were less willing to work in areas such as neurosurgery, obstetrics and all areas of pediatric medicine (parents are able to sue for malpractice on behalf of their children until the child turns 21 whereas for adults there is generally only a ten year period in which a doctor may be sued for malpractice);
- Doctors retire earlier because they do not want to carry the risk of a litigation into their old age;
- More caesarean procedures and inductions for childbirth are undertaken because doctors are unwilling to risk natural labour and birth; and
- There is an unwillingness to treat patients who are at higher risk of complication as a result of a procedure (such as those with particular habits or conditions such as obesity or smoking).

Workforce change

> "There is going to be more job change in the workforce and moving around and people are more flexible and mobile and the workforce needs to accept that, embrace it and deal with it. Leaders need to work out how to deal with this changing nature of the workforce."

The workforce itself was deemed to be undergoing both demographic and attitudinal shifts which were viewed as impacting on the way the health system operates. The main shifts were seen to be:

- A "feminisation" of the workforce which means that many workers will take time out for childrearing activities and be less willing to undertake shift work;
- An ageing of the workforce which will result in greater job losses in areas such as nursing;
- A more changeable and flexible workforce with less institutional loyalty;
- Less willingness of doctors to work excessively long hours; and
- Less willingness of doctors to go out of their way and offer placement opportunities for students without any benefit for themselves.

New technologies

> "Technology in areas like medicine is moving so fast and it does not take long for people to get out of touch and we need strong professional development frameworks in order to drive [continuing education] and they do not exist at the moment in many of the professional colleges."

Nine respondents discussed the impact of technological change on the workforce. The impact of technological change was seen to lead to:

- The development of new specialisations which crossed professional boundaries;
- The rise in new forms of patient consultation – such as via the web;
- A rise in consumer's health knowledge brought about by easily accessible health information via the internet;
- The need for health professionals to receive ongoing training in IT so that they could fully utilise the technologies on offer. This should happen at an undergraduate, postgraduate and continuing education level;
- Balance in health care funding so that large amounts of money are not spent on technologies that will only serve the need of a few to the detriment of other sections of the health system; and
- Some sectors of the health workforce becoming redundant through technological change and the need for easy mechanisms through which they can be retrained to go into other sectors of the health workforce.

> "Technology is another significant issue and this brings us back to cost effectiveness. Technology provides us with enormous opportunities but also enormous concerns as to

how we pay for it. We need to look at questions of appropriateness, i.e. is this technology genuinely appropriate for this patient?"

Growing health differential

"…the health differential is increasing rapidly….A lot of lip service is given to it in relation to indigenous health but if we are going to go any way into making changes this will take a considerable amount of money. The electorate is going to have to be convinced of this need and practitioners are going to have to turn their mind to innovative service delivery."

Several of those interviewed pointed to a growing differential between particular areas of the health system whereby some sectors are well funded, well staffed and easily accessible and others are difficult to access, and poorly funded and staffed. There was considered to be a growing disparity between metropolitan and rural, remote and regional health care; indigenous and non-indigenous health, and private and public health care. This growing differential was seen to encourage the development of a two-tiered health system in Australia and to advance the gap between rich and poor.

"God forbid we are looking down the barrel of an American model where Medicare is for the significantly underprivileged and rest of us have to get private health cover where we can. This is a sad direction given our long history in Australian of health care as a right."

The differential was seen to be brought about by:

- Gaps in health services delivery in rural, regional and remote areas;
- Under-funding of the public system and Medicare; and
- Shortages in particular specialties within the public system – such as dentistry (which has a one in five vacancy level in NSW) and mental health. Shortages in these areas were said to create a vicious cycle, where current shortages would lead to overwork of existing staff, who would then leave the system because of poor work conditions and create future shortages.

"One of the big issues is the public/private divide. A lot of professionals are making a decision to work in the private system and this needs to be balanced out so the have-nots are able to access professional care. This results in inadequate workforce in the public sector, especially in dental and mental health….The trend will be that the gap between rich and poor will grow."

The solutions offered to these issues were better funding and administration of public and rural services and more appreciation of the workforce by fellow staff and administrators.

Continuing education

> “There has to be adequate and transparent money put aside for continuing education and resources need to be made available so doctors can access this education during their working week. Currently GPs get their education mainly through drug companies and this is a big problem…”

Continuing education was mentioned as an area of health education in need of significant improvement in ten of the interviews. These respondents believed that continuing education was currently:

- Inflexible and only available in metropolitan areas;
- Conducted by drug companies or representatives of particular products or technologies who taught with the aim of promoting their product as their foremost objective;
- Lacking in important areas like the use of new technologies;
- Lacking in a discussion of anti-discrimination legislation and the social construction of disability; and
- Boring and ineffectual and in need of creative approaches to delivery.

> “There will be more expansive continuing education because of an acknowledgement of the changing nature of work within all health disciplines and this continuing education is ripe for exploitation by drug companies.”

Improvement of the continuing education of health care workers was seen as being possible through the following measures:

- Mandatory continuing education for all health care workers;
- Utilisation of flexible delivery such as online learning and web streaming so that those outside major cities could have access;
- Better funding;
- More mentoring and the encouragement of the development of informal networks between practitioners and across professional boundaries;
- Sufficient time deliberately set aside in the working week for continuing education for all health care workers; and
- Continuing education in English language skills and Australian cultural norms for overseas trained doctors.

Consumer involvement in education

> “There needs to be participation from consumers in the education of health care professionals so students have an understanding of the pitfalls they may fall into in their provision of care.”

Several respondents stated that the education system needed to assure that health care workers had a full understanding of the consumer’s perspective in relation to the provision of health care. Health care workers were seen to have a poor understanding of

the needs of consumers and to make assumptions about the care they offered to their patients which was not informed by the consumers themselves.

The solutions to these problems were seen to be:

- The involvement of consumers in all levels of health education. For example; consumers should be invited to address medical students about the traps they may fall into when dealing with their patients; and
- The direct teaching of communication skills for health care workers (see discussion below).

Communication

"Doctors need to be better communicators and communicate options and risks to patients better and work together to deliver … services to the patients."

Seven respondents pointed to a lack of communication skills amongst health workers, especially medical specialists. This was seen to be problematic because it meant that patients are unable to adequately communicate with their doctors about their health situation and health workers are unable to communicate effectively with other workers and administrators.

"Many health care professionals do not like talking to patients and patients are often left out of the decision making process."

Solutions that were offered to improve communication were:

- Ongoing inclusion of the teaching of communication skills at an undergraduate, postgraduate and continuing education level;
- Cultural education which assists health care workers to communicate with patients about sensitive issues such as sexuality; and
- Health care workers who are open to communication with their patients about their use of complementary and alternative medicines and therapies.

"Customer service needs to be improved so that the health system becomes more customer focused, not profession or system focused. Communication is a big part of this."

Business skills

"GP practices and other medical services are run more like small businesses and doctors need to be trained in management and business in order to deal with this."

Four respondents discussed the way that GPs, pharmacists and allied health practitioners often find themselves in management positions within their practice with very little

training for such positions within their university education. Health care workers need to receive a basic education in management, industrial relations, business skills and administration in order to meet this need.

> "What is missing in the education of pharmacists is an understanding of the retail industry. In a pharmacy 70% of their shop is retail and they have little understanding of retail. Their management of people, finance, industrial relations, awards etc. is very important for the running of the pharmacy but is not taught enough in their education."

Systemic change

> "How do you react to this? You may end up with a US scenario where you have poor life expectancy and below standard health care, or on the other hand you could get a better health system through some strong political leadership. For example in the UK [Prime Minister Tony] Blair put up the health taxes and found wide community support. In Australia there needs to be good quality political leadership…"

Several respondents noted that the health system was so inflexible and politicians so unresponsive that the only avenue for change within the operation of the health system was crisis driven change. This was problematic not only because it meant that the system was only dealt with once there had been a terrible crisis in its operation, but also because immediate fixes initiated at times of crisis did not provide the best outcome for the system as a whole.

Effective change was seen as dependent on:

- Strong political leadership;
- A breaking down of the domination of professional bodies which refuse to negotiate the boundaries of their jurisdiction and an opening up of these bodies to possible change;
- A process which includes all actors within the health system – government (both state and federal), consumers, health care workers, professional bodies and universities. Three respondents expressed a belief that those policy officers charged with implementing change in the health system do not effectively gauge the opinion of consumers, the university sector or professional bodies before making decisions;
- The timely support of research which will effectively map the future needs of the health care system, and a system in which this information can be incorporated into health and education planning; and
- Change that can take place gradually and is based on strongly considered trialing of contentious moves through pilot programmes.

> "Band-aid solutions do not help the system."