HEALTH WORKFORCE REFORM

John Menadue

Recently at the Council of Australian Governments meeting, the Prime Minister, Premiers and Chief Ministers acknowledged the need for health workforce reform. To date, the discussion has been about more of the same, more training the same way, and more employment the same way, when we really need root and branch change. We need to train and employ in quite new ways.

The media today is full of workforce reform, particularly in the blue-collar area where there has already been very substantial reform and improvement. Changes in the Australian workforce have helped transform the Australian economy in the last 20 years. It was begun under the Hawke/Keating governments and continued under the Howard governments.

But the health sector has not been touched. I 'guesstimate' that there is a potential productivity dividend of at least 40% in health workforce reform over the next decade. That 40% may be on the low side.

Reform of the health workforce structure, work practices, multi skilling, teamwork, and flexible training, are the key micro-reform issues that we face. The most obvious example of restrictive practices in health is in obstetrics and midwifery. In Australia, less than 10% of normal births are managed by midwives. In the Netherlands it is over 70% and in the UK over 50%. The reason why Australia is so far behind the field is obstruction by obstetricians who want to protect their market share and are highly favoured through the medical benefits scheme.

Health is Australia's largest industry, $80 b per annum or 9% of GDP. About 70% of every health dollar of expenditure is in labour costs. Such a large area of expenditure cannot be excluded from workforce reform. It is more important than any other workforce issue. Health workforce reform will not be easy but it is essential.

Four years ago I surveyed the inefficiencies and inequity of the health workforce in NSW. It is the same in other states and the same today as it was four years ago.

I was told by senior clinicians, academics and executives that 'NSW health has an archaic work structure'. …'It is quite incoherent' … 'we have boxes everywhere, junior doctors, specialists, clinicians, nurses, allieds, managers, colleges, universities, but there is not a thesis or plan that draws it all together.'

I was told consistently that no one owns workforce issues – 'workforce planning is reactive'. .. 'Improvements in people management occur in spite of the system' … 'the workforce is structured on a medical model, not a health model' … 'there is extremely poor human resources and people management skills across the workforce'.

I was told about the lack of coordination between workforce issues, service delivery, finance and infrastructure. The example often given was opening more hospital beds without the nursing staff to service them. As one clinician put it to me 'there is a hit and miss linkage between the workforce, budget and service delivery.'

I was told that there was not enough understanding and research about the extent of the workforce problems. 'Many tasks should be thoroughly re-engineered' … 'work practices are a major problem, they are quite ad hoc' … 'the medical boundaries must be invaded' … 'there is not a workforce shortage. The issue is how we use the workforce.'

I was told that education and training is supply driven and not really linked to the demands of a rapidly changing health system. I was told that education and training entrenches the boundaries within the system. 'There is no genuine health training. Almost all the training is in separate streams. Core training is incidental.'

I was told that the health workforce is inward looking with many people working their whole professional lives within the same system. 'Health is introspective, new people and new ideas are essential.'

In the last issue of New Matilda, an emeritus professor at University of Sydney, Professor Kerry Goulston said

> Our medical workforce management in hospitals is rigid and antiquated. Job sharing is rare. … Most hospitals are staffed on the front line at nights and weekends by junior medical staff, often without onsite supervision…. The traditional roles of doctor, nurse and allied health personnel have to be redesigned around the patients' needs. Many procedures carried out by doctors could be done by non-doctors. Many medical duties could be done by other health professionals. In places where it has proven impossible to recruit doctors, nursing staff have been upskilled to provide a higher level of clinical care. It is clearly possible to extend this model for use in public hospitals where better supervision is available, but would require a reduction in the strict demarcation of clinical roles. … The morale of our hospital workforce is low. Disengagement and loss of commitment is a real issue.

We clearly need to dramatically reshape our health workforce.

The UK NHS is piloting a new generic 'health care practitioner' as a broadly banded job description. The role of a health care practitioner in an acute hospital would include roles presently performed by junior doctors, senior nurses, professions allied to medicine and speech and language therapy. Such a health care practitioner in an acute hospital would assess a patient's condition, make a physical examination and arrange diagnostic tests, establish a treatment plan, implement the plan, ensure ongoing assessment and management and be responsible for admission and discharge. What a reformation that would be.

In primary care, the health care practitioner role would take up to 40% of the GP workload, with significant overlaps between the roles of nurse practitioners, general practitioners and practice nurses. Such a health care practitioner would be charged to manage a case load in a wide range of conditions – patient assessment, patient history, physical examination, diagnosis and development and implementation of treatment plans. In primary care, the health care practitioner would treat the following conditions – asthma, diabetes, hypertension, hormone replacement therapy, minor acute and wound management, self-limiting conditions, paediatric surveillance, immunisation and vaccination.

In the NHS, they are also looking at widely banded roles for health care assistants as well as health care practitioners.

These proposals are really a breaking down of the old historic workforce boundaries to establish new ways of working – team working across professional and organisational boundaries; flexible working to make the best use of the range of skills and knowledge of staff; streamlined workforce planning and development which stems from the needs of patients not of professionals; maximising the contribution of all staff to patient care, doing away with barriers which say only doctors or nurses can provide particular types of care; modernising education and training to ensure that staff are equipped with the skills they need to work in a complex, changing health system; developing new, more flexible careers for staff in all professions; expanding the workforce to meet future demands and more flexible deployment of staff to maximise the use of their skills and abilities. We highlighted these new ways of working in the Generational Health Review in SA 2003 (p126).

Professor Stephen Duckett has suggested some more limited health workforce reforms in Australia. They include nurses undertaking greater responsibility for prescribing, diagnosis and triage in hospitals; nurse anaesthetists complementing and substituting for medically qualified anaesthetists; enrolled nurses taking on some of the tasks currently done by registered nurses; midwives substituting for obstetricians; new allied health assistants supporting allied health workers to increase their capacity to treat more patients; practice nurses undertaking some of the work currently performed by GPs, including some prescribing, screening and triage.

Clearly nurses, allied health and community health workers could undertake more skilled work except for the barriers erected by other professionals.

An example of the barriers are the restrictions on nurse practitioners. Despite all the rhetoric, very little progress has been made in building the professionalism and career opportunities of senior nurses. I believed that a lot of the opposition came from doctors who didn't want their territory invaded, often in the name of quality and safety, but invariably to the detriment of people in need of care, particularly in country areas. But I think there is more to it than that. My clear impression after chairing two health enquiries is that the nurses' federations have not been doing much heavy lifting on this issue. If they have, there is not much evidence of it. They are clearly wary of 'elite' nurses. It is a pity that senior nurses are not better supported because they really hold the Australian health system together, but are denied real advancement. Large numbers leave nursing for other industries, particularly hospitality. The best that stay in the industry go into academia or health administration.

The great problem is that our health and community services workforce is trained and works in boxes – 'there are boxes everywhere'. We need dramatic change, up-skilling, multi-skilling, broad banding and teamwork.

No one is really tackling this major workforce problem despite the clear loss of morale and high staff turnover across the health and community sector. We see the problems like the tip of the iceberg, only when they are revealed before a court or medical board. The powerful sectional interests still call the shots and resist change. If they had blue collars, rather than white coats, the story would be different.

What is lacking is courage and determination to address the problem. In the late 1980s, I attended a round table discussion with UK Prime Minister, Maggie Thatcher in Sydney. She was asked 'now that you have reformed the work practices of the printers and coal miners in the UK, what do you propose to do about the restrictive practices of doctors and lawyers?' She replied, 'It is a very serious problem, but if you don't mind I will leave it until my last term'. The coal miners and printers were fair game, but not the doctors and lawyers who were put in the 'too hard' basket.

The health workforce structure is clearly at the end of its design life. The whole health system is built around provider demarcations. It is certainly not built around patients' needs. What will cause a breakthrough – a staff crisis, sinking morale, unbearable workloads or escalating costs? It takes courage to take on the powerful interests involved in health. It hasn't happened yet. The soft option is invariably more money to get the issue off the front page of the Daily Telegraph or its interstate equivalent.

I am sure that workforce reform requires, most of all, courage by health ministers, governments and senior officials to face down the powerful vested interests that oppose reform of the workforce and want to protect their privileged positions. Ministers, governments and officials must win the case for change and drive the process. Waterfront reform was a minor issue compared with this one. Health workforce reform doesn't require dogs and security guards with balaclavas, but it does require determination.

There are specific skill shortages, but I am not persuaded that we have an overall shortage of health and community service workers. I am however persuaded that we are not using our existing workforce at all well. The losers are taxpayers, the community and particularly, the outstanding professional people who perform so admirably in very difficult circumstances.

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