ACT Government

Submission

Health Workforce Research Study

conducted by

The Australian Government Productivity Commission

August 2005

Recommendations

Education and Training

Jurisdictions must be involved with the education and training planning process. This is fundamental to alleviating current and anticipated workforce shortages in the public sector and building a 'self-adjusting' workforce for the future.

1. **More Appropriate Allocation & Distribution of Courses and Places.**

- *The development of a national decision making structure with joint education, health and consumer membership that allocates courses, course type and student numbers to specific areas according to overall need of all jurisdictions.*

2. **Collaborative Development and Adjustment of Curricula**

- *The development of a joint health, education and consumer based decision making structure that ensures nationally agreed and accredited courses, that monitors course content in terms of competencies and compares it to current and future service need, job roles, evolving needs and roles, and development of new needs and* roles.

3. **Provision of Certainty Over Appropriate Funding**

- *The development of a decision making structure that enables visibility of total course costs and the appropriate allocation of funding especially in areas of need.*

4. **Development and Evaluation of Other Options for Post Graduate Medical Training.**

- *The consideration of new ways of delivering post graduate medical training.*

5. **Influence Over Other Aspects of Courses.**

- *The joint health, education and consumer based decision making structure (referred to above) ensures nationally agreed lengths of courses, levels of courses i.e. masters or undergraduate level, and entry criteria.*

What are the priority coordination issues that must be addressed?

The national decision making structure (referred to above) recognises the special needs of health, particularly in small jurisdictions.

Views on where the need for improvement in regulatory areas is most pressing and what might be done to encourage better regulatory practice

The development of a nationally consistent approach to accreditation by standardising criteria, methods and other enablers for quality health professional education will ensure that the right health workers are educated and trained at the right place at the right time; and that they are able and willing to work to their full potential. It will also increase efficiency.

Exploring how specific workforce reform might best proceed in the interim?

A national focus on workforce and workplace redesign with the goal of realigning competencies with improved job roles. A focused, targeted examination of health professional workers, such as allied health professionals, might provide the initial evidence for piloting expanded scopes of practice that includes more complex clinical skills.

Recommendations cont.

Workforce Utilisation

The traditionally defined roles and responsibilities of health workers be reviewed to meet the needs of clients of today and the future, and emerging service models rather than trying to increase the attractiveness of work for existing occupations, operating within traditional professional roles.

1. **Productivity**

- *Support role review and redesign initiatives and facilitate the development of tailored, competency based training for new roles. Ensure there are also changes to educative frameworks and curricula, enabled by supporting regulatory change.*

2. **Flexibility**

- *The serious consideration of the development of the role of a generic health worker. The broad base of their job design would allow them to undertake multiple types of work and cross over a number of existing professional demarcation lines. This would provide considerable flexibility in a small jurisdiction.*
- *The Commonwealth Government, in the light of addressing key workforce shortages, review its retirement income policies to allow some flexibility and give motivation to encourage those, who may be considering staying in the workforce, to stay.*

What are the priority coordination issues that must be addressed?

In the short-term, development of new job roles should be coordinated and regulated nationally to avoid embedding them in traditional state-based regulatory frameworks.

Views on where the need for improvement in regulatory areas is most pressing and what might be done to encourage better regulatory practice

In the longer term a national regulatory body which undertakes the process of registering health professionals and licensing workers should be considered. This would reduce the boundaries between jurisdictions and establish one national registration system which would determine common categories, qualifications and training requirements as well as ongoing competence. Membership would comprise a mix of professional, legal, government and consumer representation to ensure the public interest remains paramount.

Exploring how specific workforce reform might best proceed in the interim?

There must be major reform of the education and regulatory systems so that traditional roles are refocused, expanded or enhanced in order to:

- *Expand scopes of practice underpinned by changes to education; and*
- *Introduce appropriate skilling supported by the new and improved job role demarcation.*

The use of education and training to acquire additional or changed competencies approach builds on the current DEST model and could be an interim step to the competency cluster method.

Role change should only occur on a nationally consistent basis to avoid repeating the regulatory mistakes made to date.

1. Introduction

1.1 Overview

The purpose of this submission is to expand on previously highlighted health workforce areas of concern and specific issues for a small jurisdiction such as the Australian Capital Territory (ACT). By virtue of its population size, geographical location and limited infrastructure with education, training and service delivery capacity the ACT has specific areas of concern. The ability of the ACT to maintain critical mass, in terms of health workforce capacity and capability, is crucial to achieving social potential for health consumers.

In this regard, smaller jurisdictions may require more than the 'traditional quanta' of support and resources to achieve beneficial outcomes. For example, in smaller jurisdictions, with very limited tertiary facilities, there is a narrow range of courses on offer in the health disciplines. As a consequence, these jurisdictions must try to attract a wide range of trained health professionals to relocate to their area. Any reform agenda should empower small jurisdictions by:

- providing a level playing field to attract and retain a qualified workforce;
- ensuring that employees are able and willing to work to their full potential by aligning regulatory arrangements and requirements -such as accreditation, registration and credentialing -in a nationally consistent manner; and
- addressing underlying tensions, such as fragmented roles and responsibilities that impact performance at the workforce and enterprise level.

In its recent Issues Paper, *The Health Workforce Productivity Commission Issues Paper May 2005*, the Commission noted that it was particularly interested in several areas:

1. What are the priority coordination issues that must be addressed?
2. Views on where the need for improvement in regulatory areas is most pressing and what might be done to encourage better regulatory practice.
3. Exploring how specific workforce reform might best proceed in the interim.

This submission addresses those three questions. It focuses on the key health workforce issues for ACT Health of “education and training” and “workforce utilisation”. It also provides some views on where regulatory reform may be improved and identifies how workforce reform might proceed from the context of a small jurisdiction. The ACT Health submission is not inconsistent with the Australian Health Ministers' Advisory Council submission.

1.2 The ACT

In 2002, the estimated ACT resident population was 321,800, and if the surrounding southern area of NSW is also included in the population that ACT Health provides services to, the potential client population is closer to

500,000. For these non ACT residents the ACT is acting as the "local" provider for specialist (often high cost) services, but to maintain the clinical viability of specialist services and the teaching and research component of the ACT public hospitals, the high volume is needed and is one of the main benefits of providing cross border services

ACT Health has four key health service delivery agencies:

- The Canberra Hospital, major trauma centre and tertiary hospital for the ACT and south eastern NSW, provides a range of general and complex services;
- Calvary Public Hospital (run by the Calvary Health Care Limited for the Little Company of Mary Health Care), mainly elective surgery and oversights the ACT Health hospice;
- Community Health; and
- Mental Health ACT, provides both inpatient and community based services.

Both hospitals are affiliated teaching hospitals with the University of Canberra (UC) for nursing and some allied health professional courses, and the University of Sydney (closing its medicine course by 2007) and Australian National University (ANU) for medicine (in its second year).

ACT Health employs approximately 4,500 persons, the majority of whom is female and a significant proportion is employed part time and this is increasing. Also, a quarter of the workforce is entitled to retire within the next five years. This all puts pressure on workforce supply. ACT Health continues to face challenges to lift the recruitment rate above the separation rate as well as to retain more experienced staff.

Health workforce vacancy in the ACT is significant (Appendix 1, Table 1). Some examples and indications of the significance of medical workforce vacancy rate in 2004 include: endocrinology 66% (2 of 3 positions), neonatology 25% (1 of 4 positions), radiation oncology 20% (1of 5 positions), plastic surgery 33% (1 of 3 positions). Flow on effects also occurs, for example, the loss of the plastic surgery training position. In nursing and allied health the picture is very similar. As we are a small jurisdiction the numbers of persons in each specialty are small, so even slight changes in the numbers have a significant impact eg on call every second day instead of every third.

It is not only ACT Health which is affected by these issues, the Department of Disability, Housing and Community Services which is a large employer of Allied Health Professionals, has found that with the majority of these workers being female there are high rates of maternity leave and over 50% of its staff are working part-time. Career opportunities are limited by the small numbers in each profession and with the move of trained staff into administrative positions as a means of career advancement there are further reductions in professional staff in clinical roles.

In response to these shortages significant changes in structures and systems have taken place to reduce impact on the quality and safety of the delivery of health services for example some mental health clients receive therapy using groups rather than one on one therapy. The ability to be flexible and to respond to such shortages by ACT Health is limited though due to the small numbers of health professionals in each group, the limited number of services that can respond, for example only 2 emergency departments, and the limited ability to influence supply.

There is a flow on effect to the number of services which are able to be provided to the community. At times an ACT Health program or contracted community service cannot meet the target number of client services they are funded to provide, due to recruitment difficulties. Examples include Mental Health inpatients services, community breast screening and dental services and contracted family planning services. Family planning has found a flow on effect for their clinical training program.

This puts pressure on other areas of the health service. In response there has been some transfer of some tasks to other health service providers, for example immunisation services undertaken by GPs instead of by community care.

Attraction and retention are major issues for smaller jurisdictions which cannot offer the full range of courses for health professionals. The private sector and non-government sectors have a greater capacity to provide incentives and higher remuneration in a highly competitive market place. This will continue to be an issue if the number of full fee paying health course places increases.

The ACT Government has made a commitment to provide a comprehensive health service for the ACT community. This commitment creates diseconomies of scale and places increased pressure on the public sector which is required to provide a broad range of services to a small population which has a high level of expectation of its' public health services. ACT public hospitals meet approximately 95% of resident demand with total public hospital separations in the ACT rising by 11% over the past three years (2001-02 to 2003-04). Services with less than 50 separations per annum account for two-thirds of all hospital activity. However, a full operational service is required to provide the (almost) full range of hospital services for ACT residents.

The ACT population has the highest level of private health insurance (52% in 2004) compared to the national average (43%). It is notable though that only 30% of total ACT residents' hospital separations in 2003-04 are comprised of people using their private health insurance. The small ACT population base affects the capacity of private hospital providers to provide a comprehensive range of services. ACT private hospitals offer about 20% less admitted patient services than their counterparts interstate, principally due to the size of the ACT population putting further pressure on the public system to provide a broad range of services.

By 2014, the ACT population is expected to grow by a total of 7.08%. However, the number of hospital separations is expected to increase by around 31% over that timeframe. By 2014, the hospital separation rate for the aged 65 years and over is expected to increase by almost 75%.

2. Areas Of Concern

2. 1. Education And Training

ACT Health asserts that as the major provider of health care services across the ACT region (ACT and southern NSW) and the major employer of health workers in the ACT, it has a responsibility to directly influence the local supply of health professionals. Without this influence, impediments to effective workforce planning and service growth remain.

A major impediment to demand-side planning is the shortage of any number of related health workforces, particularly those that are not educated in the ACT. Planned growth in one part of a small health workforce must take into particular consideration the availability of related health workforces; for example the therapist workforces such as physiotherapy or occupational therapy, required to support growth in rehabilitation and geriatrics services.

Recommendation

Jurisdictions must be involved with the education and training planning process. This is fundamental to alleviating current and anticipated workforce shortages in the public sector and building a 'self-adjusting' workforce for the future.

Although ACT Health has successfully lobbied for new courses, there remain a number of disconnections between the health and the higher education interfaces, such as priorities for funding around other competencies and skills in short supply, where those courses should be conducted and meeting the needs of increasing numbers of types of health care consumers eg aged. Currently, there are no influential mechanisms for ACT Health to collaboratively establish capacity-building outcomes such as:

- appropriate course location and distribution; .
- appropriate course type, content and duration;
- the appropriate numbers of students undertaking these courses; and
- appropriate funding for clinical placements.

To overcome this, the ACT is seeking a level playing field by empowering small jurisdictions and particularly acknowledging the ACT position as a major provider of regional and rural health services for southern NSW. ACT is in a position to influence local supply by participating in collaborative decision making in education and training around:

1. more appropriate allocation and distribution of health professional courses and course places;
2. development and adjustment of curricula which is appropriate to health worker competencies and job roles;
3. provision of certainty over appropriate funding;
4. development and evaluation of other options for post graduate medical training; and
5. influence over other aspects of health professional courses.

2.1.1 More Appropriate Allocation & Distribution of Courses and Places.

There is a greater number of health disciplines than other mainstream branches of learning and currently, due to our relatively small jurisdiction, there is a narrow range of health discipline courses on offer and an inadequate number of places to meet the population needs of the ACT region compared with other jurisdictions that have numerous cities and universities. It is unrealistic to assume that the ACT could ever provide the type and number of higher education courses to meet its needs.

Many courses do not have specialised mandatory study units such as paediatrics or disability so this takes up valuable clinical time from other professionals while new graduates are orientated.

The current profiling system between the Department of Education, Science and Technology (DEST) and the universities does not specify the disciplines in which courses are to be offered, apart from medicine, thus leaving this to be determined by universities. Where universities work with government it is usually their own state government to meet local needs. Most of these courses are in large urban centres where the management of clinical placements is increasingly burdensome and complex for health service providers given the number of students concentrated in specific areas.

There are few significant mechanisms to correct maldistribution other than to participate in a national consultative process to facilitate rebalances. While the ACT can pursue initiatives within its very limited control there is a need to influence the numbers of health workforce occupations that emerge with professional education qualifications from higher education institutions in other jurisdictions. Although the ACT has done some good work to date through informal networks there is a gap in its ability to drive change. It must have some ability to influence other jurisdiction's decisions in relation to education and training positions and clinical placements.

Recommendation

The development of a national decision making structure with joint education, health and consumer membership that allocates courses, course type and student numbers to specific areas according to overall need of all jurisdictions.

2.1.2 Collaborative Development and Adjustment of Curricula

There is a need to develop cohesive and common goals between the education sector and organisations involved in the health workforce.

ACT Health is increasingly recruiting health workers who require further education, upskilling and training to reach the skill level required to meet the job requirements and the growing needs of certain population groups, for example the aged. This is most evident in nursing and medicine where

strategies such as Dedicated Education Units have been designed to assist workers to 'hit the ground running'. This reflects a lack of alignment between course content and current job roles; it also hints at a gradual but subtle transfer of responsibility from the education sector to the employer to complete the vocational elements of higher education.

At this stage there is no national attempt to rationalise course content by the development of a set of core competencies that all health professionals must undertake as well as their professional area specific learning requirements, nor a nationally agreed curriculum within the disciplines. Each discipline and university undertakes the development of their own course content, which is individually accredited by their respective professional colleges, rather than one that is done according to nationally agreed outcome criteria or workforce needs.

Recommendation

***The development of a joint health, education and consumer based decision making structure that ensures nationally agreed and accredited courses, that monitors course content in terms of competencies and compares it to current and future service need, job roles, evolving needs and roles, and development of new needs and* roles.**

2.1.3 Provision of Certainty Over Appropriate Funding

Currently it seems that there may be disincentives for universities to offer courses in health disciplines as these are generally more expensive to provide and, by necessity, involve clinical placements. Additionally, the DEST methodology for determining the costs of clinical placements, and thus funding, does not appear to be even-handed. This has significant impact if a jurisdiction only has a single university, which is expected to provide nursing and allied health professional education and oversight clinical placement. As a result there is significant flow on to the health sector of the unfunded cost of allied health professionals and the under funding of nurse's clinical placement.

By default ACT Health has had to carry a heavier burden of these costs, especially allied health professionals, as there is no other major health workforce employer in the ACT, who also undertakes this role, as would occur in larger jurisdictions.

This suggests the funding for the tertiary training of health professionals should be reviewed.

In order to maintain recruitment and retention rates, strategies such as easy access to professional development, research and career opportunities need to be supported and factored into costs.

Recommendation

The development of a decision making structure that enables visibility of total course costs and the appropriate allocation of funding especially in areas of need.

2.1.4 Development and Evaluation of Other Options for Post Graduate Medical Training.

Small jurisdictions are also often unable to provide the full range of training opportunities offered by the Australian and Australasian specialist medical colleges due in part to case mix and population characteristics such as size and age/sex groups, but also to geographic location. In some specialties the training cannot be completed in situ for many reasons, and is a major disincentive for undergoing specialist training in the ACT.

A new way of delivering postgraduate medical training is essential so that small jurisdictions are able to more easily attract medical specialists in order to maintain and build essential services.

Recommendation
The consideration of new ways of delivering post graduate medical training needs.

2.1.5 Influence Over Other Aspects of Courses.

ACT Health is unable to influence the length or types of courses. For example, extending the length of a course or changing courses from an undergraduate to postgraduate qualification has an adverse impact on supply influencing measures. Although entry to the ANU Medical School is only available to graduates, school leavers may apply for provisional admission. Those offered provisional admission to the Medical School must enroll in one of the single or combined Bachelor degree programs at the ANU. This will usually be three years for a Bachelors degree, four years for an Honours degree and four or five years for combined Bachelors degrees, depending on the degree combination. Unfortunately, this pathway will take between 16 and 18 years before completion of vocational training. This is a similar situation to a number of allied health professional courses where there are postgraduate requirements.

Entry criteria for health professional courses have traditionally been based on exam marks achieved in either secondary or another tertiary based course. Some universities are using other entry criteria e.g. communication skills and empathy as key requirements. A review of current entry requirements for courses may assist in the right person being trained for the right job.

Recommendation
The joint health, education and consumer based decision making structure (referred to above) that ensures nationally agreed lengths of courses, levels of courses i.e. master or undergraduate level, and entry requirements.

2.2 What are the priority coordination issues that must be addressed ?

The ACT recommends that a national decision making structure be developed that recognises the special needs of health, particularly in small jurisdictions. This structure could facilitate initiatives such as:

- System controls for health workforce demand such as an appropriate mix and distribution of health professional courses across Australia with a focus on small jurisdictions to address maldistribution and enhance potential supply opportunities; and
- Ensure that health workers are able and willing to work to their full potential by overseeing new educative frameworks for new competencies and expanded job roles.

Recommendation
The national decision making structure (referred to above) recognises the special needs of health, particularly in small jurisdictions.

2.3 Views on where the need for improvement in regulatory areas is most pressing and what might be done to encourage better regulatory practice

Currently, a range of professional self-interest groups is responsible for course accreditation. The process is cumbersome, long - up to two years - and is relatively costly. Accreditation standards and the methods of inspection also vary significantly between professions and can be applied inconsistently across jurisdictions. The ACT requires a greater range of health courses but current accreditation processes appear to be an insurmountable obstacle to course growth.

Recommendation

The development of a nationally consistent approach to accreditation by standardising criteria, methods and other enablers for quality health professional education will ensure that the right health workers are educated and trained at the right place at the right time; and that they are able and willing to work to their full potential. It will also increase efficiency.

2.4 Exploring how specific workforce reform might best proceed in the interim

Achieving the sustainable ACT Health workforce of the future will require nationally agreed workforce and workplace redesign. The purpose of this is to realign competencies with improved (more responsive, flexible and more effective and efficient) job roles. Broadly, this means the assignment of job roles at the appropriate education level required and allocation of an appropriate skill-mix and skill level capacity to current and evolving models of care.

The process of introducing new job roles in the ACT (nurse practitioners and allied health assistants) has highlighted a number of potential barriers to workforce and workplace redesign; but new and expanded roles, supported by a responsive higher education sector, remain essential for improved workforce utilisation.

Any initiatives which will change the scope of a profession, such as the Certificate IV Course for Allied Health Professionals at the Canberra Institute of Technology, require resources to train both professional and assistants as to the scope of their respective roles.

Recommendation

A national focus on workforce and workplace redesign with the goal of realigning competencies with improved job roles. A focused, targeted examination of health professional workers, such as physiotherapists, might provide the initial evidence for piloting expanded scopes of practice that includes more complex clinical skills.

Area of Concern

3. 1 Workforce Utilisation

In certain professions, increasing workforce supply is necessary and achievable to prevent escalating shortages and reduce choke points in service delivery. However, the ACT agrees that increasing workforce supply alone will not be sufficient to manage workforce demand, nor ensure longer term financial and service sustainability especially in a small jurisdiction. It is acknowledged that increased numbers of tertiary courses and places is just one strategy required to overcome workforce shortages.

Recommendation
The traditionally defined roles ands responsibilities of health workers be reviewed to meet the needs of clients of today and the future, and emerging service models, rather than trying to increase the attractiveness of work for existing occupations operating within traditional professional roles

Small workforces and workplaces have to be highly efficient and flexible. This affords smaller jurisdictions with the responsiveness they need to adjust to changes in workloads, growing priorities and the need to meet quickly shifting priorities.

A move to re-examine and adjust role differentiation is essential for increased productivity and improved flexibility. Changes to role differentiation can only occur when supported by better regulatory practices and redesigned educative frameworks and improved curricula.

The keys to addressing the numerous workforce and industry trends that are increasing the pressure on health professionals to do more are:

1. Productivity; and
2. Flexibility.

3.1.1 Productivity

Health workforce productivity improves through the review and revision of the mix of staffing and other inputs to achieve the health organisation's outcomes. Many staff within the health system do not realise the full potential of their training and there is opportunity to make better use of their skills.

ACT Health has established a number of initiatives to expand the role of some of the health workforce, for example, nurse practitioners and expanding the scope of enrolled nurses to administer medications.

Increased workforce productivity can result from rethinking the processes of a job role, which includes understanding the level and mix of skills required. It also means determining the most appropriate education qualification required to perform a specific job role, or, altering traditional roles with upskilling.

Productivity is also about ensuring that workers are able and willing to work to their full potential by providing appropriate education, on-going learning and satisfying job roles and the development of healthy, safe, positive workplace environments. However, while jurisdictions can assist workers to develop their skills, the presence of entrenched regulatory barriers means that much of the effort e.g. new job roles and enhanced curricula, could be ineffective.

In a small jurisdiction such as the ACT where minor upward movements in separation rates or increasing numbers of 'difficult to recruit' positions occur, productivity is impacted upon when the mix of staffing is not able to meet the outcomes required, for example not being able to meet patient throughput targets due to lack of skilled mental health nurses, radiologist etc.

Recommendation

Support role review and redesign initiatives and facilitate the development of tailored, competency based training for new roles. Ensure there are changes to educative frameworks and curricula enabled by supporting regulatory change.

3.1.2 Flexibility

In a small jurisdiction flexibility with workforce substitution is a requisite, but if a workforce is based on job design and professional demarcation, workforce substitution is not an option. Where the effects of changes in workforce supply or demand, and service demand are rapidly manifested, and little flexibility is built into the workplace dissatisfaction can quickly arise. The quality and safety of the health care delivered can also be affected as well as the workforce's own health and well being.

Workforce flexibility helps organisations accomplish more with less by having appropriately skilled workers with the necessary skills to handle multiple types of work, for example, in the ACT a number of positions in the community health and the mental health services can be filled by either an allied health professional or a nurse.

Improved flexibility can also reduce the propensity to simply increase supply through more student places and more courses.

Recommendation
The serious consideration of the development of the role of a generic health worker. The broad base of their job design would allow them to undertake multiple types of work and cross over a number of existing professional demarcation lines. This would provide considerable flexibility in a small jurisdiction.

The Commonwealth Government established the Australian superannuation system to provide an adequate income on retirement based on the compulsory provision of retirement savings by the employer as well as voluntary savings by the individual. These savings are protected until the worker reaches their preservation age and has retired. In order to provide incentives to encourage the workforce to remain in the workplace longer and allow further savings the Commonwealth Government could consider its retirement income policies and allow some flexibility especially in sectors where there are workforce shortages.

Recommendation
The Commonwealth Government, in the light of addressing key workforce shortages, review its retirement income policies to allow some flexibility and give motivation to encourage those, who may be considering staying in the workforce, to stay.

3.2 What are the priority coordination issues that must be addressed?

Existing regulatory and educative arrangements impede the realisation of workforce potential and efficiencies, and act as a barrier to better alignment between workforce supply and service demand. Issues around supervision, regulation and credentialing, and indemnity need to be managed in tandem. Health professionals have to register in each state or territory in which they want to work. There is not even a national system of defining health professionals, for example, nurse levels have different names, and the names have different meanings in each state.

New and evolving job roles are already being developed and evaluated across Australia. Given the current 'state-based' regulatory system, a new job role in one jurisdiction may not be readily or easily recognised in another jurisdiction. These circumstances will inhibit movement of qualified workers from one jurisdiction to another, and constrains the ability of these workers to perform to their full potential outside of their recognising jurisdiction.

If a person is deregistered in one state, they would be eligible to apply to obtain registration within the ACT if there is no national registration.

Recommendation

In the short-term, development of new job roles should be coordinated and regulated nationally to avoid embedding them in traditional state-based regulatory frameworks.

Similarly, any proposal to regulate a currently unregulated profession or occupation should consider the potential barriers and benefits, the skills required to do the job, and the potential for a national regulatory body to manage registration, licensing and the 'authority to practice'.

3.3 Views on where the need for improvement in regulatory areas is most pressing and what might be done to encourage better regulatory practice

The major regulatory reform is the removal of regulatory barriers. This means the removal or adjustment of job role demarcations to enable expanded scopes of practice for improved workforce flexibility and increased productivity both within, and across, jurisdictions.

Recommendation
In the longer term a national regulatory body which undertakes the process of registering health professionals and licensing workers should be considered. This would reduce the boundaries between jurisdictions and establish one national registration systems which would determine common categories, qualifications and training requirements as well as ongoing competence. Membership would comprise a mix of professional, legal, government and consumer representation to ensure the public interest remains paramount.

3.4 Exploring how specific workforce reform might best proceed in the interim

In the short term, ACT Health considers that expanded scopes of practice for non-medical workers will improve overall workforce utilisation, satisfaction and productivity. This also includes flexibility enhancements related to career growth opportunities and improvements in workforce participation rates.

Changes to regulatory parameters and course curricula surrounding the question about "who does what?" also has the opportunity to achieve a number of goals:

- Regulatory flexibility means that work within priority service areas can be reorganised to enable parallel treatments/services and thus better utilise the available workforce and optimise the 'patient journey'.
- Changes to course content, existing job roles and scopes of practice to provide greater productivity.
- Regulatory flexibility and changes to course content means new roles can be developed to better meet current and evolving patient needs leading to improved patient outcomes and a more satisfied workforce.

Other options for the ACT include vertical and lateral role differentiation, which would lead to short-term flexibility and productivity gains:

- the vertical boundaries within a traditional professional silo are relocated, with more technical/less skilled tasks allocated to lesser but appropriately qualified staff; and
- highly-skilled professionals are freed to focus on applying their advanced-level skills more frequently in a patient/client centred manner, or to take on more challenging clinical roles that have been traditionally practiced by another profession.

This approach requires the development of competency based training for new support roles, and upskilling for professional workers. Examples are dieticians, radiographers and physiotherapists extending their historical role, with support or assistant staff taking on the more technical aspects of their old roles.

Another approach is where workers identify lateral role differentiation by the analysis of boundaries between health professions and exploration of new roles:

- traditional boundaries between professions and occupations are blurred to develop composite roles tailored to service streams; and
- they combine competencies currently viewed as belonging to different professions.

It is suggested there are two methods to achieve this model:

- the reform of pre-qualification education to deliver different competency clusters. This is a long-term approach requiring major reform of the vocational training and higher education sectors, and human services industries; and
- the use of education and training to acquire additional or evolved competencies, for example up skilling non-medical workers.

Recommendations

There must be major reform of the education and regulatory systems so that traditional roles are refocused, expanded or enhanced in order to:

1. **Expand scopes of practice underpinned by changes to education; and**
2. **Introduce appropriate skilling supported by new and improved job role demarcation.**

The use of education and training to acquire additional or changed competencies approach builds on the current DEST model and could be an interim step to the competency cluster method.

Role change should only occur on a nationally consistent basis to avoid repeating the regulatory mistakes made to date.

4. CONCLUSION

With major reform in education and regulation, healthcare demand might be managed more effectively. For example, with new approaches to job roles, demarcation, team composition and skill-mix:

- an expansion in team-based cancer screening programs with fast-track treatment models for the consumer;
- 'rapid access' chest pain clinics, staffed by upskilled enrolled nurses;
- 'rapid access' fracture and soft tissue damage clinics, staffed by physiotherapists and allied health assistants; and
- an expansion in enhanced 'one-stop-shop', multi-skilled mental health teams that provide immediate and appropriate responses to crises, could be achieved.

These models of care would all use agreed expanded scopes of practice supported by more appropriate education and more flexible regulation. The benefits for a small jurisdiction are self-evident.

Appendix 1

Table 1: ACT Health specialties identified as in short supply 2003-04

Nursing	Allied Health	Medicine	Other
Aged Care (in the private sector); Cardiac (Acute & Surgical); Critical Care (ICU); Emergency; Midwifery; Mental Health; Neonatal; Neurology (Stroke Unit); Oncology; Operating Theatres; Renal Dialysis.	Social Workers; Podiatry; Medical Imaging/nuclear medicine; Radiation Therapists; Physiotherapy; Pharmacy.	Neonatal Specialists; Emergency Staff Specialists, Career Medical Officers and Registrars; Endocrinology; Geriatrics; Intensive Care; Plastic Surgery; Radiation Oncology Staff Specialists; Career Medical & Surgical Officer (CPH); Senior Surgical & Medical Registrars; Paediatricians; Psychiatric Staff specialists, Visiting Medical Officers & Registrars; Clinical Fellow position (CPH); General Practice.	Professional Officer positions in: Child and Adolescent Mental Health Service; Older Persons Team.

Source: ACT Health Workforce Pressures Report, September 2004