Submission in Response to the Productivity Commission 2005 on 'Australia's Health Workforce, Position Paper'

From the Interprofessional Education Group of the Australian Rural Health Education Network[1] (University Departments of Rural Health)

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Introduction

The following response to the Position Paper is representative of the views held by a large number of rural health professional academics employed in University Departments of Rural Health (UDRH), Rural Clinical Schools and Rural Health Schools throughout Australia. Since early this year a sub-group of those academic staff have been meeting regularly about collaboration in the development of rurally–oriented interprofessional education (IPE) initiatives. The Interprofessional Education Group meets under the auspices of the Australian Rural Health Education Network (AHREN). This response is endorsed by the Directors of ARHEN, who are identified, along with the IPE Group members, in Appendix 1.

Analysis of the Position Paper (including submissions made by a range of bodies) identifies various needs that demand increased interprofessional teaching and learning at undergraduate, postgraduate, and continuing professional development levels. Relevant extracts of the Position Paper are provided in Appendix 2. We welcome this recognition of the need for interprofessional teaching and learning but are concerned that there is little in the Paper to guide positive change to address these needs. To this end we recommend that Draft Proposal 5.2 be amended to read as follows:

> ***The Australian Health Ministers' Conference should establish an advisory health workforce education and training council to provided independent and transparent assessments of:***

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- ***Current and developing interprofessional education programs both in Australia and overseas;***
- ***Opportunities to improve health workforce education and training to include interprofessional or multidisciplinary approaches (including for vocational and clinical training); and***
- ***The means by which such changes may be introduced into current courses and curricula, and the implications for accreditation requirements and the like.***

The above recommended changes target the most relevant section of the draft proposals, but the establishment of such an advisory council assumes a certain level of related activity, and associated policy and resource support, with respect to interprofessional education (IPE) and practice (IPP). This assumption is premature because in the Australian context, there is so far negligible related policy and resource support. As a result, IPE and IPP are at infancy levels compared with peer countries facing similar pressures and issues in health care delivery (see Appendix 4 for samples of international IP activity). There are a number of implications relating to boosting to support for interprofessional learning that pervade many other areas addressed in the Paper. These include the need for associated reforms within educational, professional and various government sectors. There are numerous international exemplars and resources to guide such reform. For example, the Canadian experience (Health Canada 2004), whilst quite recent, is also relatively well-advanced and research-based compared to Australia, and offers some valuable insights about managing the change processes involved in boosting IP learning (see model in Appendix 5).

Rationale for the recommended changes to the Position Paper

In recent years, other developed countries such as the US, UK and Canada have recognised the importance of developing interprofessional education (IPE) programs and improving interprofessional practice (IPP). Recognition of the need for better collaboration and communication amongst health professionals and systems has taken an integrated and pervasive approach in the form of mandated education and training policy initiatives and very substantial long-term government funding commitments to facilitate associated program and curriculum redevelopment. IPE and IPP are seen as practical necessities in response to pressures for greater efficiency and effectiveness of team-based, interdisciplinary health care delivery.

There is now a substantial base of research evidence that shows improvements in interprofessional practice in a wide range of health care contexts can lead to significant improvements health outcomes. A selection of related references is provided in Appendix 3. The benefits have been particularly well documented in areas that have been identified in the Position Paper as being poorly addressed within traditional models of health care delivery. These include conditions that are chronic and complex such as the management of diabetes, asthma, cardiovascular disease, emergency procedures, rehabilitation, aged care, and indigenous and mental health. Improving IPP has also been shown to increase the effectiveness of interprofessional communication and reduce the prevalence of miscommunication, tension and preventable adverse events associated with clinical error. It is also suggested that effective IPE and IPP initiatives are likely to reduced workplace stress and increase job satisfaction. Such beneficial effects are of particular pertinence in rural health care where the perennial workforce shortages are projected to worsen over the next several decades.

A recent health professional development event [3] in East Gippsland, Victoria, highlighted the strong potential benefits of interdisciplinary training and regional collaboration. One of the key disincentives for health professionals considering rural practice is the perceived professional and social isolation associated with these settings. While there are typically diverse ranges of professional communities and activities in this and other regions, there is no coordinating mechanism to ensure efficient sharing of resources and expertise due to the traditional mono-disciplinary arrangements and structures that prevail. Boosting interprofessional learning opportunities was seen as a practical, achievable and much needed responses to help address the perennial issues of both workforce recruitment and retention.

Despite significant international developments in IPE, there has been very little parallel movement in Australia. There are in fact only a relatively small number of pilot IPE initiatives, involving relatively small numbers of students. These are typically isolated, mostly rural-based, short-term initiatives that probably have limited scope to effect the lasting, systemic change that is needed[4]. More optimistically, they form a solid basis

[3] 'Breaking Down the Silos', Gippsland Medical/Health Professional Education Workshop, 26th October 2005, Traralgon, Victoria. Gippsland Education & Training for General Practice (getGP).

[4] Smith, T., Thornberry, T., Cooper, R., Brown, L., Williams, L., Lyons, M. & Jones, P. (2005) 'The Challenge of Evaluating Rural Undergraduate Multi-Professional Education', in *Central to*

from which IPE may be integrated into mainstream health professional undergraduate and postgraduate education. The push towards health care innovation is intertwined with changes in educational practice. We should not expect greater flexibility in service delivery and in role delineation, unless there is change towards educational approaches that will support such innovation and community-responsive practices. What is now needed is national recognition that IPE and IPP are essential prerequisites for optimising the effectiveness of scarce health care services and human resources. This recognition would need to be manifest in policy commitment, project funding and medium to long-term change management strategies, necessarily shared by local, state and commonwealth health authorities and by the university and VET education sectors.

One of the ten key recommendations of the 8th National Rural Health Conference (NRHC)[5] held at Alice Springs earlier this year is that Australian health professional students experience IPE. Further to this, the discussion paper on the conference recommendations points out that breaking down the traditional 'uni-disciplinary silos' will require a united commitment to the development of IPP. Therefore, we strongly endorse the NRHC recommendation that:

> *'State and Federal Ministers for Health and Higher Education should immediately inform higher education institutions and health professional bodies that undergraduate health professional curricula must be changed to incorporate and/or address the need for interprofessional education and future clinical practice'.*

For several years prior to the 8th NRHC reports have carried similar messages, as well as frustration at the persistent lack of recognition of the need for greater levels of IPE. We believe that it is essential for the responsible Ministers to address the critical need to fund the strategic development of IPE-specific teaching and learning initiatives within the budgetary framework. In doing so it must be recognized that the current university funding model does not provided the necessary flexibility to support these developments.

In the international educational research community there is evidence that Australia is acquiring a reputation for being an 'interprofessional backwater':

> [Interprofessional learning in Australia] *is currently limited in size and scope by non-recurrent funding due to a policy vacuum in this area at university, state and national government levels. Curricular reform requires forward planning to fit in with review and*

Health: Sustaining Well-Being in Remote and Rural Australia, Proceeding of the 8th National Rural Health Conference, National Rural Health Alliance.

[5] http://www.ruralhealth.org.au/nrhapublic/publicdocs/conferences/8thNRHC/home.htm

development cycles of several years: this is precluded with last minute, year-to-year funding arrangements ... This lack of support at the 'top' contrasts sharply with the growing and passionate support for IPE at student, teacher and practitioner levels.

Therefore a major challenge is to engage in effective advocacy to bring IPE from the margins to the mainstream. IPE has earned far greater recognition in our peer countries ... These international developments and achievements offer inspiration and a range of models, research and experience that we can blend with our own to help Australia make progress on this very important issue.'

(Stone, N. in press) Journal of Interprofessional Care.

Coming from what is a relative hive of interprofessional development, and probably at the international forefront of interprofessional activity in the UK, Jillian Thistlethwaite[6] seemed surprised that a nation such as Australia, that prides itself on progressive approaches to health care and related education and training, has allowed such a costly oversight to continue for so long.

In the section on Workforce Innovation (p.41) the Position Paper includes amongst the key points:

'There has been considerable change and innovation in health workforce deployment across Australia in recent years ... (and) growing use of inter-disciplinary and multidisciplinary approaches to patient care. However, the evidence suggests that many opportunities for more significant workforce innovation, including job redesign and changing scopes of work, have not been progressed, or even properly evaluated.'

There are a number of very promising pilot and other interprofessional projects taking place in this country. However, they are taking place in the context of a policy vacuum and are thus destined to be of limited impact and sustainability. We rural health professional academics, who are in many cases responsible for the development of IPE initiatives, believe that the Productivity Commission's view is overly optimistic about the current status of IPE and IPP in this country. While the importance of interprofessional learning and practice is slowly becoming evident at some levels, mostly within the areas of applied health care education, training and practice, it appears that the greatest barrier is a lack of institutional support and commensurate strategic planing. The future development of effective IPE and IPP will require fundamental policy change and funding support. It is essential to call this urgent need to the attention of health authorities and education providers at the highest administrative echelons.

[6] Thistlethwaite, J. (2005) News from the Antipodes. Journal of Interprofessional Care, 19, 3, 191-193.

Appendix 1

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Appendix 2 – Relevant Extracts from the Position Paper

'There has been a growing focus on multidisciplinary teams, particularly in relation to the provision of chronic care'. p.xx1

'Moreover, the increased incidence of chronic disease associated with population ageing will see more emphasis on team-based management of patients and the provision of care in residential aged care and community settings. The previously noted rise in non-age related chronic diseases associated with the greater prevalence of obesity and diabetes may reinforce this shift.' p.xxiv

'In undertaking these functions, the Commission emphasises that the agency would complement rather than supplant other initiatives to improve workforce deployment. That is, its work would not preclude other job substitution and redesign initiatives — for example, in individual workplaces or within particular professions, or through greater use of inter/multidisciplinary approaches.' p.xxxv

'Hence, beyond the immediate impacts on education institutions and the courses they provide, the decisions of accrediting bodies have an important influence on such matters as job design, the division of work between professions, and the scope for interdisciplinary and multidisciplinary approaches.' p.xlii

'Of particular importance in this context will be the increase in the incidence of chronic disease as the population ages (fuelling a shift in demand from episodic acute care to ongoing team-based management and care in community settings)'. p.15

Entrenched custom and practice
Custom and practice are important drivers of behaviour in the health workforce, as they are in various other workforces. Often, of course, the experience underpinning such custom and practice serves patients well. However, along with remuneration concerns, it can also stifle necessary and justifiable innovation and change in workplace practices and the evolution of job design and education and training arrangements. Among other things this can, in turn:

• impede transferability of skills across professional boundaries;
• prevent appropriate recognition of prior learning;
• constrain the move to a more competency-based education and training system; and
• discourage the further development of multidisciplinary care approaches.

Similarly, inflexible practices in the workplace can reduce productivity and job satisfaction. pp.26-27

Improvements in on-the-job efficiency have been made and there has been growing use of inter-disciplinary and multidisciplinary approaches to patient care. p.41

New or extended roles for workers in particular job settings have been adopted and there has been growing use of inter-disciplinary and multidisciplinary team-based approaches to care. p.44

In NSW, integrated primary health care services are being developed, where groups of GPs, community health workers and other clinicians will provide 'accessible and appropriate care' in the community, with the aim of preventing unnecessary admissions or readmissions to acute care (sub. 20, pp.11–12). In addition ... hospital-level

innovations are being trialled. Solutions to patient flow problems ... included multidisciplinary care meetings to improve coordination of patient care between units (ARCHI 2004).

Two rounds of coordinated care trials have been funded by the Australian Government (the second round is due to finish in late 2005), with the aim of reducing hospitalisation of people with chronic or complex needs by managing and coordinating their care (see box 10.4 in chapter 10). Individual care plans spanning primary, acute and allied health services, and the pooling of funding from existing government programs, are key features of the trials. p.45

A benefit–cost multidisciplinary approach would underpin the agency's assessments — it would consider not just the likely effects for the health workforce of change, but the broader institutional and regulatory implications for the health and education systems, including accreditation and registration, as well as the financial implications. Where relevant, the agency would draw on international experience and research.
p.53

Accreditation has an important influence on such matters as job design, the division of work between professions, and interdisciplinary and multidisciplinary approaches, on the one hand, and educational and training curricula and facilities on the other.
p.89

Changing models of care and scopes of practice
A variety of models of care have long been employed in Australia's health care system to meet the diverse care needs of patients. While some forms of care can be supplied by a single professional, others have always required a multidisciplinary approach. Similarly, there has been a blend of care provided in community, private and institutional settings.
p.242

However, the balance of the care mix has been changing and will need to evolve further in the future. The Commission was frequently told that a multidisciplinary approach to patient care involving close cooperation between medical practitioners, nurses, pharmacists and allied health professionals will become increasingly more important in the treatment of chronic disease, which is becoming a larger share of Australia's burden of disease (DOHA, sub. 9). In addition, the tightening general labour market, in conjunction with greater technological possibilities for arm's length care, is likely to see a greater emphasis on care provided in community settings.
p.243

Problems identified with the current arrangements
Reinforcing traditional roles
… current accreditation processes do not fit easily with the expansion of scopes of practice or new workforce roles, particularly roles which might combine aspects of two or more existing professions eg a generic allied health professional. (AHMAC)

Accreditation has an important influence on such matters as job design, the division of work between professions, and interdisciplinary and multidisciplinary approaches, on the one hand, and educational and training curricula and facilities on the other. p.89

From the Aboriginal and Torres Strait Islander Health Workforce
'As part of the push to address Indigenous health issues, the Aboriginal and Torres Strait Islander Health Workforce Strategic Framework aims to:... develop... policies to enhance the focus of training on preparing for work in multidisciplinary teams in

integrated and coordinated services. The framework is now embodied within the broader National Health Workforce Strategic Framework (see chapter 3). p.190

From the Committee of Deans of Australian Medical Schools:
'… the growing provision of health care by teams rather than individuals, particularly for the aged and chronically ill, has presented the as yet largely unrealised challenge of interprofessional education and learning … suggested a different paradigm of medical practice, one which was more community-based and more generalist. (sub. 49, p. 6) p.17

From the Australian Health Policy Institute:
'At present, patients with complex health issues are typically managed in the same way as patients with discrete problems — by a succession of individuals addressing specific problems, often without relative priorities or proper recognition of the interactions. As the population ages the proportion of patients with multiple or complex health care needs will increase. Each patient needs to be managed by a form of case manager who is able to coordinate a team of multi-/ inter-disciplinary care providers and establish a care plan by consultation and then ensure it is delivered. (sub. 22, p.1) p.17

From General Practice Education and Training:
Much medical education occurs in acute care settings but increasingly the system must focus on chronic conditions managed by … multidisciplinary teams in community settings. (sub. 129, p. 28) p.17

'New or extended roles for workers in particular job settings have been adopted and there has been growing use of inter-disciplinary and multidisciplinary team-based approaches to care.' p.44

'... most workforce changes have involved either initiatives in particular job situations or greater use of team based approaches.' p.45

'Some concerns were also expressed about credentialing by professional bodies:
… while Australia retains this plethora of organisations that 'register and/or credential' individuals, and while these are focused on narrow professional categories, their concentration will remain on delineating roles and protecting patches rather than on creating an environment in which more effective team structures can evolve.' (Australian Healthcare Association, sub. 151, p. 6)

From James Cook University Faculty of Medicine:
A number of submissions suggested delegation of tasks would encourage workforce flexibility:
… the devolution of 'medical' tasks to other members of the health team under the local supervision and delegated authority of a Medical Practitioner … has a number of attractions: clear clinical governance in diagnosis, investigation and technical management; greater likelihood of uptake and acceptance by the medical profession; less regulation, red-tape and external constraint on scope of practice; opportunities for participation by a broad range of health professionals …; easier uptake by the private sector; Medical Practitioners able to focus on complex and technically difficult cases; and simpler indemnity arrangements...

The greatest expansion in the delivery of clinical care is likely come through the devolution of 'medical' tasks to other members of the health team under the local supervision and delegated authority of a Medical Practitioner.'
(sub. 106, p. 3)' p.112

From the Australian Medical Association
‘The AMA … supports task delegation to appropriately trained nursing and allied health colleagues. This approach would build on the long history in health of providing health services in clinical teams. (Australian Medical Association, sub. 119, p.5)’

From the New South Wales Government
‘The New South Wales Government noted that while greater emphasis on integrated or multidisciplinary models of care will be required in the future, the involvement of some health professionals in such teams may be discouraged by the current structure of MBS rebates, particularly in rural areas (sub. 178, pp. 21–22).’ p.123

‘The New South Wales Government noted that while greater emphasis on integrated or multidisciplinary models of care will be required in the future, the involvement of some health professionals in such teams may be discouraged by the current structure of MBS rebates, particularly in rural areas (sub. 178, pp. 21–22).’ p.181

From the Victorian Government
‘Victoria proposes that a multidisciplinary, nationally consistent approach to course accreditation and assessment of international practitioners be established through a national council.’ p.xliv

‘The Victorian Government was somewhat more specific in its proposal. It suggested the Australian Government and the States and Territories work together towards the establishment of a National Health Education and Accreditation Council which would be a ‘multidisciplinary model for national course accreditation, curriculum leadership and the assessment of international practitioners’ (sub. 155, p. 51).’ p.94

The single discipline focus is opposed to current policy directions that encourage interdisciplinary approaches, optimal use of workforce skills and workforce adaptability. (Victorian Government) p.xliv

Appendix 3 – Selected References

Birrer, R.B. & Vemuri, S.P. (2004) Depression in Later Life: A Diagnostic and Therapeutic Challenge. *American Family Physician. 69*, 10, 2375-2383.

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Appendix 4. Selected Examples of International IP Activity

Three-centre Research on Interprofessional Practice in Learning & Education (TRIPLE) http://www.triple-ltsn.kcl.ac.uk/

Promoting Interprofessional Education http://www.pipe.ac.uk/evaluation.html

Social policy and social work subject centre of the Higher Education Academy http://www.swap.ac.uk/learning/ipe.asp

Great Lakes Geriatric Interdisciplinary Team Training http://gitt.cwru.edu/index.html#map

Interprofessional Education for Collaborative Patient-Centred Practice (Health Canada) http://www.hc-sc.gc.ca/hcs-sss/hhr-rhs/strateg/interprof/index_e.html

University of Toronto Interprofessional Education:http://ipe.utoronto.ca/aboutipe.html

Centre for Excellence in Teaching and Learning in Interprofessional Education, Queen's University (Belfast): http://www.qub.ac.uk/ceipe/

Kings College, University of London Interprofessional Education http://www.kcl.ac.uk/depsta/medicine/dmde/clinicalskills/ipe.html

CHIP - Center for Health Interdisciplinary Programs, University of Minnesota http://www.ahceducation.umn.edu/OofE/interproedu.html

Centre for Collaborative Health Professional Education, University of Newfoundland http://www.med.mun.ca/cchpe/

The Alliance of Primary Care
The Alliance promotes discussion and seeks to resolve issues of concern to primary care, fosters liaison between bodies representing members of primary care teams, promotes and develops teamwork, acts as an advocate and advises member organisations of issues affecting primary care teams. Its members include professional associations representing practice managers, directors of social services, nursing groups and general practitioners and other doctors, social work, plus CAIPE (see below) and the NHS Confederation. For further information contact: Rosey Foster, AMGP, Suite 308 -The Foundry, 156 Blackfriars Road, London SE1 8EN. Tel: +44 (0)171 721 7080. fax: +44 (0)171 721 7090.

CAIPE: The UK Centre for the Advancement of Interprofessional Education
Comprising individual and corporate members from health and social care throughout the United Kingdom, CAIPE promotes and develops interprofessional education, offers advice and information to its members, encourages networking, runs national and regional conferences and workshops, publishes a bi-annual Bulletin and allows access to its data base. For further information contact: Barbara Clague, Chief Executive, CAIPE, 344 Gray`s Inn Road, London WC1X 8BP. Tel: +44 (0) 20 7278 1083. Fax: +44 (0) 20 7278 6604. Go to CAIPE Website

CHIME: The Centre for Health Informatics & Multiprofessional Education
Based at the Whittington Hospital Campus of UCL, one of CHIME`s aims is to develop multiprofessional activities in partnership with nursing and the clinical professions, calling upon its expertise in monitoring the training needs of healthcare professionals, analysing the changing careers of healthcare professionals, reviewing and developing curricula,

evaluating methods of teaching and learning, designing staff development programmes, contributing to continuing professional development and reviewing learning materials. For further information contact CHIME at University College London, 4th Floor, Archway Wing, Wittington Hospital Campus, Archway, London N19 5NF. Tel: +44(0) 20 7288 3372, Fax: +44(0) 20 7288 3322 Email CHIME

The Commission on Primary Care
Established by the Royal College of General Practitioners in association with other health and social care professional bodies, the Commission promotes improvements in services to patients through better interprofessional working, facilitated by shared learning. The Princes of Wales Fellowships, which it manages, have this as their purpose. They are awarded annually. For further information contact: The Commission on Primary Care, Royal College of General Practitioners, 14 Princes Gate, London SW7 1PU. Tel: +44 (0) 20 7581 3232

EMPE: The European Network for the Development of Multiprofessional Education in Health Sciences
Comprising individual and organisational members throughout Europe, EMPE holds an annual conference, circulates a periodic newsletter and has a home page* about development in shared studies between university-based courses at bachelors and masters level. Go to EMPE Website

JET: The Interprofessional Education Joint Evaluation Team
Comprising teachers and researchers from City, Oxford Brookes and Westminster universities, this Group is undertaking a systematic on-line search and critique of evaluations of interprofessional education worldwide. The review will be repeated periodically. Work will start shortly to prepare indicative guidelines for such evaluation, with a view to comparative research across institutions. Dr Marilyn Hammick, School of Health Care, Oxford Brookes University, Level 4, Academic Centre, John Radcliffe Hospital, Headington, Oxford OX3 9DU. Tel: +44(0)1865 221571/225987. Fax: +44 (0)1865 220188. Email Marilyn Hammick

The Interdisciplinary Health Care Team Conference (USA)
Holds an annual conference in the United States for practitioners, educators and researchers from health professions. Further information from: Dr Arthur Van Stewart, Director, National Institute for Interdisciplinary Studies, 743 East #109 Broadway, KY 40202 USA. Tel: 001 (502) 852 1332. Fax: 001 502 852 4388
Email Arthur Van Stewart

The Health Care Professions Education Forum
The Forum facilitates closer working together between health care professions in the UK to promote effective professional education and training through biannual conferences. Professions included are: speech therapists, orthoptists, radiographers, medical laboratory scientists, physiotherapists, chiropodists, nurses, midwives and health visitors, occupational therapists, dieticians and psychologists. For further information contact: Thelma Harvey, Health Care Education Forum, The Chartered Society of Physiotherapists, 14 Bedford Row, London WC1R 4ED.

Appendix 5. Canadian Framework from http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/hhr/iecpcp.pdf