Submission to Productivity Commission Position Paper: Australia's Health Workforce

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3 November 2005

For the three years prior to April 2005 I worked on health modernisation in the UK for London South Bank University and the Department of Health. I have been surprised to realise on my return how far behind Australia is on this agenda. I have always thought of us as being a flexible and innovative workforce. As Jill Thistlethwaite, an English primary care academic who came to Australia on sabbatical commented in an editorial in the Journal of Interprofessional Care this year, 'Given the apparent lack of interprofessional teamwork in the workplace, I was not surprised to find a dearth of IPE (Interprofessional Education)'.[1]

Overall I strongly support the position paper.

In summary my comments are:

- Engagement of consumers is an important aspect of making the most of the opportunity to reform health services which appear to be presenting itself at the moment – it would be worth adding this dimension to the position paper
- Proposal 4.1 to establish an advisory health workforce improvement agency – the report suggests this should be modelled on the Modernisation Agency in the UK. That an agency should be established is supported, but it is suggested that the recommendation be reworded to ensure that the organisation is one working closely with local partnerships; rather than a remote national planning superstructure
- Proposal 6.1 runs the risk of seeing an organisation with equal-strength stove pipes. More is required for interprofessional work and learning to develop, eg the skills escalator adopted in the UK
- Proposals 8.1 and 8.2 are supported, but the real issue in funding is the problem that the MBS currently rewards procedural medicine to a greater extent than intellectual medicine, whereas a more logical application of skills to tasks would see the most highly trained people undertaking complex diagnostic tasks, and being rewarded accordingly, with many of the simple

[1] Thistlethwaite, J. Editorial: News from the Antipodes. J of Interprof Care, 2005; 19(3): 191-193

procedures currently undertaken by doctors performed by others competent to do so.

Engagement of consumers

Whilst I appreciate that scoping this work has been extremely difficult, I do think that engagement of consumers cannot be neglected, for three reasons:

1. Consumers, once reassured that quality and safety will be protected, and made aware of the advantages (reduction in waiting lists), may well become useful strategic partners in achieving reform
2. Encouraging a greater shift towards self-managed care is realistic way of managing demand
3. Derek Wanless, in the UK, has demonstrated that the 'fully engaged scenario' makes the most economic sense.

At London South Bank University I led a project the aim of which was to extend the roles of nurses, radiographers and cardiac physiologists in cardiac catheter laboratories to create a generic practitioner who could perform across all three roles, as a first step in addressing workforce shortages in the labs.

We engaged with consumers and from this we learned:

- Consumers were comfortable with reforms provided quality and safety would not be compromised, and could see there may be advantages to them
- Some consumers related proposed reforms to micro-economic reforms which had taken place in their own industries (in this case multiskilling)
- Consumers were very useful in assisting us in considering patient satisfaction in the design of the evaluation of the impact of the extended roles we had developed[2].

In 2002 Derek Wanless, a former CEO of the NatWest Bank, was asked to examine future health trends and determine the long-term financial and resource needs of the NHS to 2022. He undertook economic modelling based on three scenarios:

- Slow uptake – no change to level of public engagement in health, health status constant or deteriorates, unresponsive health sector with low rates of technology uptake and low productivity
- Solid progress – more engagement, health status improves, high rates of technology uptake and more efficient use of resources
- Fully engaged – public engagement high, health status improves dramatically, people are confident of the health system and demand high quality care, high rates of technology uptake, particularly in relation to prevention and efficient use of resources.

[2] Ellis, N and Lovegrove, M. Cardiac Catheter Laboratory Project: Report at completion of stage 1. Unpublished report, Centre for Research and Allied Health Professions, London South Bank University, London, March 2005

He found that the fully engaged scenario would reduce the funding increases needed in the longer term through a combination of reduced demand (relative to other scenarios) due to success of prevention and public health and improved supply through productivity. This scenario required more upfront investment. The Government adopted his recommendations, increased the investment in the NHS and in 2004 asked Derek Wanless to review the extent to which this investment was achieving the 'fully engaged scenario'[3].

In short, if the problem is shortage of workforce, then reduction of demand through greater self-managed care and prevention, and gaining public support for efficient use of resources are useful potential solutions, and should be included in the position paper.

Proposal 4.1 – advisory agency for health workforce improvement

This proposal is supported in principle, however the text implies the agency should be modelled on the UK Modernisation Agency. The Modernisation Agency was not a success in the UK. The hard pressed NHS saw the Agency as lacking practical expertise and not value-adding. A comment that was often heard was that if the MA budget had been divided up amongst the Trusts for work on innovation much greater progress would have been made.

In the three years I was in England the Changing Workforce program had a very low profile and was threatened at one stage, although I note it has now been rejuvenated.

I observed that success was often associated with local partnerships between health services, health policy makers and academia. Examples of success stories I knew of were:

- Uni of Southhampton Health Innovation Unit led by Professor Debra Humphris – a long term strategic partnership between academia, health services providers and health policy makers
- London South Bank University Cardiac Catheter Laboratory Generic Practitioner Project (interest declared, I was Chief Investigator) – a partnership between 5 tertiary cardiac care hospitals in London, the NorthWest London Strategic Health Authority and London South Bank University.

Critical to success is an appreciation that the workforce innovation is a combination of clinical practice improvement and skills development. All too often initiatives are designed as if they are one or the other. In reality the principles and practice of both are required – hence the need for academic, health service and health policy partnerships.

Currently proposal 4.1 sounds like a remote, national, high level committee. It is suggested that an additional dot point is added to this proposal, 'the agency shall work closely with local academic, health service and health policy partnerships'.

Proposal 6.1 – national accreditation agency

[3] Wanless, D. Securing good health for the whole population: Final report, HMSO, Norwich, 2004

The text and the discussion at the round table suggested to me that there is lack of understanding in Australia of modern thinking in competency-based development and the skills escalator, and that there is a significant risk the proposals as written will result in a multi-professional organisation with more equal stove pipes.

In health, competency-based training has been embraced by the professions as a means of making their own professional standards more transparent for reasons of equity. However in the more modern concept competencies are used to transcend professional boundaries. Rather than describing what a doctor, nurse, pharmacist or physio are able to do competencies are developed for much smaller packets of tasks.

Health practitioners are then encouraged to develop career pathways by picking up smaller packets of skills/competencies and being rewarded for doing so.

In the UK this theory is evolving into practice, enabled by the industrial work undertaken to develop a common skills escalator onto which all existing health professions (with the noteable exception of doctors) have been mapped. In the future remuneration will be based on further skills acquisition.

The skills escalator describes a common framework from entry point, to assistant, to practitioner, advanced practitioner, consultant and beyond. So as well as the health professions as we know them assistants who have undertaken a Foundation degree, can come onto the ladder and describe new career pathways up the escalator.

In the future learning, enabled by e-learning, will be done in much smaller units and there will be a much closer connection between educators and the workplace. In the UK a new role has emerged to facilitate this – practice facilitators (half uni appointment, half service appointments).

I agree however, with the caveat made in the Brisbane round task that Australia's geography will mean we need more new workforce generalists than the UK.

It is suggested that proposal 6.1 should require the national accreditation agency to develop a single national framework for health competencies.

Proposals 8.1 and 8.2

See summary above – no further comment.