Australia's Health Workforce

A response to the Productivity Commission's Position Paper

MARLENE EGGERT
PhD Scholar
Australian National University, Medical School

Contact details: Marlene Eggert, Australian National University, Medical School, Canberra ACT 0200. Email: marlene.eggert@anu.edu.au ph: 02/62843699

Contents:

Draft proposal: Facilitating workplace innovation

There is no doubt that many traditional, professional boundaries in the healthcare system have become inappropriate as the capability of many allied and nursing professionals has increased. These inappropriate, traditional boundaries are significant contributors to remaining inefficiencies in the health care system. Successfully addressing inappropriate boundaries through workplace redesign and job innovation can make a significant contribution to increasing the health care system's productivity.

A circuit breaker, such as the proposed National Health Workforce Improvement Agency, to deal with contested issues arising out of professional patch related conflicts and systemic impediments to change is essential to the success of such a project. The composition of this agency needs to fairly represent the health workforce and must be independent of any professional body or group. Major changes in role boundaries require formal evaluation and review processes to derive data which establish their quality and safety and provide a platform for discussion and eventual formulation of new boundaries.

Draft proposal: More responsive education and training arrangements

Integrated training of various health professional groups in undergraduate and post-graduate courses might in the future assist with bedding down any role boundary changes. This is already happening in some courses, such as the Postgraduate Certificate of Diabetes Education and Management offered by University of Technology, Sydney and this should be introduced on a broad basis. Integrated training may reduce misconceptions and misinformation about the degree of training and education other professional groups undertake, facilitate the appreciation of each other's professional capabilities and might soften some entrenched practices and customs in the health care setting. Partially combined training may also produce efficiencies in the educational sector.

Draft proposal: Supporting changes to registration arrangements

State based and profession specific registration bodies provide a forum for professional and regional regulatory matters such as desirable standards, issues related to overseas trained professionals or professional misconduct occurring in specific settings. However, these benefits can be made national by having specialists with specific professional and/or regional expertise employed in a national registration body. Such a body is likely to deliver a number of significant benefits such as:

- Efficiencies in health professional registration
- Reduction in administrative costs and the requirement for multiple registrations
- Simplification of workforce data collection
- Facilitation of professional role design adjustments over time and
- Development of national standards.

A national registration body for health care professionals may reinforce in the community and among health care professionals a view of a health workforce as a team rather than an assembly of various professionals.

Draft proposal: Improving funding-related incentives for workplace change

The commission rightly identified that an efficient and cost-effective use of the health workforce is dependent on significant changes to the MBS. While the commission believes that these changes are outside its brief for the health workforce inquiry, a deployment of the health workforce that effectively uses its capabilities in the delivery of health care to the Australian people will depend on continuing work towards these significant and far reaching changes. A carefully staged approach through trials, which assess the effectiveness and cost implications of these changes may be an appropriate way forward.

The current medical practitioner centered approach to MBS denies many Australian people essential expertise without which their health cannot be maintained or restored. Additionally, significant funds, which were invested to train these health care professionals, are wasted, as their training is not utilized to a maximum extent.

In the following section it is argued that the "delegation of less complex tasks" by General Practitioners to Practice Nurses who are Registered Nurses serves to reinforce such waste of professional capability.

Delegation involves the handing of a task to a subordinate, assigning authority and responsibility to the person to carry out specific activities but ultimate responsibility cannot be delegated.

Registered Nurses are trained in a wide range of skills to effectively address the complex medical and psychosocial issues affecting a person's health status. This makes Registered Nurses valuable health care professionals in the General Practice setting.

The current model of "delegation of less complex tasks" for purposes of MBS reimbursement does no doubt increase the efficiency of the Medical Practitioner's workday but not necessarily the efficiency of their practice. This is because the carrying out of tasks utilizes only a small portion of a Registered Nurse's capability. Registered Nurses have particular expertise in the orchestration of care processes and a wider utilization of the skills of a Registered Nurse will significantly increase the productivity in the primary care setting. For example, responsibilities which would make good use of the training and skills of a Registered Nurse are care planning, case management and monitoring of less complex patients, particularly those with a chronic disease.

Rather than accepting continued productivity losses to counteract a blowout in MBS costs, it may be a better move to reimburse Practice Nurses outside the MBS fee-for-service model for their work. This may be achieved through a MBS block grant to a central agency, such as a Nursing Syndicate or Division of General Practice. General Practitioners indicate the hours of nursing input they require and a Registered Nurse is placed into their practice. This frees the General Practitioner from the various responsibilities involved in employing staff and takes the Practice Nurse from the less productive task driven work to an environment where their training can be fully utilized to increase the productivity of the primary care setting. General Practitioners may object to giving up their sense of control by not employing the Practice Nurse themselves. However, this may be balanced by the benefits of not having to deal with the many employment related matters including the professional development of

Practice Nurses. Additionally, this model allows for the prediction, monitoring and control of costs related to Practice Nurses and guards against MBS fraud.

A comment on the idea of a generic allied health professional

The specialization of health care professionals evolved in response to the increasingly complex medical conditions in the patient population. It is difficult to see a generic allied health professional that can fill an effective role and indeed, what such a role should be.

However, there may be a role for a generic allied health professional trained in the specific lifestyle interventions effective in chronic illness and trained in coaching patients to implement and maintain such changes. Chronic illness related lifestyle interventions require knowledge and skills in diverse areas such as sleep hygiene, healthy eating, stress management, physical activity, problem solving skills, some social skills such as conflict resolution and assertiveness and basic cognitive behaviour therapy skills. These practitioners should also have an adequate working knowledge about diabetes, hypertension, chronic heart disease, arthritis, chronic back pain and common mental health problems such as depression and anxiety. They must also have good health assessment skills.

Such a generic allied health professional may be useful particularly in rural areas (and possibly in the aboriginal community) where it is difficult to assemble the full health care team usually required to successfully care for a population with a specific chronic illness, such as diabetes or heart disease. The generic allied health professional may be grafted on an existing allied health or nursing qualification. This would ensure the necessary science base and depth of knowledge to fulfill what will be a complex and demanding role.

Workplace environments in which people want to work

There is now emerging evidence about the negative workplace cultures in many health care facilities in Australia. The commission noted that job redesign might make a significant contribution to job satisfaction. This stance is disappointing, as it doesn't address the significant cost to the Australian nation through the loss of health care professionals who choose not to work in settings, which have a negative culture and/or are overly demanding workplaces. Both, the shortage of rural doctors and the

shortage of nurses are indicators that the nature of their workplaces contributes to the problem.

Some Australian health care facilities have responded to the problem of recruiting and retaining health care professionals by identifying their workplace culture and working towards improvement of the culture. Some of this work was recently listed on the *Australian Resource Centre for Healthcare Innovation (ARCHI)* website but is also available from the *Best Practice Australia* website.

Taking an approach to job redesign through mainly the regulatory and education systems will not embed these new jobs in the operational arm of the health care system. This is because health workplaces often have strong, tribal professional and hierarchical cultures and thus don't have the flexibility to accommodate professional role change. It is difficult to influence health workplaces from a federal level of government. However, a scheme could be devised which financially rewards state health services which can prove that they achieved both, a positive work culture AND the implementation of redesigned jobs.

Unless tribal and hierarchical work cultures in the health care system are addressed, the final, significant component of embedding job redesign in the system is not dealt with and the failure of this venture is almost guaranteed. This would be a great loss of opportunity to the health care system and the Australian people.