Australian Health Care Reform Alliance

POLICY POSITION PAPER:

HEALTH WORKFORCE

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Key Points

- Australia's health workforce is our most valuable health care resource
- Workforce costs comprise a large share of recurrent health expenditure
- Workforce roles have been slow to evolve relative to changes in population health status
- Better use of the health workforce can improve efficiency and help meet future challenges
- The current health workforce is poorly distributed
- There are both under and over supply issues in many areas of health care
- Increasing workforce flexibility and breaking down of regulatory barriers through reform of professional scopes of practice should be among key priorities

WHAT IS THE HEALTH WORKFORCE AND WHY IS IT IMPORTANT?

Australia's health workforce comprises all health professionals working within the health and aged care systems. This includes both the public and private sectors and encompasses care contexts ranging from community to hospital settings. The health workforce embraces many professional groups, including allied health providers, indigenous and aged care workers, in addition to doctors and nurses.

Australia's health workforce is our most valuable health care resource and underpins the effective functioning of the health system. Health care is Australia's largest industry and employs about 7% of the civilian workforce. With labour costs a major part of health expenditure, health workforce issues have a major impact on the overall quality and efficiency of our health system.

HEALTH SYSTEM CHALLENGES

Australia's health system is facing significant challenges, including an ageing population and an ageing health workforce. Changes in disease patterns, in particular a growing level of chronic disease, are driving demands for more complex and long-term care. In addition, health budgets are coming under pressure as the cost of care rises, putting additional stress on the health system.

While not directly workforce-related, developments in information technology and other emerging technologies are immensely important in terms of access, productivity and quality of care. These developments will see new approaches in telehealth, diagnostics, monitoring and treatment that require a flexible and well-educated health workforce while concurrently displacing some existing practices.

Our current health system has a focus on increasingly expensive and specialised acute care in major metropolitan centres to the detriment of the provision of high quality primary care, the development of population health initiatives and preventive care. This emphasis on secondary and tertiary care increases the overall cost of care and is not an optimum use of resources. A stronger commitment to primary health care with early diagnosis, prevention and management of chronic conditions, along with closing the gap in indigenous health, are among the changes needed to realise better outcomes.

If our health system is to meet the challenges of the future, it will need to move beyond a concentration on specialist medicine and acute care beds, to a system that employs a diverse health workforce and having a stronger focus on primary and community care.

Generalist skills will be needed in addition to specialist care in developing a multi-disciplinary team approach that mobilises a range of practitioner competencies to better address chronic conditions as our population ages.

Innovations in the structure of the health workforce would contribute to the long-term ability of our health system to meet the needs of the Australian population. However, this will require the development of new workforce models - including the creation of new roles and the realignment of existing roles.

These changes should ensure the workforce is utilised in the most effective way, by taking advantage of the full range of available workforce skills and competencies. The changes need to be developed in full consultation with consumers, healthcare professionals and other stakeholders and assessed against their capacity to improve health outcomes and overall productivity.

Some key issues to be addressed are outlined below.

WORKFORCE FLEXIBILITY AND INNOVATION

While many areas of the economy have undergone micro-economic reform and significant workforce changes in the past 30 years, the health sector has been slow to respond. Many structural elements reflect the practices of a bygone era. The objective in care should be the provision of right care – right place – right time, focusing on the needs of the consumer, rather than professional or institutional structures.

Changes to the health workforce structure, improved work practices, multiskilling, enhanced teamwork, and flexible training are among the key reforms required. Breaking down historic workforce boundaries and establishing new ways of working in inter-professional teams can capitalise on the range of skills and knowledge held by health practitioners.

Examples of the potential benefits from regulatory reform and modified scopes of practice have been outlined in the 2015 Productivity Commission Research Paper *Efficiency in Health (pages 46-48)*. These include the introduction of physician assistants and wider use of paramedics, pharmacists and allied health professionals through expanded community and primary care roles. The former Health Workforce Australia (HWA) also funded successful pilot programs across a range of workforce areas, including ways to expand professional scopes of practice, expand prescribing roles and address barriers to reform.

Along with a regular efficacy review of the Medicare Benefits Schedule (MBS), unnecessary impediments to practice should be examined, such as the lack of access to MBS fee-for-service item numbers by various professional practitioners.

Options for change could include suitably-trained nurses, physician assistants or nurse practitioners undertaking greater responsibility for initial diagnosis and triage in hospitals; enrolled nurses taking on some of the tasks currently done by registered nurses; new allied health assistants supporting allied health workers to increase their capacity to treat more patients; and suitably-trained practice nurses or physician assistants undertaking some of the work currently performed by General Practitioners. More use of dental hygienists and oral health therapists would be valuable.

Other changes might involve midwives substituting for obstetricians (in Australia, less than 10% of normal births are managed by midwives compared with 90% in New Zealand) or appropriately trained nurses (and physician assistants) performing endoscopies - as occurs in the United States and United Kingdom.

The wider use of nurses, pharmacists, paramedics and physician assistants in vaccination, health monitoring, chronic disease management and counselling roles are further options; while there are many opportunities for delegation and expanded scopes of practice for members of the dental workforce.

The Australian College of Rural and Remote Medicine (ACRRM) has recognised that physician assistants can be part of a broader range of solutions for increasing participation in health care to meet the needs of communities. It has recommended the adoption of clinical governance frameworks that support local delegated medical practice in determining appropriate clinical roles and supervision within a health care team, enabling physician assistants (and others) to work to the full extent of their evolving abilities.

Implementing these reforms will require review of existing regulatory frameworks and scopes of practice, as well as education and training arrangements, to ensure that practitioners are equipped with the skills they need to work in a complex, changing health system. The objectives are to usher in more flexible educational pathways and careers for health professionals, which will create a dynamic health workforce able to respond more rapidly to changes in demand and emergent health care needs.

WORKFORCE DISTRIBUTION

Australia's health workforce is currently not optimally distributed across health professions, specialties, demographic groups and geographic locations. Australians living in different parts of the country have unequal access to appropriate health care. The disproportionate impact of preventable injuries among remote and rural Australians has been outlined in research published by the Royal Flying Doctor Service (February 2016).

However it is not only people living in rural and remote areas who are disadvantaged by workforce distribution factors. Some urban areas also have widely disparate services and shortages of specific health care professionals.

Another underlying reason for problems with the distribution of doctors is that the medical training pathway is poorly coordinated which can increase the length of time it takes to train specialists and results in an uneven distribution of numbers between specialties.

OVER AND UNDER SUPPLY

HWA workforce research identified a lack of medical generalists as well as growing shortages in some key specialist areas such as obstetrics and gynaecology, psychiatry and radiation oncology. In other areas, such as cardiology and gastroenterology, there is likely to be a future over-supply.

Workforce modelling indicates that if current training patterns and workforce roles continue, there will be a shortage of 109,000 nurses and 2700 doctors by 2025. There also will be insufficient postgraduate medical training places for the number of graduates expected, leaving Australia highly dependent on the recruitment of overseas-trained health professionals.

Placing workforce supply matters into perspective, there are currently few physician assistants in Australia, yet a looming abundance of well-educated paramedics, with more than 7,000 students currently (2016) undertaking tertiary studies and whose skills can be better mobilised within the community. Nurse practitioners appear under-utilised and under-employed and their capabilities could be better used under revised practice models that freed up other highly skilled medical resources.

Conversely, Aboriginal and Torres Strait Islander Health practitioners number fewer than 600, despite strong demand for culturally aware and relevant practitioners to help close the gap in the health of our Indigenous population.

The ACRRM has also noted that an Australian physician assistant training pathway represents a route into expanded, flexible, clinical careers for interested paramedics, pharmacists, allied health practitioners, nurses, Aboriginal and Torres Strait Islander Health workers and military medics who might otherwise be lost to the health care system.

National training strategies are needed to improve alignment between health system requirements, the activities of the higher education and training sectors, and broader workforce distribution patterns. In concert with demographic considerations, a national strategy should draw on an analysis of regulatory structures and state and territory health workforce industrial arrangements to identify barriers and enablers to workforce reform.

ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

While there has been a relative increase in Indigenous participation in health-related training and education, there is still a significant under-representation of Indigenous people in the health workforce. This under-representation contributes to the lower rates of Indigenous people accessing health services and their overall poorer health status. Great challenges remain in providing culturally safe services with culturally competent staff across urban, rural and remote Australia.

Aboriginal Community Controlled Health Organisations need to be fostered as an important component of the health system since they lead, develop and deliver services with culturally competent staff in a culturally safe environment. Cultural competence training also is essential for non-Indigenous service providers to facilitate collaboration with the Indigenous workforce; a prerequisite towards closing the gap in Indigenous health.

Developing both an appropriate Indigenous health workforce and a more broadly representative health workforce involves targeted leadership, mentoring, pre-vocational training, vocational training and work experience focussed on Indigenous health. This will create opportunities for Indigenous people to participate in further educating the dedicated Indigenous health workforce.

MENTAL HEALTH

Access rates to mental health care remain unacceptably low and the National Mental Health Commission has called for a doubling the proportion of the population accessing mental health services at a local community level. Mental health nurses also are among the oldest cadre in the workforce, creating further sustainability pressures. The necessary scale of growth is simply not possible without some fundamental re-thinking about our mental health workforce[1].

For example, there is strong evidence that peer support workers can reduce admission rates and aid recovery[2]. Other countries are investing heavily in these resources, whereas Australia's 4th National Mental Health Plan set a target that these workers should account for just 1% of the total mental health workforce.

Current policy settings are out of step with both the evidence and what is needed to address Australia's growing demand for mental health care. Critical here is the development of a mental health workforce capable of aiding people's recovery within the community.

FUTURE AGENDA - WHERE WE WANT TO GO?

The Productivity Commission in its *Efficiency in Health*[3] report has addressed many of the measures available to bring about the necessary workforce changes. Principal among these is that state and territory governments hold the key to advancing health workforce reform (page 49) and should take responsibility for achieving greater progress.

The Australian Government can help by facilitating innovations in workforce roles. For example, it can identify opportunities to expand the types of health professionals that could access reimbursement for MBS and PBS items. It could also monitor the effectiveness of any changes. Action is needed to advance the workforce innovation agenda initiated by the now defunct HWA.

AHCRA's vision is that Australia must develop a nationally coordinated approach towards a sustainable and affordable workforce for the future. This requires a high order of collaboration between governments, professional bodies, regulatory bodies, the higher education system and training providers. Although ambitious, AHCRA believes the goals of enhanced and equitable care can be achieved through the following short and longer term strategies:

Immediate objectives

- Identify the health workforce distribution requirements for Australia through evidence-based policy and planning
- Analyse workforce practices internationally and relevant regulatory and health industry legislation to identify barriers and enablers to the flexible and innovative use of the workforce, distribution, profession-specific demarcation and restrictions on health professionals working to their full scope of practice

[1] http://about.au.reachout.com/wp-content/uploads/2015/01/ReachOut.com-Crossroads-Report-2014.pdf

[2] Pepper, J & T. Carter. *A review of the literature on peer support mental health services*, Journal of mental health; August 2011; 20 (4) 392-411

[3] Productivity Commission 2015, *Efficiency in Health*, Commission Research Paper, Canberra.JEL codes: I10, I18

- Maintain (and modify as needed) data collection on health care delivery with expansion to include primary care and out-of- hospital domains with data collection across the full continuum of care to better inform evidence-based practice
- Streamline clinical training funding.

Near term objectives (1-3 years)

- Design and support programs for improved distribution of the health workforce across different health care settings, service sectors and geographic areas
- Create more opportunities for multidisciplinary education and internship training
- Develop a culturally competent workforce able to improve the distribution of services for Indigenous people - creating a coherent pathway for rural and regional education and training
- Develop strategies to grow a workforce of mental health peer support workers.

Longer term objectives (3-5 years)

- Ensure a capable and qualified workforce – through appropriate regulation and registration, accreditation, training and continuing professional development
- Increase the supply of workers in certain identified health professions – and facilitate better distribution of the workforce in terms of geography and services provided
- Continue to develop the peer support workforce in mental health, ensuring it reflects Australia's cultural diversity and operates as part of effective multidisciplinary teams
- Support improved Indigenous health – through activities that promote a diverse workforce including the recruitment of Aboriginal and Torres Strait Islander health practitioners to increase the capacity to address the needs of Indigenous people.

CONTEXT AND CONTACT DETAILS

This paper is one in a series developed by AHCRA focussing on the future of Australia's health system. The other papers in the series include: Universal Health Care; Primary Health Care; Mental Health; Prevention; Aboriginal and Torres Strait Islander Health; Oral Health; and Efficient Opportunities in the Australian Healthcare System. These position papers are all available on the AHCRA website www.healthreform.org.au

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