Health Professionals Workforce Plan Taskforce

Discussion Paper to inform and support the NSW Government's Health Professionals Workforce Plan

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Foreword

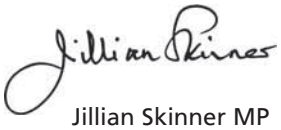
With the challenges facing the health system from an ageing population, increases in chronic disease and the changes arising from the National Health and Hospital Reform it is vital that NSW Health has an adaptable, flexible and skilled workforce able to meet future challenges. The NSW Government is committed to a 10 year ***Health Professionals Workforce Plan*** as part of its overall ***Plan to Provide Timely, Quality Health Care***.

Underpinning the Plan to Provide Timely, Quality Health Care, is the focus on patients and ways to improve their access to quality health care. The Health Professionals Workforce Plan will be a key enabler to achieving this.

Another key commitment of the NSW Government is to ensure a culture and working environment in the public health system where our hardworking doctors, nurses and allied health staff are respected, supported and can spend more time caring for patients.

This discussion paper is an opportunity for you to provide input as to how the Health Professionals Workforce Plan 2011-2025 can best develop and support our health professionals to provide excellent care for patients.

Dr Mary Foley
Director-General



Jillian Skinner MP
Minister for Health

Message from the Chair of the Taskforce

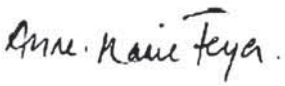
As Chair of the Health Professionals Workforce Plan Taskforce I am pleased to provide this discussion paper as a first step in opening the conversation about the NSW Health system and what changes are needed to ensure that we have the right workforce to provide quality health services to the people of NSW.

This discussion paper has been developed to gain wide-spread feedback on the key workforce challenges facing the NSW Health system, what the workforce will need to look like to meet these challenges, and potential strategies that need to be put in place now to ensure that we get there. Throughout this paper there are a number of discussion points with key questions raised. These questions are designed as a platform for the discussion on these challenges. A summary of the discussion points is also included at the start of the Discussion Paper.

The input of a broad range of stakeholders is vital to the process. The paper is available at www.health.nsw.gov.au/workforce/hpwp. Your feedback on these questions can be submitted via the website at https://surveymonkey.com/s/HP_Workforceplan.

Feedback gathered during the consultation process in October will be used to form the foundation of the Health Professionals Workforce Plan 2012-2025, which will guide workforce priorities, policy and action.

I encourage you to provide feedback, ideas and thoughts via the website by 14 November 2011.



Dr Anne-Marie Feyer
Chair, Health Professionals Workforce Plan Taskforce

Discussion Points Summary

Discussion Point	Section	Questions
Discussion Point One	Health Care Settings	Does the use of health care settings provide a sound basis for better integrating workforce planning with service planning? Why/Why Not?
Discussion Point Two	Health Workforce Reform for More Effective, Efficient and Accessible Service Delivery – Workforce Redesign and Scope Of Practice	Workforce Design/Redesign focuses on optimising the use of the existing workforce. Do you have any examples of where workforce redesign or changes in scope of practice have occurred locally, nationally or internationally? How did this redesign/change benefit patient care or workforce recruitment and retention? What made this strategy effective? How do we determine the most effective scope of practice consistent with quality patient care?
Discussion Point Three	Health Workforce Reform for More Effective, Efficient and Accessible Service Delivery – Collaborative Practice	What examples do you have of effective collaborative practice? How were the barriers to collaborative practice addressed? Is collaborative practice supported by both the education and health service delivery institutions in NSW?
Discussion Point Four	Health Workforce Reform for More Effective, Efficient and Accessible Service Delivery – Expanding Opportunities for Generalists	How would building a generalist workforce assist health care provision to 2025 and provide expanded opportunities for medical graduates? What strategies do you think will be most effective in developing a generalist workforce? How do you attract new health professionals to a generalist career?
Discussion Point Five	Health Workforce Reform for More Effective, Efficient and Accessible Service Delivery – Improving Workforce Distribution	What changes need to be made to education and employment models to ensure effective rural health service delivery? What strategies are most effective in attracting and retaining a rural workforce? What strategies would assist rural communities in developing their workforce from the community?
Discussion Point Six	Health Workforce Capacity and Skills Development - Education and Training	What curriculum changes are required for the current health education and training systems to provide a workforce that is fit to practice? Are changes to the way we educate our health workforce necessary? If so, what needs to change and for which professions? What role can NSW Health play in ensuring that education programs (university and VET) provide us with a workforce that is, on graduation, able to meet the patient care needs of NSW, at the beginning level of practice?

Discussion Point	Section	Questions
Discussion Point Seven	Health Workforce Capacity and Skills Development - Attraction Strategies	Is attracting workers from other industries and reskilling a viable option for the health sector, and if so in what professions? Are there strategies that can improve the way in which education systems can retrain workers with existing skill sets into new roles/careers? What are some of the most effective attraction strategies that you have used to attract workers to difficult to fill roles?
Discussion Point Eight	Health Workforce Capacity and Skills Development - Career Planning and Support	Would a structured career planning approach for new practitioners and for existing workers assist with retention? What are the most important messages to include in promoting Health careers? What is an effective way to provide mentoring and support across NSW Health? How can we best provide support and development to staff in rural locations?
Discussion Point Nine	Leadership for the Sustainability of the Health System	How can NSW Health create a culture that values the role of leader, preceptor and educator? What support programs are needed to develop an understanding of leadership roles? What education or workplace programs have been effective in developing leadership skills?
Discussion Point Ten	Health Workforce Planning	A skilled and able workforce is essential to the delivery of healthcare services. Service design with limited regard for the workforce can exacerbate workforce shortages What improvements can be made to ensure that strategic workforce planning is an integral part of any service development/design initiative at the local and state-wide level?
Discussion Point Eleven	Health Workforce Policy, Funding and Regulation	What employment models would assist NSW Health to create an attractive and supportive working environment for health professionals? What are the barriers to implementing those employment models, and how would they be overcome?

Contents

The Context

1.1 The NSW Health Professionals Workforce Plan 2012-2025

The NSW Government outlined its vision for health in its *Plan to Provide Timely, Quality Health Care.* The plan detailed action against three priority areas;

1. **Keeping people healthy and out of unnecessary hospitalisation:**

- Preventative health; and
- Better management of chronic disease

2. **Fixing public hospitals to improve patient access to timely, quality health care:**

- Restoring local decision making;
- More beds available and employing more nurses;
- Relieving emergency department blockages by addressing occupancy rate of acute adult overnight hospital beds;
- Introducing transparency to the management of waiting lists and operating theatres for elective surgery; and
- Providing improved facilities, equipment, treatment and medical retrieval.

3. **Returning Quality Services to Mental Health, Dental Health & Indigenous Health.**

One of the key commitments was a ten year Health Professionals Workforce Plan and a Taskforce has been established to help progress this commitment.

In line with the Government's commitment the *Health Professionals Workforce Plan 2012-2025* will ensure NSW trains, recruits and retains doctors, nurses and midwives and allied health professionals, working with the Commonwealth, Health Workforce Australia, colleges and universities to do so. It will also consider new models of care involving interdisciplinary teams undertaking varied roles.

The *NSW Health Professionals Workforce Plan 2012-2025* will be implemented against a complex background of macro factors. The environment is one of change in communities, patients and workforce. Patient need is shifting from an acute to a chronic model placing a greater emphasis on the need for effective primary and preventative health care. There is also a continued need to focus on prevention strategies where there is inequity in health outcome, such as that which occurs in Aboriginal and rural and remote communities.

Clearly, the changes taking place are not confined to NSW, and are occurring nationally and internationally. Accordingly, major national health system and workforce reform are also prominent features of the current environment.

The implementation of the *Health Professionals Workforce Plan 2012-2025* will need to take account of these broader changes in communities and the workforce in addressing the challenges facing the NSW community and NSW Health.

1.2 Changing Communities

The rate of change that individuals, communities, systems and organisations experience over their life cycle is accelerating. Often this change is associated with technological change. Kurweil (2001)[1] posits that consideration of the pace of technology shows that the rate of progress is not constant, and that it is human nature to adapt to the changing pace, so the pace of change will continue at an exponential rate.

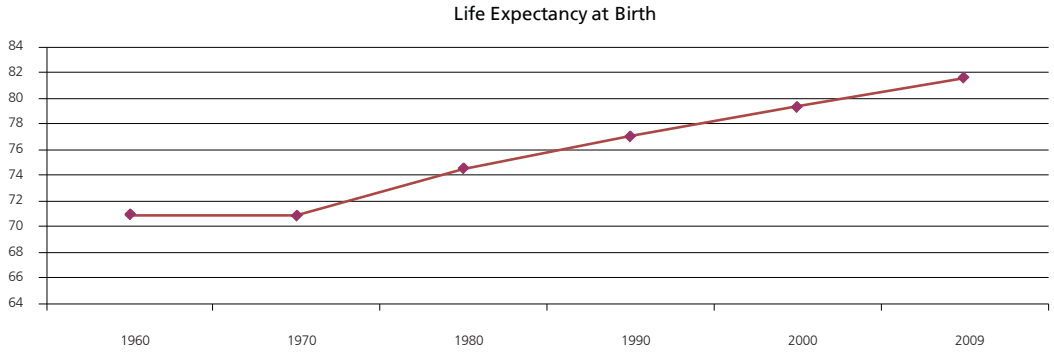
We have moved exponentially and quickly from one telephone in a fixed location in a home to mobile technology and smart phones, from computers that took up whole rooms to laptops, from 42% of households having access to the internet in 2001 to 67% in 2007[2], from operations requiring extended length of stays to laparoscopic procedures as day surgery. However, change is also evident in our lifestyles and communities.

It is not the case that we will experience a hundred years of progress in the twenty-first century; rather we will witness in the order of twenty thousand years of progress (at today's rate of progress, that is)

Kurzweil, R (2001)

Smoking rates in Australia have reduced dramatically from 43% of all people in the 1960s to 17% in 2007[3]. Conversely obesity rates in Australia have increased from 8% of the population in 1980 to 24% in 2007[4]. We are living longer, with life expectancy at birth rising from 70 in 1970 to 81 in 2009[5], but having fewer children, with fertility rates declining from 2.86 in 1970 to 1.9 in 2009.[6]

The world of work has also changed. The average number of hours worked per week has decreased over the last three decades, falling from 35.7 hours per week in 1979 to 32.8 hours per week in 2009, largely due to an increase in the proportion of people working part time. The average hours worked by full-time workers rose during the 1990s, peaking at 41.3 hours per week in 2000, but decreasing to 39.7 hours per week in 2009[7]. The participation rates for women in the workforce has increased from 44% in 1979 to 59% in 2009.[8]



1 Kurzweil, R (2001) The Law of Accelerating Returns. [online] http://www.kurzweilai.net/the-law-of-accelerating-returns

2 OECD (2010), "Country statistical profile: Australia", Country statistical profiles: Key tables from OECD.doi: 10.1787/20752288-2010-table-aus

3 Source: OECD Health Data 2011 http://stats.oecd.org/Index.aspx?DataSetCode=HEALTH_LVNG

4 Source: OECD Health Data 2011 http://stats.oecd.org/Index.aspx?DataSetCode=HEALTH_LVNG

5 Source: OECD Health Data 2011 http://stats.oecd.org/Index.aspx?DataSetCode=HEALTH_STAT

6 www.oecd.org/els/social/family/database

7 Australian Bureau of Statistics (2010) 1370.0 - Measures of Australia's Progress, 2010 http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/1370.0~2010~Chapter~Hours%20worked%20(4.3.5.5)

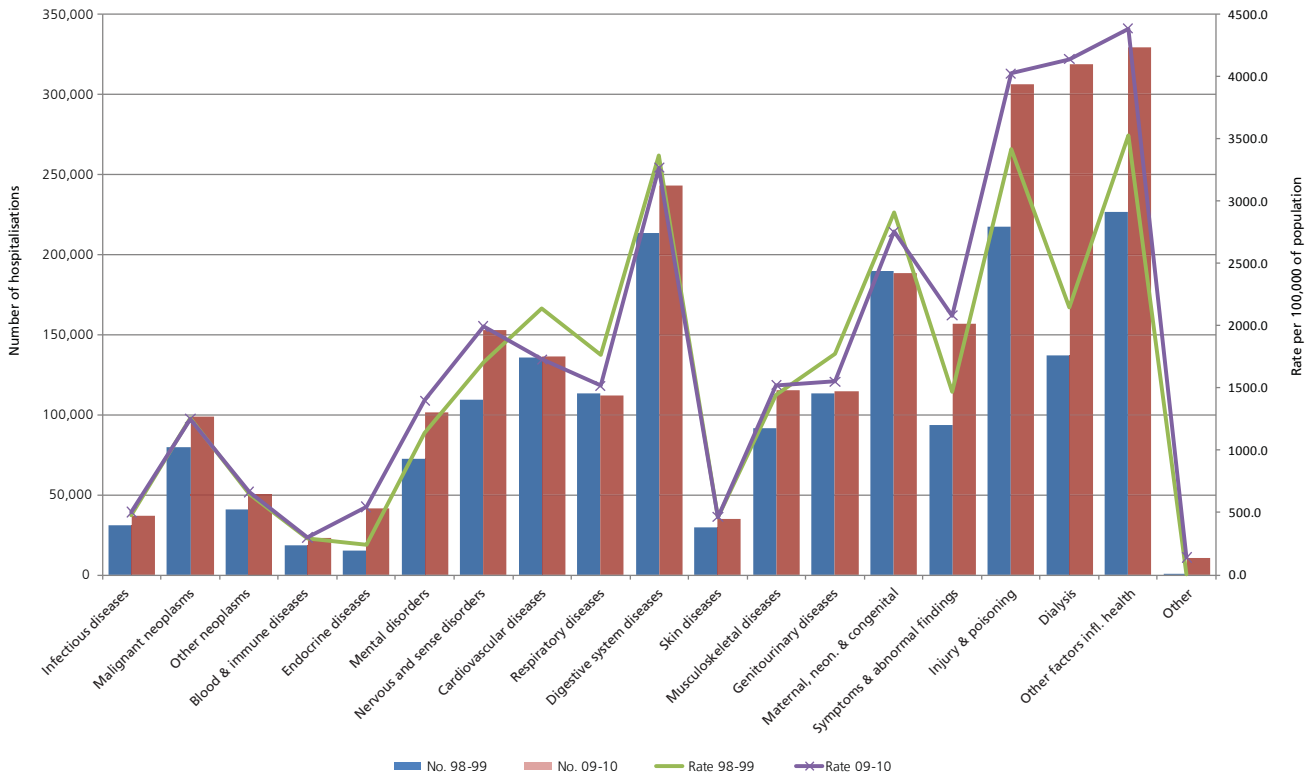
8 Source(s): ABS Labour Force, Australia, Detailed - Electronic Delivery (cat. no. 6291.0.55.001) http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/1370.0~2010~Chapter~Labour%20force%20participation%20(4.3.5.2)

1.3 Changing Patient Profile

In the 1960s the health care systems in many countries were focused on treating infectious diseases, although acute illness was already the predominant reason why most people sought medical care. During the past 50 years, health care systems have gradually transformed themselves to focus on treating acute illnesses. Currently, the predominant reason why people seek medical care in many countries is chronic disease. As a result, another transformation is underway and countries are beginning to respond to the growing cost and prevalence of chronic conditions. The latest challenge is the growing prevalence, cost and poor outcomes associated with people with multiple chronic conditions.[9] Further details of these analyses can be found in the Technical Paper.

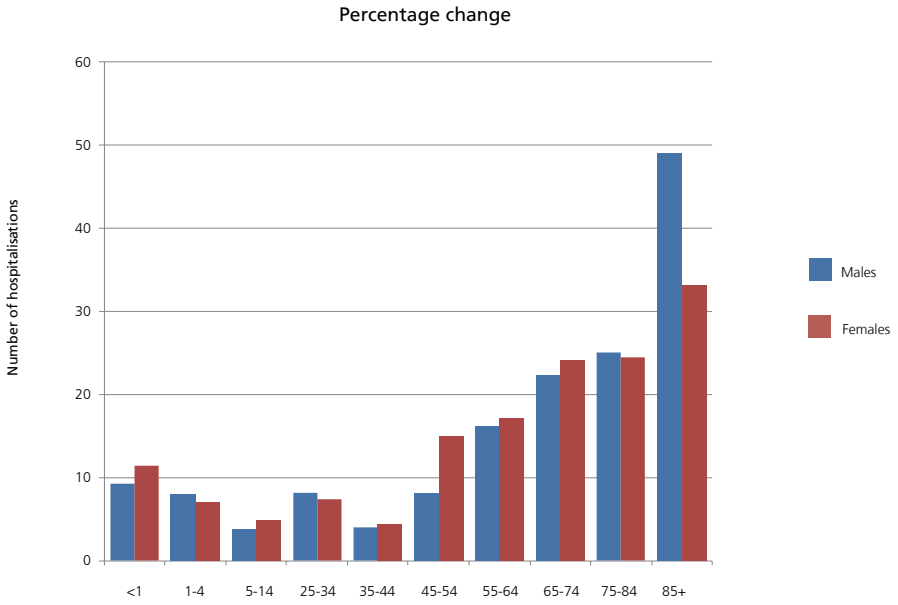
Patients in NSW reflect an ageing community and an increase in patients with chronic illnesses. The changes over time of the reasons for hospitalisations in NSW Local Health Districts (LHDs) indicates that there has been a greater increase as a proportion of the population in hospitalisations for dialysis and injury and poisoning.

The ageing of patients is not only a feature of NSW. Nationally our patients are ageing. The growth in hospitalisations between 2005/2006 and 2009/2010 in Australia shows a dramatic increase in hospitalisations in those over 55, and markedly in those over 85.[10]



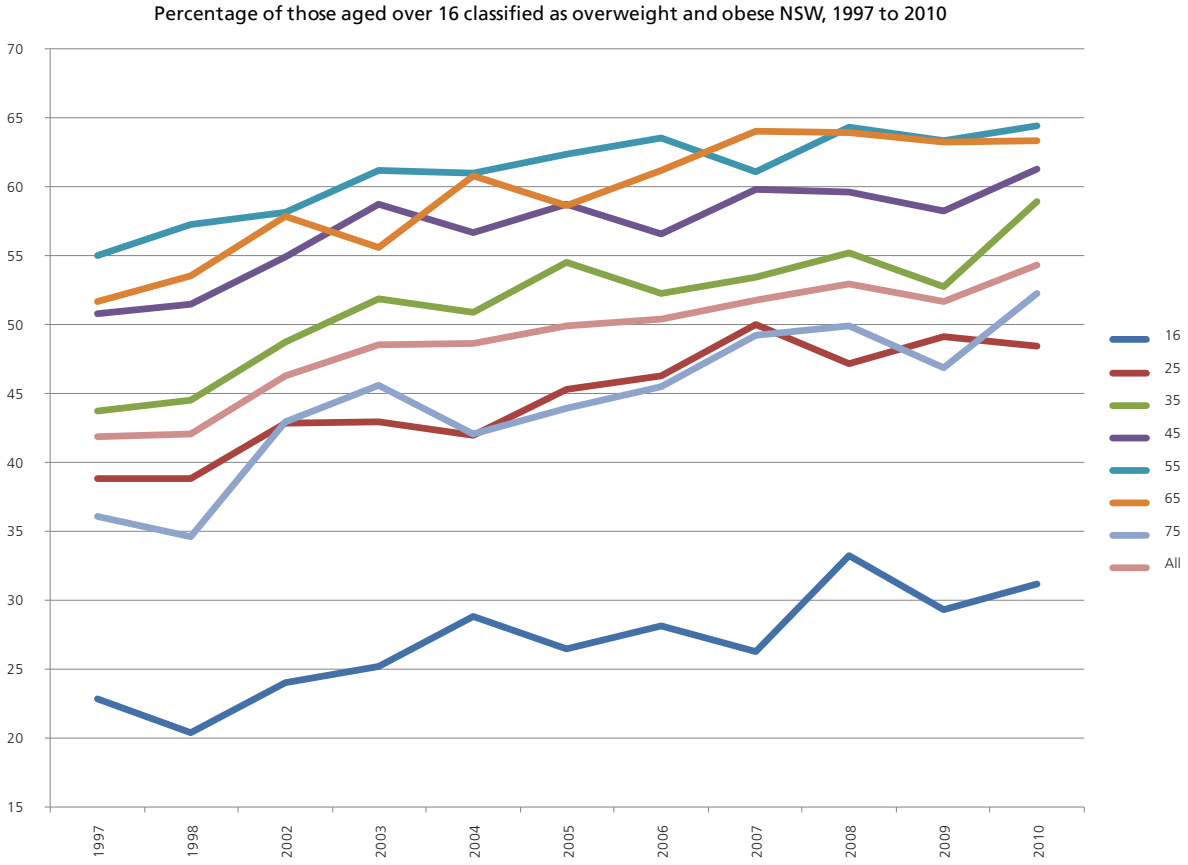
9 Anderson, G (2011) For 50 Years OECD Countries Have Continually Adapted To Changing Burdens Of Disease; The Latest Challenge Is People With Multiple Chronic Conditions. [online] http://www.oecd.org/document/17/0,3746,en_2649_37407_48127569_1_1_1_37407,00.html

10 Australian Institute of Health and Welfare (2011) Australian hospital statistics 2009–10 [online] http://www.aihw.gov.au/publication-detail/?id=10737418863



% change in hospitalisations by age and gender for all Australian hospitals, between 2005/2006 and 2009/2010

Prevalence of risk factors for chronic disease is steadily increasing. The incidences of people who are overweight or obese in NSW is increasing. The increase in the proportion of NSW amongst people aged over 16 classified as overweight or obese in NSW rose from 41% in 1997 to 54% in 2010.[11]



[11] Centre for Epidemiology and Research. Health Statistics New South Wales. Sydney: NSW Department of Health. Available at: www.healthstats.doh.health.nsw.gov.au. Accessed 13 Sept 2011.

1.4 Changing Workforce Profile

The workforce that provides our health services is also changing. The following provides an overview, with detailed analyses available in the Technical Paper.

A profile of the **Medical Workforce** in NSW[12], for both public and private practitioners, shows that in the last nine years there has been a reduction in the proportion of medical practitioners working as general practitioners, and a reduction in proportion working in hospital non-specialist roles. Specialists in NSW are getting older and working less hours but are more likely to be working in non-metropolitan settings than previously. Specialists in training are now more likely than previously to be equally female or male, but are dramatically reducing the hours they work.

Generally, there has been a decrease in the proportion of specialists, specialists in training and general practitioners indicating their location for work as metropolitan, which indicates more practitioners in regional or remote settings. There has however been no change in hospital non-specialists working in metropolitan locations.

	Proportion		% Male		Average Age m/f		Average Hours m/f		% in metro	
	2000	2009	2000	2009	2000	2009	2000	2009	2000	2009
General practitioner	40	38	69	60	51/43	55/52	50/46	43/32	82	77
Specialist in Training	10	11	63	51	32/32	34/33	54/49	47/43	94	91
Specialist/Consultant	35	37	84	74	51/45	52/46	50/42	43/36	90	77
Hospital Non-Specialist	15	10	55	48	32/32	34/31	50/46	36/42	87	87

For the **Nursing Workforce**[13] (which includes midwifery) the ratio of Enrolled Nurses to Registered Nurses has only slightly changed in the nine years between 2000 and 2009. The workforce remains predominantly female, works in the public system and in a hospital setting. A greater proportion of Registered Nurses indicate their work location as metropolitan compared to Enrolled Nurses. One factor that may contribute to this greater distribution of Enrolled Nurses in non-metropolitan locations is the differential acuity in regional and remote facilities.

	Proportion		% Female		Av. Age m/f		% in metro		% in public sector		% in hospital setting	
Nurse	2000	2009	2000	2009	2000	2009	2000	2009	2000	2009	2000	2009
Registered	83	84	92	90	42/42	44/46	63	65	74	70	63	60
Enrolled	17	16	93	90	38/42	43/47	47	49	75	73	57	62

There has been an increase in the female representation of **Dentists**, who overall are getting older. Female Dentists are working fewer hours, whilst the average hours worked has not changed for male Dentists. Dentists predominantly work in metropolitan settings.

	% Male		Average Age m/f		Average Hours m/f		% in metro	
	2000	2009	2000	2009	2000	2009	2000	2009
Dentists	77	68	42/37	52/42	40/40	40/34	80	79

12 2000 and 2009 Medical Labour Force Profile, NSW
13 2000 and 2009 Nursing Labour Force Profile, NSW

The profile for the **Physiotherapist** workforce shows there has been no real change in the gender makeup of the profession. However, Physiotherapists are getting older and in the case of female Physiotherapists, working fewer hours, and - in the main - in metropolitan locations. **Pharmacists** are most likely to be employed in retail/private settings, have increased the proportion of female practitioners and are also working fewer hours. The average age of male **Psychologists** has increased and their average hours have increased, however for females the average age has remained stable but the average working hours have decreased significantly.

	% Female		Av. Age m/f		Av Hours m/f		% in private sector		% in metro	
	2000	2009	2000	2009	2000	2009	2000	2009	2000	2009
Physiotherapist	74	73	33/37	37/41	36/37	43/31	58	54	77	79
Pharmacist	49	55	50/40	47/38	41/41	40/34	86	72	76	80
Psychologist	69	76	45/39	49/39	41/42	43/31	35	35	78	77

The size of the NSW Health Workforce as a proportion to the population has increased for all health professionals in the period between 2005 and 2010.

Workforce Profile: NSW Health Workforce Growth

Clinical Staff per 100,000 Population Medical, Nursing and Allied Health (NSW)

2010

Medical	% Female
Nursing	119.55 FTE/100,000
Allied	113.44 FTE/100,00

2008

Medical	% Female
Nursing	110.32 FTE/100,000
Allied	105.00 FTE/100,00

2005

Medical	% Female
Nursing	498.22 FTE/100,000
Allied	96.04 FTE/100,00

5 Year Growth FTE/100,000 2005 - 2010

Medical	% Female
Nursing	53.7 FTE/100,000
Allied	17.4 FTE/100,00

2 Year Growth FTE/100,000 2005 - 2010

Medical	% Female
Nursing	4.33 FTE/100,000
Allied	8.44 FTE/100,00

1.5 National Workforce Reform Context

In February 2008 the Federal Cabinet formally approved the establishment of the National Health and Hospitals Reform Commission, responsible for developing a long-term health reform plan for Australia. The plan[14] details the action to be taken across four themes against the reform goals of

- tackling the major access and equity issues that affect people now,
- redesigning the health system to meet emerging challenges and
- creating an agile and self-improving health system for future generations.

Given the pressures facing the community from an ageing population, a community with more chronic health care needs, and inequities in health outcomes for the Aboriginal population, the Commission recommended reforms to the way that hospital acute services are provided, an increased focus on prevention and primary care and programs to address the health needs of specific groups within our population

As a result of the National Partnership Agreement for Hospital and Health Workforce Reform (2008), Health Workforce Australia (HWA) was established in 2009 as a body to operate across the health and education sectors to devise solutions that effectively integrate workforce planning, policy and reform with the necessary and complementary reforms to education and training.

In 2010 the Australian Health Ministers Conference (AHMC) signed off on a work program for HWA that included the development of a *National Health Workforce Innovation and Reform Strategic Framework for Action*. The purpose of the Framework is to support sustained national effort and to support and guide work at the jurisdictional and local levels.

The *National Health Workforce Innovation and Reform Strategic Framework for Action* 2011–2015 is a national call for action for workforce reform across the health and education sectors. The aim of the Framework is to help to reshape Australia's future health workforce while supporting and enabling the productivity of the existing workforce.

It aims to attract and retain a highly valued workforce and to expand the size and nature of the future workforce to meet current and emerging demands. The Framework outlines actions across five domains of reform, which provide guidance for workforce reform at the state and National level:

- Health workforce reform for more effective, efficient and accessible service delivery;
- Health workforce capacity and skills development;
- Leadership for the sustainability of the health system;
- Health workforce planning; and
- Health workforce policy, funding and regulation.

1.6 Changing Nature of Health Service Delivery

1.6.1 Introduction

The NSW Government believes that those closest to the patient are best equipped to make good decisions about improving health care. Consistent with international trends of localism and devolved management of health care systems, local clinicians and communities need to have a real say in decision-making at their local hospital or health service, and that they have access to transparent information to make those decisions.

To facilitate this Local Health Districts have been established with a key focus on restoring local decision-making. Local Health District Boards are now responsible for leading, directing and monitoring the activities of Districts and Specialty Networks in a way that is responsive to patients, clinicians and communities. Their functions include ensuring that effective clinical and corporate governance frameworks are established; approving systems that support the efficient and economic operation of the district, to ensure the network manages its budget, to ensure performance targets are met, and to ensure that resources are applied equitably to meet the needs of the local community .

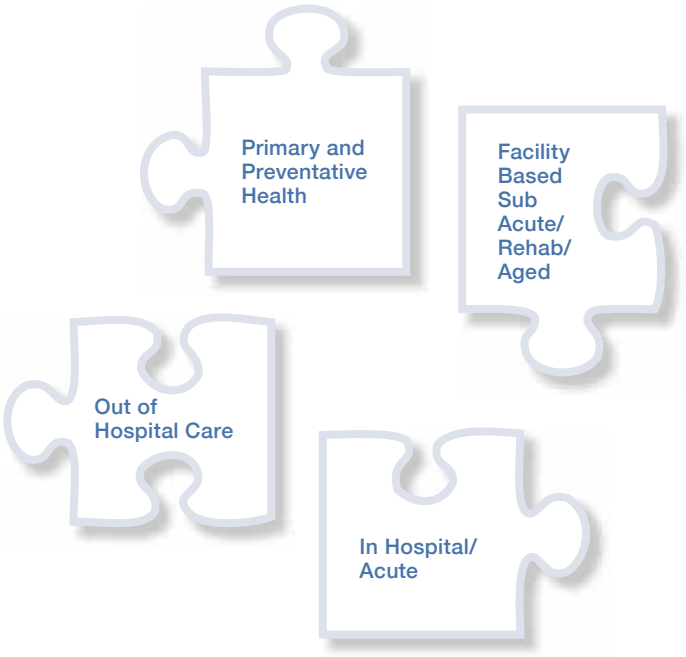
This new District structure addresses the trend to localism and patient centred care across a continuum of healthcare settings, positioning the health system well to take a fresh look at how to best marry workforce planning with health services planning.

[14] Commonwealth of Australia 2009. A healthier future for all Australians - National Health & Hospitals Reform Commission Final Report June 2009.

1.6.2 Workforce Planning Across the Continuum of Care

In considering the health professional workforce needs into the future it is critical to envision roles in the context of service delivery and the drivers of service demand.

In the 1960s most health care systems were hospital centric. This was both a legacy of the infectious disease era and the beginning of the acute illness orientation. Between 1960 and 2008, the percentage of the total health bill spent on hospitals in most OECD countries increased initially as the acute care era became predominant and later decreased as the prevalence of chronic disease increased. For example, in Australia, 40.4% of all health care spending was for hospital services in 1960; the percentage peaked at 52.7% in 1977; and by 2007 it had declined to 39.9%.[15]



The discussions in this paper around health service delivery are considered within the main health care settings by which services are arranged:

- Primary and Preventative Health
- Out of Hospital Care
- In Hospital/Acute
- Facility Based Sub Acute/Rehabilitation/Aged Care

Considering workforce requirements in the context of healthcare settings aims to avoid the traditional "siloed" professional workforce planning and recognises the complexity of health care provision into the future. The use of the term "health care settings" is not intended to represent "bricks and mortar" but rather services provided addressing particular patients' needs. Moreover, vulnerable and special needs groups – Aboriginal people, rural and remote communities, those with mental health disorders, for instance – need to have services provided across all care settings.

Discussion Point One

Does the use of health care settings provide a sound basis for better integrating workforce planning with service planning?

Why/Why Not?

[15] Anderson, G (2011) For 50 Years OECD Countries Have Continually Adapted To Changing Burdens Of Disease; The Latest Challenge Is People With Multiple Chronic Conditions. [online] http://www.oecd.org/document/17/0,3746,en_2649_37407_48127569_1_1_1_37407,00.html

1.6.3 Primary and Preventative Health

Currently, the predominant reason why people seek medical care in many countries is chronic disease. As a result, transformation is underway and countries are beginning to respond to the growing cost and prevalence of chronic conditions. The latest challenge is the growing prevalence, cost and poor outcomes associated with people with multiple chronic conditions.[16]

The Commonwealth is responding to this with the introduction of Medicare Locals. General practitioners will remain the centre of the primary health care system and continue to work with individual patients to determine what clinical care they require – but Medicare Locals will take responsibility for the primary health care needs of each local community.

The shift in patient need from an acute to a chronic model places greater emphasis on the need for effective primary and preventative health care. Whilst in Australia in the main, private practitioners provide the majority of primary health care services[17], the shift will have an impact on health service delivery for NSW Health. There will be greater need for collaboration between the primary and acute and subacute areas of NSW Health with an aim to ensure people are being be treated in the most appropriate place for them, to avoid hospitalisations, and to keep people well for longer.

Best medical practice and simple common sense indicate that our primary activity focus should be on preventative health measures. Keeping people out of hospital in a way consistent with their best medical interests is vital.[18]

The focus on preventative health will increase, with an increasing focus on healthy weight and healthy eating. There will be a continued need to focus on prevention strategies where there is inequity in health outcomes associated with potentially preventable hospitalisations. The Office at Preventative Health is being created to provide recommendations on preventative health strategies for NSW.

1.6.4 Out of Hospital Care

"A strong integrated network of primary and community health services that are also integrated with other parts of the health system and wider human services sector can lead to a healthier population, reduced health inequalities, and less need for more intensive and expensive treatments including hospital inpatient care"[19]

With an expected increasing strain on the health system due to an ageing population with more chronic issues there will continue to be an emphasis on treating people out of acute care settings, reducing length of stay and overnight admissions and trying to prevent health issues arising.

Hospital Care at Home is clinical care that reduces the length of stay in hospital or in some instances can avoid an admission altogether. A range of clinical conditions can be effectively and safely managed without a patient needing to stay in hospital. There is evidence that certain conditions can be well managed through this type of care, including cellulitis, pneumonia, deep vein thrombosis, chronic obstructive pulmonary disease (COPD) and urinary tract infections. Providing this option for patients who are suitable to be managed Out-of-Hospital, saves the patient an unnecessary stay in hospital and makes sure NSW has beds available for patients who need to be in hospital for their care.

In rural and remote communities particularly, alternative models such as 'hub-and-spoke' or 'walk-in-walk out' models and innovative e-health models to tackle issues of distance and professional isolation[20] will be required. Intersectoral approaches involving working with other sectors (such as education, housing, industrial, legal and communication sectors) will also be needed to produce the best outcome for improvements in population health. Interprofessional team-based care focuses on the importance of health professionals working collaboratively, often beyond the boundaries of traditional practice models, to provide effective care to those living outside urban centres.[21]

16 Anderson, G (2011) For 50 Years OECD Countries Have Continually Adapted To Changing Burdens Of Disease; The Latest Challenge Is People With Multiple Chronic Conditions. [online] http://www.oecd.org/document/17/0,3746,en_2649_37407_48127569_1_1_1_37407,00.html

17 NSW Department of Health, 2006. Integrated Primary and Community Health Policy 2007–2012. Sydney: NSW Department of Health [online] http://www.health.nsw.gov.au/policies/pd/2006/pdf/PD2006_106.pdf Accessed 29 August 2011

18 Health Services Amendment (Local Health Districts and Boards) Bill 2011. Second Reading)

19 NSW Department of Health (2007). Future Directions for Health in NSW – Towards 2025 – Fit For the Future.[online] http://www.health.nsw.gov.au/pubs/2007/pdf/future_directions.pdf

20 Commonwealth of Australia (2008) "Towards a National Primary Health Care Strategy. A Discussion Paper from the Australian Government.

21 The Australian Rural Health Education Network

1.6.5 In Hospital-Acute Care

The need for an acute care system will remain. The challenge will be to ensure that the acute system is able to direct its resources to dealing with acute episodes, and not become focussed on dealing with sub acute health care as a de-facto model of care due to a lack of services or lace of access to primary, community, sub-acute or aged care services.

The inpatient projection model used by NSW Health aIM 2010 (Acute Inpatient Model) - has been developed to take into account projected growth in inpatient activity based on specialty groupings (SRGs – service reference groups). The largest projected growth in is renal medicine, endocrinology and ophthalmology – all specialities associated with the increase in rates of diabetes. There is also a projected growth in non subspecialty medicine. The lowest growth areas are cardiothoracic surgery, transplantation, gynaecology and obstetrics and drug and alcohol. The projected increases for the Acute Inpatient Model (aIM) type of stay in NSW public hospitals indicates that there is a larger annual increase in same day procedures (2.5%) compared to the annual average increase in overnight hospitalisations (1.9%).

1.6.6 Facility Based Sub Acute /Rehab/Aged

NSW Health Sub Acute Inpatient Modelling (SiAM) projections indicate:[22]

- That there will be a significant growth in subacute active episodes (both day only and overnight) and patient days over the next two decades, and a slight decrease in average length of stay.
- In the public sector, overnight active episodes are projected to increase from 37,900 to 54,700 between 2008-09 and 2021-22, an annual average growth rate of 3.1 per cent.
- Day only episodes contributed 7,400 separations in 2008/09; by 2021-22, this is expected to increase to approximately 11,800. This represents a 4.0 per cent average increase per annum.
- The highest levels of growth in active episodes will occur for people aged 70-84 years and for people aged 85 years and over.

There is a need for a better transition from Hospital to the Home. This is critical to enable a decrease in admitted bed days. A critical issue is the level of support available outside the hospital – due to changing family dynamic, increasing numbers of older people have to rely on the health workforce to meet their basic needs. State-wide, there has been a 1.4% per annum growth in inpatient (overnight) bed days in rehabilitation over the last two years. Considering this growth is not proportional to the growth in acute activity nor growth in the aged population in the same period, it is likely to be a result of fixed system capacity rather than decreasing population need.[23]

[22] Source: Siam 2010, Strategic Planning and Capacity Development Unit, NSW Health

[23] NSW Health (2011) Rehabilitation Redesign Project [online] http://www.archi.net.au/documents/resources/models/rehab_redesign/rehabilitation-moc.pdf

Impetus for Workforce Reform in NSW Health

2.1 Introduction

Australia is generally regarded as having one of the best health systems in the world with government guaranteed universal access to public health care, mid range spending on health as a percentage of Gross Domestic Product (GDP) compared to other OECD countries, efficient health care delivery through a mixed public and private system and generally good health outcomes.[24] However, a larger older population and a comparatively smaller working age population can put a strain on publicly funded health and social services including healthcare, social care and pensions.[25] Quite apart from the chronic disease burden associated with an ageing population, the need to close the gap in health outcomes for indigenous Australians and perceptions of increasing demand pressures and fragmentation between health services due to differences in national and state and territory funding and governance arrangements, has resulted in calls for reform and renewal of the Australian health care system.[26]

The pressure for change and reform of the NSW health system was identified by the NSW Government in its Plan to Provide Timely, Quality Health Care. The Health Professionals Workforce Plan is an integral part of this reform. To support and inform the Health Professionals Workforce Plan the need for workforce reform is examined in relation to five major drivers: improving health outcomes; impending workforce shortages; geographical distribution of populations in NSW and access to services; the future affordability of health care; and, the increasing specialisation of healthcare professionals.

2.2 Health Outcomes

With the ageing population, chronic disease on the rise and an acute system under growing pressure, it is increasingly likely that people will be inappropriately forced into acute and residential care as a result of their care needs not being able to be met in the community. There have even been anecdotal reports of carers leaving aged relatives in Emergency Departments due to a lack of available respite or other community care.[27] With an ageing population with chronic and complex problems, there is a need to ensure that care is delivered in cost effective and appropriate settings. The acute sector is increasingly becoming the fall back position due to insufficient services in other sectors including community and aged care.

The projected growth in the population aged over 65 in NSW between 2008 and 2028 is 74%, compared to only 12% for the 20-64 year old age group.

With the shift in health burden changing the focus has shifted from acute to chronic health need. Change is required to the way, and the location in which, health services are provided. The differential health needs of sectors of the community also indicates a need to refocus the way we provide services.

A key case in point can be found in looking at the cause of hospitalisations in NSW during 2009-2010[28]. Aboriginal people had a lower rate per 100,000 of population for hospitalisations due to cancer, nervous system and sense disorders, digestive system disease and musculoskeletal and connective tissue diseases.

However in every other area, the hospitalisations rate was greater for Aboriginal people, with the greatest differences evident in hospitalisations for mental and behavioural disorders, cardiovascular disease and respiratory disease. For hospitalisations where dialysis was the reason for hospitalisation the difference was staggering.

[24] Cranny, C and Eckstein, G. (2010). Framework for Development of Primary Health Care Organisations in Australia [online] Accessed at http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/publications 29 August 2011

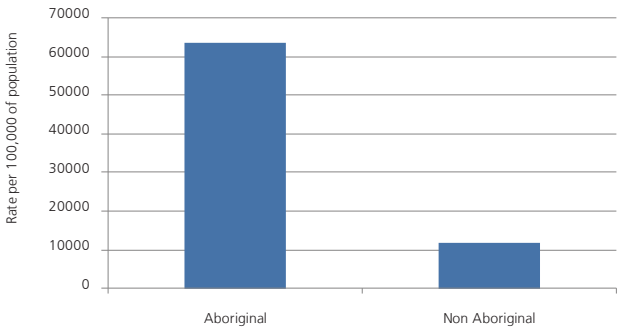
[25] Taylor, R (2011) Ageing, Health and Innovation: Policy Reforms to Facilitate Healthy and Active Ageing in OECD Countries [online] http://www.oecd.org/document/17/0,3746,en_2649_37407_48127569_1_1_1_37407,00.html

[26] Cranny, C and Eckstein, G. (2010). Framework for Development of Primary Health Care Organisations in Australia [online] Accessed at http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/publications 29 August 2011

[27] http://www.smh.com.au/national/why-old-souls-are-abandoned-20110521-1exnv.html, http://www.theage.com.au/victoria/tis-the-season-for-granny-dumping-20101217-190vt.html http://www.heraldsun.com.au/news/victoria/grannies-dumped/story-e6frf7kx-1111118250842

[28] Centre for Epidemiology and Research. Health Statistics New South Wales. Sydney: NSW Department of Health. Available at: www.healthstats.doh.health.nsw.gov.au. Accessed 14 Sept 2011

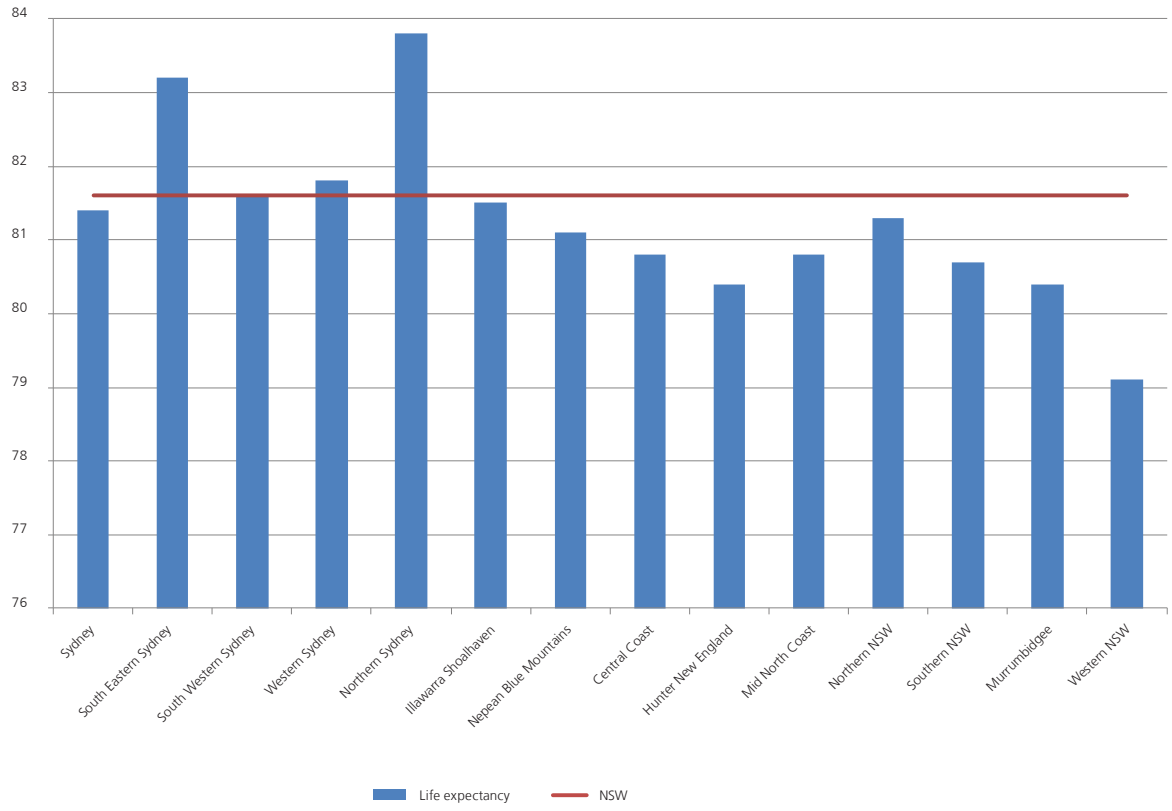
Factors influencing health: dialysis



Another key case in point can be found in health outcome disparity by geographic location in NSW. The life expectancy at birth differs between metropolitan cities and outer regional, regional and remote areas, as can be seen by the life expectancy for each Local Health District. Residents in the Western NSW Local Health District have a life expectancy 2.5 years less than the average NSW resident, and more than 4.5 years less than residents in Northern Sydney Local Health District (Data for Far West LHD not available).

Additionally, while patients are living longer with chronic illness the end point of their chronic disease is often death via an acute episode, which accounts for the heavier use of hospital facilities at the end of life. Treating chronic disease well may postpone this reliance. "Chronic disease increases with age, but it is possible to defer the onset, and confine its impact to a shorter duration at the end of life, so-called compression of morbidity. Morbidity compression firstly focuses policy on creating circumstances where people live healthy lives. Even if we cannot eliminate all cancer, diabetes, mental illness and heart disease, we can delay onset by many years, which is nearly as good demographically speaking".[29]

Life expectancy at birth, by Local Health District in NSW, 2003 - 2007



[29] Penman, A (2011) Addressing the impact of chronic disease in an aging nation [online] http://www.openforum.com.au/content/addressing-impact-chronic-disease-aging-nation

2.3 Workforce Shortages

NSW Health will struggle to meet the forecast growth required in the health workforce based on current health service patterns and models of care, as the differential growth in age groups in the population in general will mean that the working age population will not keep pace with the increased demand for service.

Growth in people in the age likely to be entering the workforce from school and post-secondary education (15 to 29 years) is projected to be much lower than general population growth, at 9.6%, or 142,000 people in total across NSW between 2008 and 2028. As an annual average growth this is only an average additional 7,118 people potentially available to enter education or the workforce. At a macro level, if you assume that the health sector in NSW increases its supply in proportion to the national share of the total labour force (7.7% in 2008, AIHW,2010, p. 406)[30] there would be, on average, some 548 additional people aged 15-29 per annum available to enter all health occupations in NSW (public and private).

However, not all members of a population cohort participate in the labour market, and participation rates vary by age and gender. So to look at this in some more detail for the NSW Health workforce using projections of the growth in NSW population between 2008 and 2028[31], the proportion of the 2008 population by age and gender that work for NSW Health[32], and current NSW Labour Force participation rates by age and gender[33] the likely projected size of the NSW Health workforce in 2028 based on maintaining our current labour force participation rates, is represented in the following table. This is representative for the entire instances of employment in the NSW Health workforce, including casual employees and non-health professionals.

Projected Workforce Supply Based on Population Growth in NSW

	2008		2028		Projected Growth - NSW Health	
Age	Labour Force	NSW Health	Labour Force	NSW Health	Number	Percent
20-24	398,727	7,414	433,449	8,077	663	8.9%
25-29	419,556	13,290	460,322	14,573	1,283	9.7%
30-34	404,008	14,861	472,365	17,350	2,489	16.8%
35-39	420,156	16,240	465,202	17,949	1,709	10.5%
40-44	402,976	15,882	462,697	18,287	2,405	15.1%
45-49	427,155	19,295	443,157	20,067	772	4.0%
50-54	366,398	18,001	406,627	20,045	2,044	11.4%
55-59	273,816	12,621	321,105	14,886	2,265	17.9%
60-64	163,787	6,403	207,773	8,192	1,789	27.9%
65-69	57,108	2,266	93,089	3,707	1,441	63.6%
Total	3,333,687	126,273	3,765,788	143,133	16,860	13.4%

30 Australian Institute of Health and Welfare 2010. Australia's health 2010. Australia's health series no. 12. Cat. no. AUS 122. Canberra: AIHW.

31 Centre for Epidemiology and Research. Health Statistics New South Wales. Sydney: NSW Department of Health. Available at: www.healthstats.doh.health.nsw.gov.au. Accessed 4 Aug 2011.

32 Source: HIE-PWP Annual 2008

33 Australian Bureau of Statistics (2008) Labour Force, Australia, Detailed - Electronic Delivery, Sep 2008 (cat. No. 9291.0.55.001)

However, this likely supply of employees falls short of the size that the workforce will potentially need to increase to meet current health service demand projections. The projected total increase of the workforce for all of NSW Health falls short of the projected demand even when only looking at the expected numbers of Nursing and Medical employees required. Based on the projected increase by 2028[34], there is a requirement for an increase of 26,000 employees for Registered Nurse, Enrolled Nurse and Medical positions. However the likely available increased supply of workers across ALL of NSW Health is only 16,860.

Projected Size of Workforce by Classification			
Classification	**2008**	**2028**	**Increase Required**
Registered Nurse	40,083	55,410	15,327
Enrolled Nurse	7,058	12,758	5,700
Medical	8,800	13,948	5,148
TOTAL			26,174

The potential shortfall of over 9,000 employees is even more concerning when it is considered that the 16,860 additional employees will also need to cover positions in Allied Health, Corporate and Administrative Services, Clinical Support and Technical and Scientific roles. Given that Nursing and Medical roles make up 50% of the workforce, and assuming that the other roles in NSW Health would increase at similar levels to Nursing and Medical positions, it is estimated that there will be a substantial shortfall of employees across NSW Health by 2028.

Another way to look at whether the supply is enough to meet our needs is to look at historical growth. Between 1998 and 2008 the NSW Health workforce increased by 15%. If the NSW Health workforce continues to increase by 15% each decade to 2028 to meet demand increase[35] the overall shortage of total employees could be over 20,000 by 2028. In order to meet this increase NSW Health would need to increase its proportion of the labour market from 3.8% to 4.43%. This attempt to increase the share of the labour market would occur in an environment of an increased demand in other sectors such as aged care, and within an increasingly competitive job market, in which NSW Health could be argued to already have challenges in attraction given, for example, unsocial working hours.

This shortfall is based on historical workforce growth projections. If, as expected, the demand for services increases with an ageing population and an increase in the burden of disease due to chronic conditions, then the growth in the workforce required could be even greater. The projected workforce shortfall would be even larger.

Initiatives that explore new service delivery models and ways of better utilising existing staff may increase workforce capacity and improve patient care and staff satisfaction by making best use of available skills.[36] Improving the supply of an optimally trained workforce across all areas is important. However, increasing workforce supply alone will be insufficient to manage workforce demand and ensure longer term service sustainability.

The NSW Government identified in its Plan to Provide Timely, Quality Health Care the intent to attract experienced nurses back to NSW hospitals and fill current nursing vacancies.

The 2011-12 NSW Government budget included funding for additional intern positions, medical specialist training positions and expansion of the medical training networks for emergency medicine, general medicine and radiology.

It also included funding to support additional nursing positions across a broad range of service settings including; medical, surgical, inpatient wards and units, mental health units and rehabilitation units.

[34] NSW Nursing and Medical Labour Force profile and internal modelling

[35] 1.5% annual increase falls between projected average NSW population growth of 1.12% (22.3% growth between 2008 and 2028) and the projected growth in service demand from the NSW Acute Inpatient Model (aIM) projections of 1.88% per annum) and so is considered to be a conservative growth increase

[36] Victorian Government (2009) Shaping the future: The Victorian mental health workforce strategy. Final report

2.4 Geographic Distribution of the Workforce

The Australian Standard Geographical Classification Remoteness Areas (ASGC -RA) system was implemented from July 1 2010 by the Department of Health and Ageing (DOHA) to replace existing systems including the Rural, Remote and Metropolitan Areas (RRMA) classification system in use for rural health workforce programs. The RA categories are defined in terms of remoteness - the physical distance of a location from the nearest Urban Centre (access to goods and services) based on population size. There are five categories: RA1 Major Cities; RA2 Inner Regional; RA3 Outer Regional; RA4 Remote; RA5 Very Remote. The RA classification is the basis upon which many Australian government and NSW rural health programs are assessed. Generally the more remote the location the greater the incentives, such as GP relocation allowances. A map showing the RA categories in NSW is included in the Technical Paper.

As with any broad classification system, the RA system is imperfect. Many smaller towns feel disadvantaged under the new classification system because they are now undifferentiated from larger cities and towns with the same RA classification, despite there often being differing levels of access to services. Moreover, many of the metrics we use to understand the distribution of service provision, for instance workforce to population ratios, do not comprehensively reflect the challenges faced by rural and remote NSW communities. While it is essential to recognise that these tools sometimes provide only crude estimates of health need and workforce complexity, equally, it is necessary to recognise that these are the tools currently available. Accordingly, contextualisation of the data is always required – the approach taken here. Further details of the analyses can be found in the Technical Paper.

Analyses of population data to workforce size do not always capture issues of access to services. The majority of metropolitan centres also have a range of other private and primary care options not as readily accessible by regional and remote populations. Therefore the issue of low population to workforce ratios is further exacerbated by a lack of alternative providers.

Additionally, the distribution of populations over greater geographic areas means that access to care is impacted in regional and remote Australia. NSW is no different in this regard. The dispersed nature of the population places heavy cost burdens on both consumers and providers of health care services because of the distances they are required to travel to access and provide health care. The tyranny of distance and lack of transport are major impediments to accessing healthcare for many rural Australians. Health care systems servicing the needs of rural and remote Australians cannot be seen apart from the transport system that either takes services to the people or brings patients to those services. [37]

An analysis of the NSW Health workforce data indicates that, using the RA classification, regional and remote Local Health Districts have a lower health workforce to population ratio compared to metropolitan facilities. The geographical maldistribution is evident across the Medical and Allied Health professions. The population to workforce ratio data illustrates that rural Local Health Districts have less favourable practitioner to population ratios in Medicine and Allied Health when compared with metropolitan LHDs.

This trend is less evident for the Nursing workforce where data suggests that some regional and remote LHDs have higher Nursing workforce to population ratios than metropolitan LHDs. This could be explained by changes to models of care within rural facilities to meet the challenges of providing quality care despite difficulties in recruiting a Medical workforce. Alternatively it could also be due to the prevalence of smaller facilities which do not have the volume of services to sustain a stable Medical or Allied Health workforce.

[37] Humphreys, J and Wakerman, J (undated) Primary health care in rural and remote Australia: achieving equity of access and outcomes through national reform. A discussion paper

An examination of the distribution of different classifications or employment types within a profession can also highlight difference based on locations. For example, in Southern NSW Local Health District (LHD) the distribution of permanent Medical positions to Visiting Medical Officer (VMO) positions is approximately 40/60. Additionally, possibly due to difficulties with attraction, the majority of permanent positions are filled by agency staff. The outcome of this is that Southern NSW LHD is mainly dependent on contract staff for medical services. In Murrumbidgee LHD the ratio of permanent positions to VMO positions is 70/30, and whilst they may also have difficulties with attraction the majority of permanent positions are filled permanently, so whilst Murrumbidgee LHD is still more reliant on a contract workforce than metropolitan LHDs the reliance is not as great as Southern LHD.

This situation illustrates a common issue across a number of rural facilities – the reliance on a contract workforce comprising either locums or short term fee-for-service VMOs. A short-term contract workforce impacts on the cost of providing services. Anecdotal information suggests that such a workforce is increasingly unwilling to participate in education and training activities and/or in afterhours cover. These challenges feed into a vicious cycle, as issues of workforce shortage are exacerbated. The rural facility is unable to attract a more stable workforce (despite overall increases in supply) as it cannot provide Medical, Nursing and Allied Health students and postgraduate trainees with training, and so fewer graduates gain exposure to rural facilities.

In many Allied Health professions, the majority of the workforce provides services in the private sector. While there may be an adequate supply of new entrants to the workforce statistically, it should be remembered that there are significant locations in NSW where the community have little or no access to private practitioners. Consequently, these communities rely solely on publicly funded allied health professionals for their care. This is particularly relevant in some outer regional areas, most small rural locations and remote communities.

2.5 Affordability

The *2010 Intergenerational Report Australia to 2050: future challenges* found that total government spending is projected to increase to 27.1% of GDP in 2049/50 with around two thirds of the projected increase expected to be on health. Spending on health will rise from 4% of GDP in 2009/10 to 7.1% in 2049/50 and the bulk of the increase will be on Medicare Benefits Schedule (MBS), hospital services and the Pharmaceutical Benefits Scheme. Aged care expenditure is also projected to rise significantly from 0.8% of GDP in 2009/10 to 1.8% by 2049/50 with residential aged care recording the highest growth. [38]

The Intergenerational Report indicates that demographics play an important role in increasing health system costs. In national terms:

- As the population ages, more people fall into the older age groups that are the most frequent users of the system. From 2009-10 to 2049-50, real health spending on those aged over 65 years is expected to increase around seven-fold. Over the same period, real spending on those aged over 85 years is expected to increase around twelve-fold.
- The Federal Government estimates that the proportion of working age to support each Australian aged 65 years and over will fall to 2.7, compared to 5 working age people today and 7.5 in 1970. (p. 4) [39]

2.6 Increasing Specialisation

From the late 1930s and 1940s, the growth of specialty medical colleges within Australia has mirrored the international trend away from generalism and towards specialisation. During the 1950s this trend was encouraged by fundamental changes in the nature of medical practice such as the growth of technology and increasing focus upon hospital-based services.

However, today's patients are presenting with multiple problems. Our health system is still largely based on a curative model of care which treats the predominant

[38] Cranny, C and Eckstein, G. (2010). Framework for Development of Primary Health Care Organisations in Australia [online] Accessed at http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/publications 29 August 2011

[39] Commonwealth of Australia (2010) Australia to 2050: future challenges. The 2010 intergenerational report Overview. Commonwealth Copyright Administration, Barton ACT. Page 8

problem of the patient at the time of the presentation. Given the variety of treatment options that can be offered to a patient with multiple and complex co-morbidities, health providers are increasingly required to have knowledge and skills which go beyond a particular sub speciality.

The medical specialities with greatest shortage[40] are general medicine, general surgery, geriatric medicine, palliative care and psychiatry.

Common themes across these specialities are their relative unpopularity amongst the Australian trained workforce. All these specialities rely heavily on the international medical graduate workforce; they are also an ageing workforce and have high attrition rates. The reasons for this picture are many and varied, but they have the following in common,

- *Patient mix* – general medicine, geriatric medicine and general surgery are usually faced with patients with complex and multiple co-morbidities. A significant proportion of their patient load is based on the inability of the patient to be treated in another sub-speciality.
- *Funding model* – the Australian health funding model is skewed towards remunerating procedural specialities at a higher rate. Whilst effort has been made to balance the payment system and remove some of the perverse incentives, further work is still necessary in this area.
- Inability to "cure" – the increasing advent of Allied Health and Nursing in clinical care has resulted in medical care being targeted towards patients with higher acuity. Whilst this is a desired workforce outcome, the inverse effect of an increasing acute patient mix is that the medical workforce is largely grappling with patients with such chronic morbidities that "cure" is not an option. This currently goes against the ethos of medical care and as a result younger doctor's tend to shy away from professions where they cannot "cure" a patient. This requires a rethinking of the current medical model for training and service delivery to enable a wider focus beyond short term treatment options to long term management of care.

It is clear that workforce strategies will only be part of the story in creating a sustainable workforce. Even with workforce design, attraction campaigns and additional training places the pressure on the available supply will be too great unless there is significant reform in the way that health services are delivered. Having more people within the health system cannot be the only strategy that we rely on in addressing the increased health burden.

[40] NSW Health, internal workforce modelling

What changes will be needed in the NSW Health Workforce?

3.1 Introduction

The answer to the question of what workforce is needed to respond to the changes in the population of NSW, in its size, make-up and health needs, and the changing balance of service delivery between health care settings, is not a simple one to answer. The concept of employment, attraction and retention are all impacted by the way in which the workforce is systemically designed, the skills that are needed versus the skills that are available or valued, the desires of individuals to work, the factors that motivate individuals to choose different professions and work in different areas, and the things that keep people satisfied in work.

In order to meet the expected increase in service delivery arising from an ageing population and the increasing burden of chronic illness, there are changes that need to be made in order to ensure efficient health service delivery. Some of these changes will involve looking at who provides different levels and types of care, and to which patients, in order to ensure that the most competent and cost effective workforce is delivering service. There will also be a need to address the trend of increasing specialisation in order to ensure that all communities are able to access appropriate health care. **What is clear is that more of the same is not the answer.** Given the shift in balance in the age profile of the population, with a growing older population requiring care, and a shrinking in the proportion of working aged people, the supply of workers will not be able to meet demand.

The following sections look at expected changes to the way that the workforce will need to be structured in an increasingly challenging environment, and some of the current and potential strategies to address the dual challenges of health service delivery and workforce - both in NSW and in other jurisdictions. These strategies are aligned to the five domains from the National Health Workforce Innovation and Reform Strategic Framework for Action 2011–2015. These domains will be used by NSW in the development of the Health Professionals Workforce Plan to capitalise on alignment with directions across Australia. Within those domains there is a myriad of options that can be taken to ensure NSW is taking steps to align strategies, policies and the workforce to what may be required in the future. A number of questions are posed to prompt discussion around these strategies and to seek feedback from stakeholders on refinement of the strategies and/or alternative strategies, as well as seeking to harness lessons learned elsewhere.

3.2 Health Workforce Reform for More Effective, Efficient, and Accessible Service Delivery

3.2.1 Workforce Redesign

Workforce redesign aims to improve service sustainability, including its ability to respond to changing demands while maintaining the quality of patient care. This is achieved by enabling the best possible use of the skills and competencies required of the workforce in the workplace.[41]

In delivering services that are integrated it is also necessary to consider the way in which the team is organised - the delineation of roles, task delegation (which professional completes which task) and task substitution (where a person from one professional background performs a task traditionally performed by another type of health professional) to maximise the use of the various skills of the team in order to provide effective and efficient care.[42]

Task shifting in the health workforce presents an option to accelerate the expansion of human resources while reorienting clinicians toward care coordination and the chronic disease model of primary care. Several components of a Medical Practitioners' competencies are teachable to mid-level providers (nurse practitioners and physician assistants). These mid-level providers can manage care coordination for less complex patients and can take on behavioural health counselling and routine tasks of

41 Victoria's Workforce Redesign Toolkit, [online] http://www.health.vic.gov.au/__data/assets/pdf_file/0015/360420/Victoria-Workforce-Redesign-Toolkit---Sept-25.pdf

42 "Zwar, N., Dennis, S., Griffiths, R., Perkins, D., May, J., Hasan, I., Sibbald, B., Caplan, G., Harris, M. (2007) Optimising Skill-Mix in the Primary Health Care Workforce for the Care of Older Australians: A Systematic Review. Australian Primary Health Care Research Institute. Available at http://www.anu.edu.au/aphcri/Domain/Workforce/Zwar_25_final.pdf "

Examples of Workforce Redesign Undertaken in NSW Health	
Role	**Description**
Emergency Department Physiotherapy Practitioner	• Primary care specialist physiotherapist, based in ED. • Provides specialised management for acute soft tissue injuries & bone fracture, seeing patients directly from triage. • Ability to investigate, treat & discharge this population of patients. • Provides referrals as appropriate to community based health care services. • Education role with nursing & medical staff.
Cardiac Liaison Nurse	• Facilitates optimal management of cardiac patients in the ED. • Facilitates rapid access to Exercise Stress Testing (EST) for appropriate patients presenting to ED with chest pain. • Facilitates efficient patient flow from the ED to cardiac clinical areas (including CCU, Cardiac Catheter Lab and the cardiology ward). • Liaises with patients & their families regarding admission processes & provides information related to admission, diagnostic tests & clinical condition. • Provides an educational resource for nursing & medical staff
Emergency Department Nurse Practitioner	• See and treat patients with minor injuries or illness. • Collaborative patient groups managed with senior ED medical staff • 'Fast tracking' patient groups. • Clinical assessment, diagnostics & therapeutic interventions in line with ED nurse standing orders and the ENP formulary. • Determine and identify health risk and initiate crisis interventions as appropriate. • Consult and refer to other health care providers within the ED and hospital. • Identify patients outside the scope of practice and refer/discuss as appropriate with a senior ED medical officer.

preventive health. This provides additional time for doctors to spend on those medically complex patients with multiple chronic conditions.[43]

Current example of task delegation and substitution in Australia can be found in general practice, with the increasing emphasis on the role of practice nurses supported by the Medicare Benefits Schedule (MBS) Practice Nurse items. This allows more efficient use of the skills of the practice nurse and general practitioner. Similarly, there have been recent changes to the MBS to allow greater use of the allied health workforce. On 1 November 2010, new laws came into effect that give eligible nurse practitioners and midwives access to specific items in the MBS and access to a limited list of items under the Pharmaceutical Benefits Scheme (PBS).

One solution trialled in rural locations in sites across Australia is the use of trained allied health assistants working under the supervision and delegation of allied health professionals located in larger sites. The introduction of vocational qualifications for allied health assistance and discipline specific allied health assistance such as physiotherapy assistance enables communities to have access to essential services closer to home.

[43] Anderson, G (2011) For 50 Years OECD Countries Have Continually Adapted To Changing Burdens Of Disease; The Latest Challenge Is People With Multiple Chronic Conditions. [online] http://www.oecd.org/document/17/0,3746,en_2649_37407_48127569_1_1_1_37407,00.html

In the former Greater Southern Area Health Service, introduction of the Rural Allied Health Assistant program enabled existing allied health assistants without a prior qualification to gain recognition for skills obtained through experience as well as access formal training to extend their skills. This enabled communities with little or no public or private allied health services to benefit from continued access to programmed intervention following rehabilitation or major injury upon return to their own home and reduced length of stay in sub-acute care. This project received a National Accolade Award in 2009 from the Industry Skills Council.

3.2.2 Scope of Practice Commensurate with Skills and Training

Much is said about changing and extending scopes of practice for health care professionals as a way of addressing increasing demand for health services, but what is meant by this?

"Advanced Scope of Practice" is taken to mean an increase in clinical skills, reasoning, knowledge and experience so the practitioner is an expert working within the scope of traditional practice. "Extended Scope of Practice" includes expertise beyond the currently recognised scope of practice of the profession.[44]

Scope of practice of a profession

A profession's scope of practice is the full spectrum of roles, functions, responsibilities, activities and decision-making capacity that individuals within that profession are educated, competent and authorised to perform. Some functions within the scope of practice of any profession may be shared with other professions or other individuals or groups. The scope of practice of all health professions is influenced by a range of factors, including the wider environment, the specific setting, legislation, policy, education, standards and the health needs of the population.

Scope of practice of an individual

The scope of practice of an individual is that which the individual is educated, authorised and competent to perform. The scope of practice of an individual ... may be more specifically defined than the scope of practice of their profession. To practise within the full scope of practice of the profession may require individuals to update or increase their knowledge, skills or competence. [45]

Changing scopes of practice

Changes in scope of practice are inherent in our current healthcare system. Delivery of healthcare is necessarily evolving. These changes relate to demographic changes (such as the ageing of the population) advances in technology; decreasing healthcare dollars; and advances in evidence-based healthcare procedures. Healthcare practice also needs to evolve as healthcare demands and capabilities change.[46]

Pharmacy has evolved from a profession with a product-focused practice to one with a patient-focused practice. Large-scale pharmaceutical manufacturing, the expanded use of automation, and the broader role and more widespread employment of pharmacy technicians to perform routine dispensing activities has enabled pharmacists to shift their focus from compounding and dispensing medications to optimising patients' healthcare outcomes.

Pharmacist practice has evolved to facilitate better patient care; prescribing is one tool to facilitate the delivery of safe and effective healthcare. Prescribing by pharmacists can take a variety of forms, including initial-access prescribing, prescribing in emergency situations, adapting prescriptions, and performing comprehensive medication management. Most Canadian provinces now have legislative support for some form of prescribing by pharmacists. Key components that ensure safe and successful pharmacist prescribing include adequate access to patient information, the establishment of a relationship with the patient, collaboration with other healthcare providers, documentation, communication, and individual responsibility. Ultimately, pharmacist prescribing improves patient care by improving access to care and using pharmacists to their full scope of practice.[47]

44 Health SA, Allied Health Scope of Practice Tool [online] http://www.health.sa.gov.au/

45 Australian Nursing and Midwifery Council (2007). National framework for the development of decision-making tools for nursing and midwifery practice

46 National Council of State Boards of Nursing. Changes In Healthcare Professions' Scope of Practice: Legislative Considerations [online] https://www.ncsbn.org/ScopeofPractice.pdf

47 Prescribing by Pharmacists: Information Paper (2009). The Canadian Journal of Hospital Pharmacy Vol. 63, No. 3 – May–June 2010

In addressing current and future health priorities we need to ensure that the *most competent and cost effective* workforce is delivering the service. This may require changes in scopes of practice for different positions to expand the current role, such as increasing the scope of practice for Nurses and Allied Health practitioners to allow the specialist medical workforce to focus on tertiary care, rather than on sub-acute or preventative care.

Some overlap among professions is to be expected and should be embraced. No one profession actually owns a skill or activity in and of itself. Simply because a skill or activity is within one profession's skill set does not mean another profession cannot and should not include it in its own scope of practice.[48]

Full Scope of Practice

The factors motivating the extension in roles are many and complex. In common with other developed countries, the NHS in England faces rising demand for health care, pressure to constrain costs, poor access to services in deprived urban areas, and medical workforce shortages. A common response to such challenges has been to extend the role of Nurses into areas that were previously the domain of Doctors alone.[49]

The role of health professionals is constantly changing and developing in response to the health needs of the population, advancements in knowledge and changes in the health care system. This means that health workers must continuously update their practice through the incorporation of new knowledge and skills for the benefit of patients.[50] It is important that each profession, and each individual in that profession, is encouraged to continually explore where their profession or individual scope of practice can be reviewed, changed or developed to meet health care needs or to recognise the development of skills.

Ensuring health professionals are properly supported and able to focus on the clinical roles for which they trained of caring for patients, rather than being overburdened by administrative tasks that are better undertaken by other categories of workers, contributes to job satisfaction and staff recruitment and retention. The NSW Government has identified this issue as a key one for the Health Professionals Workforce Plan particularly to enable nurses to devote more time to clinical work and patient care.

Discussion Point Two

Workforce Design/Redesign focuses on optimising the use of the existing workforce.

i) **Do you have any examples of where workforce redesign or changes in scope of practice have occurred locally, nationally or internationally?**

ii) **How did this redesign/change benefit patient care or workforce recruitment and retention?**

iii) **What made this strategy effective?**

iv) **How do we determine the most effective scope of practice consistent with quality patient care?**

48 National Council of State Boards of Nursing. Changes In Healthcare Professions' Scope of Practice: Legislative Considerations [online] https://www.ncsbn.org/ScopeofPractice.pdf

49 Sibbald, B., Laurant, M.G and Reeves, D (1996) Advanced Nurse Roles in UK Primary Car. Medical Journal of Australia, 185, No 1

50 NSW Nurses Association. Fact Sheet; Scope of Practice http://www.nswnurses.asn.au/multiattachments/25841/DocumentName/Scopeofpractice.pdf

3.2.3 Collaborative Practice

The success of strategies to implement new ways of working is dependent on professional respect, understanding of each others' roles and building trust within the team. Supporting workforce changes with sound clinical governance, planning, team meetings and team activities can help foster understanding and respect.[51]

The World Health Organisation has identified that collaborative practice in healthcare occurs when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers and communities to deliver the highest quality of care across settings. This practice includes both clinical and non-clinical health-related work, such as diagnosis, treatment, surveillance, health communications and management.[52]

There is a growing understanding of the positive benefits to patient outcome and service delivery when health professionals work collaboratively to deliver care. The interconnectivity between health professionals who bring a range of varied skills, knowledge and expertise contributes to better patient care and outcomes as well as improved health service efficiency.

Interdisciplinary practice is defined as a partnership between a team of health professionals and a patient in a participatory, collaborative and coordinated approach to shared decision-making around health issues.[53] With the increased focus on primary and preventative care, and the increase in patients with chronic illnesses and co-morbidities, the need for interdisciplinary practice increases.

The NSW Government has recognised this in its commitment to include in the Health Professionals Workforce Plan ways in which models of care can be improved through greater participation of our Allied Health workforce. This means that workforce modelling must take a holistic approach to future need that anticipates more multidisciplinary teamwork in the care of patients including the comprehensive profiling of future Allied Health workforce requirements, as outlined in the NSW Government's Plan to Provide Timely, Quality Health Care.

Both the education and service delivery systems need to work together to help create true collaborative practice. Training students interprofessionally and then having them work in silos will not allow a change in focus. If we expect health professionals to work collaboratively then the education system needs to ensure that health workers have the skills to do so, and the workplace needs to enable these skills to be applied.

Some of the strategies needed to develop collaborative practice include: [54]

- **Institutional supports.** Institutional mechanisms can shape the way a team of people work collaboratively, creating synergy instead of fragmentation. Staff participating in collaborative practice need clear

Legislation to support collaborative practice

In 2008, the Government of British Columbia in Canada passed legislation that included a provision on interprofessional collaboration. Each of the province's health professional regulatory colleges are now asked, "(k) in the course of performing its duties and exercising its powers under this Act or other enactments, to promote and enhance the following: (ii) interprofessional collaborative practice between its registrants and persons practising another health profession"

Government mechanisms shaping interprofessional education in Norway

In 1972, the Norwegian Government stated that to prepare students to work across boundaries and to further interprofessional collaboration, health professional students should be educated together. In 1995 they recommended that all undergraduate allied health, nursing and social work programmes include a common core curricula that covered: scientific theory; ethics; communication and collaboration; and scientific methods and knowledge about the welfare state. All university colleges adopted the common core. Government encouraged shared studies, but provided a great degree of flexibility for university colleges that had too few professions or were located far from potential partner institutions.[55]

[51] [online] www.health.nsw.gov.au/Initiatives/HealthOneNSW/enablers_workforce_education.asp

[52] World Health Organization 2010, Framework for Action on Interprofessional Education & Collaborative Practice. [online] http://www.who.int/hrh/nursing_midwifery/en/

[53] Orchard, C.A, Curran, V and Kabene, S (2005) Creating a Culture for Interdisciplinary Collaborative Professional Practice. Med Educ Online [serial online] 2005;10:11. Available from http://www.med-ed-online.org

[54] World Health Organization 2010, Framework for Action on Interprofessional Education & Collaborative Practice. [online] http://www.who.int/hrh/nursing_midwifery/en/

[55] World Health Organization 2010, Framework for Action on Interprofessional Education & Collaborative Practice. [online] http://www.who.int/hrh/nursing_midwifery/en/

governance models, structured protocols and shared operating procedures. They need to know that management supports teamwork and believes in sharing the responsibility for health-care service delivery among team members. Adequate time and space is needed for interprofessional collaboration and delivery of care. At the same time, personnel policies need to recognise and support collaborative practice and offer fair and equitable remuneration.

- **Working culture.** Collaborative practice is effective when there are opportunities for shared decision-making. This enables health workers to decide on common goals and patient management plans, balance their individual and shared tasks, and negotiate shared resources. Structured information systems and processes, effective communication strategies, strong conflict resolution policies and regular dialogue among team and community members play an important role in establishing a good working culture.
- **Environment.** Space design, facilities and the built environment can significantly enhance or detract from collaborative practice in an inter-professional clinic. In some cases, effective space design has included input and recommendations from the community and patients, as well as members of the health-care team. Most notably, physical space should not reflect a hierarchy of positions:

Discussion Point Three

i) What examples do you have of effective collaborative practice?

ii) How were the barriers to collaborative practice addressed?

iii) Is collaborative practice supported by both the education and health service delivery institutions in NSW?

3.2.4 Bucking the Trend – expanding opportunities for generalists

"It is said that when students enter medical school, they care about the whole person, and by the time they graduate all they care about is the hole in the person. Current medical education inculcates the dominant values of modern medicine: reductionism, specialisation, mechanistic models of disease, and faith in definitive cure…these values are part of a wider societal march toward reductionism and specialisation".[56]

Patients are presenting with multiple problems. Given the variety of treatment options that can be offered to a patient with multiple and complex co-morbidities, health providers are increasingly required to have knowledge and skills which go beyond a particular sub speciality. Patient complexity due to rising rates of chronic disease, increases in co-morbidities and growing multi-morbidities will mean that there is a need for a generalist model of primary care workforce into the future. The corollary of generalism is the ability of this scope of practice to deal with undifferentiated problems, be the first point of access and provide a holistic approach.[57]

[56] Grumbach, K (2003) Chronic Illness, Comorbidities, and the Need for Medical Generalism. Annals of Family Medicine 2003 May; 1(1): 4–7

[57] Pashen, D., Murray, R., Chater, B., Sheedy, V., White, C., Eriksson, L., De La Rue, S., Du Rietz, M. The Expanding Role of the Rural Generalist in Australia – A Systematic Review. Australian College of Rural and Remote Medicine, Brisbane 2007.

Case Study – Physician Training in New Zealand based on conversation with Professor Des Gorman, Chair, Health Workforce New Zealand

New Zealand has introduced a new funding model which links funding for postgraduate training in physician specialities with General Medicine training. All sub specialities requesting state-wide funding for postgraduate training in physician specialities are required to establish dual training programs which include general medicine.

A study commissioned on General Medicine by NSW Health *(The Role of the General Physician and Approaches to General Physician Training, NOVA Public Policy Pty Ltd, August 2011)* indicated that trainees in NZ are more favourable to generalist training as they increasingly recognise that the increasing complex patient requires broad based care which cannot be fully delivered within a sub speciality focus. The NZ experience is a reminder that health training systems should be geared to respond to the health needs of the population.

Another major impetus for exploring generalism in Australia is the scarcity of specialist medical services in a majority of rural and remote communities. As a consequence of population catchments being unable to sustain resident specialist services, the situation for rural specialist service provision is such that:

- The poorer relative health status in rural areas is compounded by poorer access to specialist services
- Australian supply for the common medical specialties and filling of training posts in rural centres does not reflect demand
- General practitioners with procedural skills represent an important element in ensuring access to procedural services, particularly for obstetrics and anaesthetics. The general practitioners in these roles require specialist support and maintenance of their skills to provide an effective service.[58]

In addressing the issue of increasing specialisation the public health system faces challenges in a system where the specialist colleges have multiple roles as the gate-keeper, curriculum developer, recruiter and trainer. Specialist colleges concentrate their efforts on the role of the practitioner in treating the patient which in turn has influenced the focus of health services. Issues such as cost effective and affordable care, appropriate care and when should the curative and acute care cease and be replaced by palliative care and end of life decisions are only now being broadly discussed at a community and political level, as evidenced, for example, by the public health promotion of Advanced Care Plans.

The Australian Primary Health Care Research Institute[59] identifies three policy areas for consideration in enhancing generalism as follows:

- Increase the importance and status of primary health care generalist workforce through career pathway development and remuneration.
- Enhance the educational content and settings that strengthen a generalist primary health care workforce. This includes how curricula can be expanded to increase focus on chronic disease management, given that primary health care professionals will spend a greater proportion of time in the future tackling the increasing burden.[60]
- Build and transfer evidence about strategies that strengthen generalism in the 2020 primary health care team.

Generalist is not in opposition to specialist. A large aspect of the generalist discourse has been pitting the generalist as an alternative to the specialist. It should be noted that both generalist and specialist health care focus on patient care as the key and primary aim of their discipline. The main difference is that the generalist knowledge and qualification is not presented as an advanced qualification. This contributes to the generalist profession being undervalued or misunderstood.[61] This has also contributed to specialists not being trained or equipped to provide comprehensive services. Generalism can represent expanded opportunities for the increasing number of post-graduate doctors in our health system helping to address the NSW Government commitment in this area.

Strategies are required to address the attractiveness of generalist roles, particularly in an environment where specialist colleges have a role in driving sub specialisation by developing new specialities and advocating for their recognition within the funding model.

Strategies for increasing the generalist skills of health professionals, as well as creating more attractive generalist positions could include:

- The identification of clinical champions to counter the peer pressure and to promote a generalist pathway as a viable alternative to specialisation. These champions need to be drawn from medical schools, postgraduate training providers and from the workforce.
- A review of medical school curricula to reflect the patient needs of the future and to focus on the development of broad technical skills
- Service models which place sub specialty care as peripheral care and generalist care as the core service delivery model
- That multiple specialities require all physician sub specialists to undertake training in generalist care including ongoing continuing practice development.-

[58] Pashen, D., Murray, R., Chater, B., Sheedy, V., White, C., Eriksson, L., De La Rue, S., Du Rietz, M. The Expanding Role of the Rural Generalist in Australia – A Systematic Review. Australian College of Rural and Remote Medicine, Brisbane 2007.

[59] Australian Primary Health Care Research Institute (2007) What Is the Place Of Generalism In The 2020 Primary Care Team? [online] http://www.anu.edu.au/aphcri/Domain/Workforce/Gunn_25_approved.pdf

[60] Commonwealth of Australia (2008) "Towards a National Primary Health Care Strategy. A Discussion Paper from the Australian Government

[61] Gunn, J., Naccarella, L., Palmer, V., Kokanovic, R., Pope, C. and Lathlean, J. (2007) What is the Place of Generalist in the 2020 Primary Care Team? Australian Primary Healthcare Research Institute, The University of Melbourne and the University of Southampton

- A review of remuneration models to reward patient outcomes as opposed to procedures performed. This is a complex exercise as it would require a shift away from a fee for service model to a remuneration model which focuses on outcomes rather than inputs. The outcome being an improved quality of life with fewer presentations.
- Consideration of the impact of the increasing specialisation of the medical workforce on other health professionals such as Nurses and Allied Health practitioners, and whether this affects the attractiveness of certain pathways and positions at the expense of generalist roles in those professions.

Discussion Point Four

i) **How would building a generalist workforce assist health care provision to 2025 and provide expanded opportunities for mediacl graduates?**

ii) **What strategies do you think will be most effective in developing a generalist workforce?**

iii) **How do you attract new health professionals to a generalist career?**

3.2.5 Bucking the Trend – Improving Workforce Distribution

The issues of providing services to all members of the community, in a timely and appropriate fashion will remain as a great challenge for the public health system. It is vital that we review the way in which services are provided, and by whom, in order to ensure the most efficient and effective service.

It is expected that, to meet the needs of the community, there must be an effective presence in metropolitan, regional and remote locations in NSW. However, as population growth contracts in some areas, and increases in others it will be necessary to look at what services are required, how they are delivered, and which services are better delivered in larger centres. It is expected that the skills of the workforce distributed in rural and regional areas will need to be more generalist in nature.

Redistribution, attraction and retention strategies to address maldistribution.

Some of the key areas that will need to be considered in health service delivery in rural and remote areas include:

- Shifting the workforce model from a **mainly transient workforce to a permanent workforce**. This will assist with the training and support for junior staff and collaborative team based practice. To achieve the shift consideration of current funding models, award structures, and rostering arrangements is required.
- **Maximising the investment being made by some larger regional facilities.** Larger regional hospitals such as Wagga, Orange, Gosford and Wyong have already making significant inroads into expanding their junior doctor workforce. It is expected that over time this investment in training will result in an increased number of medical specialists (including general practitioners) who are committed to rural practice. To sustain and continue to improve retention will need a continued investment in expanding the rural training pipeline across medical nursing and allied health, from internship to fellowship within those rural facilities which have an appropriate clinical load to meet training and supervision requirements.
- Recognising that for **some rural health facilities a medical service model may no longer be conducive** for a range of quality and safety reasons such as volume of activity that allows the health professional to maintain their skills, changing population dynamics which require a more long term care plan (as opposed to a short term treatment option) and availability of other health services. Alternative models of service delivery emerge, including:
  - **Hub and spoke model** with the large rural facility as the hub and the smaller facilities as the spoke for services which require volume and the availability of a suite of other support services (such as radiology, pathology) to ensure quality and safety. The hub and spoke model could also be used for those locations which find it difficult to recruit a long term workforce - as well as for those areas where the workforce is unwilling to move.
  - **Mobile Health Services** – that allow services and the workforce to go to the community to be delivered.

- Increased access to tele-Health Services as outlined by the Government in it's Plan to Provide Timely, Quality Health Care.

Securing a stable Medical Workforce for Rural NSW Communities

Rural communities rely on GPs for health services. The NSW Government identified in its *Plan to Provide Timely, Quality Health Care* support for a rural generalist training program and pathway for GP training in NSW. Consequently a NSW pathway for rural general practice training has been proposed, which is designed to provide medical graduates with a structured training program which balances community GP exposure with rural hospital experience. The proposed training pathway seeks to encourage increased numbers of medical graduates to choose rural and procedural general practice as their preferred training and career choice. A structured and supported training experience is fundamental to trainees choosing rural and procedural general practice and going on to provide health services in rural communities and hospitals. The *NSW Rural General Practitioner Training* program draft paper proposes two training pathways which form the NSW Rural generalist program.

Training Pathway 1 is a procedural GP training pathway. The training pathway provides an opportunity for the GP trainee who has completed the procedural component of their training to be credentialed for independent practice in a rural facility. This pathway enables GP trainees to maintain their interest and skills in the procedural speciality whilst undertaking the community GP component of their training.

Training Pathway 2 provides for dual hospital/ community general practice training terms. The GP trainee would work a combination of hours in a community general practice and in a rural public facility (both in hours as well as on call).This allows rural hospitals to access the GP trainee workforce and allows Regional Training Providers (RTPs) to expand overall GP training places by offering a mix of training opportunities.

The discussion paper is at http://www.health.nsw.gov.au/pubs/2011/stable_med_workforce.html

It is crucial to note that a change in services does not mean an absence of services locally. The community needs to be engaged in understanding the reasons for service changes, and service alternatives. Some facilities may benefit from the use of appropriate service providers who can provide a core suite of services (primary/preventative and community health) coupled with effective referral and outpatient services for secondary or tertiary level care. In these scenarios efficient patient transport systems, regular specialist outpatient clinics, and ongoing care being provided by the most appropriate health workforce (for the local population) are often a more appropriate investment pathway than attempting to establish a secondary level medical service.

These changes in service delivery require the development of new programs to **skill an alternative workforce** to provide some of the services e.g. provision of training to a nurse in a multipurpose service to extend the scope of practice in particular types of morbidity which are common to the population served. This training would ideally cross professional boundaries and include aspects of medical, nursing and allied health care. Supervision could be provided remotely and involve a medical practitioner or allied health practitioner for selected services.

- **Recognising the complexity of attraction and retention**, and catering for it. Health professionals, like other professional workforces, are attracted to areas for diverse reasons including a viable social and economic infrastructure and attractiveness at different points in time of their life cycle. Over time these reasons for remaining may shift as professional and family /lifestyle requirements also change. Recognising the attraction factors, and leaving influencers, can be one and the same at different points of time, requires strategies that support health professionals to move in and out of rural communities. It may also be possible to mitigate the leaving influencers by supporting access to education and other professional development.

There also needs to be flexibility in the employment arrangements that are on offer to encourage people to consider rural placements. Whilst it is accepted that many people will live in a range of locations and change jobs throughout their professional lives, there is an inverse expectation that committing to rural practice is a lifelong commitment. Recruitment and retention systems need to be sufficiently flexible to allow individuals to consider rural practice as one part of their overall health career – a job opportunity that they can move in and out of based on their personal choices and career goals.

A review of factors[62] influencing the recruitment and retention of nurses in rural and remote Queensland noted that lifestyle factors are both a motivation for rural practice as well as a reason for leaving rural practice.

"On the one hand, 'rural lifestyle' was ranked as the third most important factor for staying in rural and remote practice and, similarly, 'sense of belonging to the community' was ranked fifth. However, when respondents were asked to identify the most important factors that influenced them to leave rural and remote health services, just under 40 per cent of respondents cited issues related to the isolation caused by distance from basic amenities as one inducement for them to resign. These issues included travelling long distances to basic social and commercial activities, distance from family, friends and medical specialists, the comparatively high cost of living and a lack of communication facilities such as the Internet, which would mitigate personnel and professional isolation."

Linking training opportunities with employment options

There is consensus that a training program, which provides rural exposure, and is coordinated and structured to match training with employment opportunities, will contribute to securing a sustainable medical workforce for rural communities.[63]

If the recruitment of trainees is not linked to the service needs of health facilities, the benefits from the exposure to a particular geographical location and/or speciality are not realised in the recruitment process.

Anecdotal advice from the sector suggests that across all health professions there are graduates who face difficulty securing ongoing employment despite the continuing workforce shortages. This illustrates that the workforce supply chain is not fully aligned with the service demand.

Training as a lever to address geographical and speciality maldistribution

Research is conclusive that exposure to a location or speciality influences future choice of practice – this is the premise of the current postgraduate medical education system which seeks to influence geographical and speciality choice by providing opportunities to train in these.

Strategies developed in NSW to influence the geographical choice of practice have used training as a key lever.

The link between rural background and rural medical practice[64]

GPs with at least 6 years of their childhood spent in a rural area were significantly more likely than those with 0-5 years in a rural area to be practising in a rural location. However in the case of specialists, at least 11 years rural background was considered as necessary for a rural career. For doctors with a rural background, the size of the community that they grew up in was not significantly associated with the size of the community in which they currently practise. Both female GPs and female specialists are similarly much less likely to be practising in a rural location compared with males.

Recent initiatives include:

- **Rural Scholarships** for medical, nursing, midwifery and allied health students.
- **Expansion of prevocational and vocational medical training opportunities** in rural and regional locations. In NSW as part of the response to the *Garling Commission of Inquiry into Acute Care in Public Hospitals* 45 new PGY 2/3 training positions in rural locations and a further 22 vocational training positions were established, the majority of which were based in rural and regional and remote locations
- **Targeted recruitment to rural locations** such as the NSW Rural Preferential Recruitment (RPR) Scheme which allows rural hospitals to merit select medical graduates to intern training positions. The RPR Scheme recruitment is undertaken prior to the main allocation rounds, thus allowing graduates to consider rural facilities as a first choice. From a modest start of 15 graduates in 2007, the

[62] A review of factors influencing the recruitment and retention of nurses in rural and remote Queensland - Hegney, D., Rogers-Clark, C., Gorman, D., Baker, S., McCarthy, A. (2001) cited in Literature review on labour turnover and retention strategies, MINTRAC http://www.mintrac.com.au/files/newsletter/research%20turnover%20and%20retention%20.pdf

[63] Securing a stable medical workforce for rural communities – A discussion paper, NSW Health, August 2011

[64] Nature of association between rural background and practice location: A comparison of general practitioners and specialists Matthew R McGrail, John S Humphreys, and Catherine M Joyce http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3074548/

"The role of the non-medical wife or husband as a prime decision maker or decision reverser as to whether or not a relocation will happen at all is often overlooked. Unless the spouse is committed to a move it is pointless proceeding with a recruitment process". Source: Shortage of Rural Doctors in Australia (and what can we do about it, if anything?)" [65]

program recruited 80 graduates in the 2011 intern allocation round (for commencement in 2012).

- **Establishment of Training networks** which link metropolitan, regional and rural based facilities thus providing metropolitan based trainees with the opportunity to rotate to rural locations.
- **Establishment of a Rural Medical Practitioner Training program** which provides a structured and coordinated training pathway for procedural general practice and links training with employment opportunities.

Discussion Point Five

i) **What changes need to be made to education and employment models to ensure effective rural health service delivery?**

ii) **What strategies are most effective in attracting and retaining a rural workforce?**

iii) **What strategies would assist rural communities in developing their workforce from the community?**

3.3 Health Workforce Capacity and Skills Development

3.3.1 Education and Training

What is taught in Medical, Nursing, and other health profession schools has changed dramatically since the creation of the OECD. With the growing prevalence of chronic disease and the growing prevalence of people with multiple chronic diseases, the upcoming challenge will be to redesign the curriculum once again.[66]

In spite of the significant change in the burden of disease and the associated change in how health care is delivered, most clinical education, particularly for Medical and Nursing professionals, remains hospital centric. Medical , Nursing, and other health professionals continue to receive a large portion of their clinical training in hospitals. Unlike infectious and acute care which tends to be hospital centric, chronic care tends to be more ambulatory based.[67] It is necessary to consider ways to revise the orientation to make clinical education more ambulatory care oriented.

Greater alignment of funding and management of clinical training opportunities between undergraduate, pre-vocational and vocational training is needed to allow the development of more innovative vertical training models.

Podiatrists employed in the Hunter New England Local Health District recently piloted the use of telehealth to link high risk foot clinics between Tamworth and Newcastle. The telehealth service provided a link between clients with complex diabetes foot complications to podiatrists and other members of a multidisciplinary team. The pilot telehealth clinic resulted in a reduction in travelling time for Tamworth based clients needing to travel to Newcastle to access the Diabetes Team. This improved satisfaction and quality of life for both clients and their families. Rural based podiatrists identified improved job satisfaction, improved professional support and increased knowledge in the management of complicated high risk foot conditions.

Overall, improved service access to the specialist team has the potential to reduce or prevent the prevalence of lower limb amputation for high risk clients residing in rural areas. The risk of amputation of the lower limb is increased up to 15-fold in people with diabetes. Diabetes-related lower-limb amputation poses a substantial personal and public health cost in Australia.[68]

[65] ". Source: Shortage of Rural Doctors in Australia (and what can we do about it, if anything?) Stephen Migrate, Country Mayors Association (NSW), August 1999

[66] Anderson, G (2011) For 50 Years OECD Countries Have Continually Adapted To Changing Burdens Of Disease; The Latest Challenge Is People With Multiple Chronic Conditions. [online] http://www.oecd.org/document/17/0,3746,en_2649_37407_48127569_1_1_1_37407,00.html

[67] Anderson, G (2011) For 50 Years OECD Countries Have Continually Adapted To Changing Burdens Of Disease; The Latest Challenge Is People With Multiple Chronic Conditions. [online] http://www.oecd.org/document/17/0,3746,en_2649_37407_48127569_1_1_1_37407,00.html

[68] Payne, C.B (2000) Diabetes-related lower-limb amputations in Australia . Medical Journal of Australia, MJA 2000; 173: 352-354

This may include:

- greater support for regional training schemes and primary health care clinical training places;
- exploring models of funding that promote the importance of the teaching role, like part time academic positions and practice based teachers, to increase the status of teaching within the professions themselves;
- supporting innovative learning (e.g. simulated learning) and greater e-learning options for busy health professionals;
- accelerating entry to the workplace without compromising quality or standards (e.g. fast-tracking or streamlining training);
- considering how multi-skilled health workers could be supported through an enhanced focus on interdisciplinary learning.

Increasing Technology

Medical informatics, the onrushing world of electronically entered, stored, transported, and accessed medical information will eliminate imprecisions of the departing world of hard-copy medical information. With this revolution will come an enormous potential to increase the efficiency of clinical practice, reduce human errors, and increase the quality of medical care. Electronic medical information will also democratise medicine. The role of the "customer" in health care can only grow with the ability to access information.[69] There will be a need to ensure that the health professional workforce is technologically savvy, and able to deal with new technologies as they are introduced into the workplace.

Interprofessional Education (IPE)

Health professionals, such as Doctors, Nurses and Allied Health practitioners need to work together effectively to take care of patients, particularly with the increases in patients with co-morbidities. Training and educational programmes have been developed as a possible way to improve how professionals work together to take care of patients.[70] Interprofessional Education (IPE) occurs when learners from two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes.[71]

Physiotherapists in Emergency Departments

Hunter New England LHD in collaboration with The University Department of Rural Health (UDRH) and the co-located Rural Clinical School (RCS) has developed a multidisciplinary program for students studying medicine, nursing and allied health disciplines at the University of Newcastle.

Run at the Tamworth Base Hospital Emergency Department (ED) the program has a Physiotherapist who acts as a clinical preceptor of undergraduate medical and physiotherapy students in orthopaedic and musculoskeletal placements in the ED. The placement provides an opportunity for medical and physiotherapy students to experience being an active member of the ED in a "hands-on" capacity.

As well as offering clinical services, the Physiotherapist supervisor provides tutorials to medical and physiotherapy students and in-service training to medical and nursing staff in the ED. Medical and physiotherapy students work together interprofessionally during the placement and gain a better understanding of each other's roles and skills leading to improved care for patients with musculoskeletal and orthopaedic conditions.

"IPE aims to encourage different professionals to meet and interact in learning to improve collaborative practice and the health care of patients/clients, and therefore has more potential for enhancing collaborative practice than a programme of multiprofessional education (where professionals share their learning experiences but do not interact with one another, such as a joint lecture) or uniprofessional education (where professionals learn in isolation from one another)."[72]

Effective interprofessional education relies on curricula that link learning activities, expected outcomes and an assessment of what has been learned. Research indicates that interprofessional education is more effective when principles of adult learning are used, learning methods reflect the real world practice experiences of students, and interaction occurs between students.[73]

69 Masys, D, R. (2002) Effects Of Current And Future Information Technologies On The Health Care Workforce Health Affairs, 21, no.5 (2002):33-41

70 Reeves S, Zwarenstein M, Goldman J, Barr H, Freeth D, Hammick M, Koppel I (2009). Interprofessional education: effects on professional practice and health care outcomes (Review) The Cochrane Library Issue 4

71 Canadian Interprofessional Health Collaborative (CIHC) WIKI

72 Reeves S, Zwarenstein M, Goldman J, Barr H, Freeth D, Hammick M, Koppel I (2009). Interprofessional education: effects on professional practice and health care outcomes (Review) The Cochrane Library Issue 4 page 3

73 World Health Organization 2010, Framework for Action on Interprofessional Education & Collaborative Practice. [online] http://www.who.int/hrh/nursing_midwifery/en/

A range of mechanisms shape effective interprofessional education and collaborative practice. These include:

- supportive management practices
- identifying and supporting champions
- the resolve to change the culture and attitudes of health workers
- a willingness to update, renew and revise existing curricula
- appropriate legislation that eliminates barriers to collaborative practice [73]

Work Readiness and Education

Health providers and policy makers are familiar with murmurings of "ill equipped" medical interns and recent health practitioner graduates, and the challenges in the transition from medical student to pre-vocational trainee, or from student to effective health care provider. This can be particularly evident in rural settings where knowledge deficits are quickly exposed. Given that today's medical graduate has undertaken at least 5 years of undergraduate or 4 years of post graduate tertiary education prior to embarking on prevocational training – the question that needs to be asked is: – Why are they not work ready?

Systems are required for the development of effective communication and development pathways between employers and training providers. NSW Health, as both an employer and trainer, needs to be specific about their concerns with the work-readiness of the graduate/trainee. Training systems should be geared to respond to this feedback in a constructive manner. Each stage of health education and training should seek to ensure that the graduate or trainee is fit for purpose/work ready. This communication and flexibility in regard to curriculum review needs to extend to ensuring that the curriculum is flexible enough to respond to changing demands on the healthcare system.

Essential to the *Health Professionals Workforce Plan 2012-2025* are the NSW Government's commitments to:

- Develop adequate programs for training of registrars following completion of their residency.
- Develop strategies to provide protected teaching time to achieve highest quality education for doctors.
- More rapidly develop the clinical skills of new nursing graduates.

The focus for NSW Health on working with the new graduate to increase their work readiness was addressed by the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals, which recommended the establishment of the Clinical Education and Training Institute (the Institute) as one of the "four pillars" essential to supporting the ongoing development and improvement of the NSW public health system. The Commission recommended that a key focus of the Institute be "to design, institute, conduct and evaluate a program for the postgraduate clinical education and training for all new postgraduate professional clinical staff employed in NSW public hospitals (recommendation 36 (1a))"

The Institute has lead responsibility for the development of clinical education and training programmes for all new starters in the medical, nursing and allied health professions within NSW Health. It has developed Team Health as its new starter training program with the aim of improving teamwork, communication and collaboration for safer patient-centred care and improved staff experiences. The focus is on the development of skilled and effective multi-disciplinary teams, not just individuals.

Linking training opportunities to the areas with the greatest workforce need

Training pathways which link metropolitan, regional and rural facilities under network arrangements have been successful in expanding education and training opportunities in rural and regional areas. Training networks not only provide exposure to different geographical locations and alternative settings, but they also allow smaller outer metropolitan, regional and rural facilities to expand their training effort. A small facility may not be able to provide all the exposure necessary for training in a particular clinical area, but may be able to provide some.

Greater flexibility in the accreditation practices of training providers would enable facilities to be accredited as rotation facilities thus allowing trainee exposure to these smaller facilities. This includes greater consideration of the use of technology in the supervision of trainees where on site supervisors are unavailable.

Inter-professional supervision of trainees to enable experienced staff from other professions to supervise also needs to be considered. This is particularly important for small rural facilities which rely on a VMO workforce. This workforce is usually not available at all times to provide supervision for trainees. This restricts the ability of the

Intern training opportunities in Rural NSW

Increased numbers of medical graduates are entering our health system. The number of intern training positions in NSW has grown from 680 positions in 2010 to 846 positions in 2011 - an increase of approximately 24%. The NSW Government indicated that the Health Professionals Workforce Plan must address the need for greater intern capacity and other post-graduate medical training. One of the ways to expand opportunities is in relation to rural positions. There were 89 intern training opportunities advertised in rural locations as part of the Rural Preferential Recruitment Scheme in 2010, of which 53 were filled through direct recruitment. 89 RPR positions were advertised in 2011 with 80 positions filled via direct recruitment.

It is noted that some rural facilities have not increased their intern training opportunities over the past 2 years. Increasing the supply of doctors will not address rural distribution issues if rural training opportunities cannot be accelerated at a similar rate. The challenge for rural locations over the next few years is that as the supply of medical graduates grows over the next few years, are rural facilities able to absorb these additional graduates? Failure to do so will result in continuing issues of maldistribution.

practice to expand their training program which in turn limits their ability to grow their workforce. In such situations, opportunities for off-site supervision by senior clinicians combined with on site supervision by other health professionals could be considered.

Discussion Point Six

i) **What curriculum changes are required for the current health education and training systems to provide a workforce that is fit to practice?**

ii) **Are changes to the way we educate our health workforce necessary? If so, what needs to change and for which professions?**

iii) **What role can NSW Health play in ensuring that education programs (university and VET) provide us with a workforce that is, on graduation, able to meet the patient care needs of NSW, at the beginning level of practice?**

3.3.2 A Fresh Look at Attraction Strategies

The development of strategies to attract workers to different roles, changed roles, changed care settings or regional and rural locations needs to be multi-faceted and targeted. There is no one strategy that will meet the needs of all individuals. There is also a need to neither under nor over sell the benefits and challenges of different roles, and different locations.

The priorities of individuals, both personally and professionally, change over time, dependent on their personal circumstances, their ambitions, and their level of experience. We need to offer flexible opportunities to allow people to move locations, roles and services as their needs change.

Reconnecting

The NSW Government has identified attracting experienced nurses back to NSW hospitals and health services as a key strategy in its HP Workforce Plan. Nursing Re-Connect is a method of assisting and supporting nurses and midwives to re-join the workforce. Re-Connect is a strategty to re-engage registered nurses, midwives and enrolled nurses who are not currently working in nursing positions. The Mental Health Connect complements Nursing Re-Connect and continues to attract nurses who are seeking to start or re-establish a career in mental health. Nursing Re-Connect has been a successful initiative with over 1900 nurses and midwives employed through this initiative. Of these, over 80% have remained employed in the public health system.

Relocating

The development of the NSW Health employment site, NSW A Great Place to Live and Work, provides a one-stop shop for NSW health professionals to find out information on the availability of a range of health careers in NSW health, registration and recognition requirements in NSW and information on living in NSW, and the process for moving to NSW from interstate or overseas.

Reskilling

The changing nature of Australian industry can provide an opportunity for NSW Health to improve the participation rates from the labour market. With an ageing labour market, and decreased growth in younger age groups re-skilling of workers from declining industries may become an increasing focus. The relative proportion of workers employed in various industries shows a decline between 1998-1999 and 2008-2009 in agriculture, manufacturing and wholesale trades.[74]

Similarly, there needs to be re-skilling from within the workforce as certain positions become redundant, as the skills requirements the organisation needs changes, or as individuals choose to change careers. These situations offer further opportunities to provide alternate supply for the future workforce.

Discussion Point Seven

i) **Is attracting workers from other industries and reskilling a viable option for the health sector, and if so in what professions?**

ii) **Are there strategies that can improve the way in which education systems can retrain workers with existing skill sets into new roles/careers?**

iii) **What are some of the most effective attraction strategies that you have used to attract workers to difficult to fill roles?**

[74] Australian Bureau of Statistics (2011) 1301.0 - Year Book Australia, 2009–10

3.3.3 Career Planning and Support

The factors involved in career decision making are varied and can be influenced by a number of factors The NSW Government has identified as part of the Health Professional Workforce Plan the need for strategies to enhance career pathways for Nurses, Midwifes and all Allied Health groups to assist with attraction and retention.

The need for **career advice** during undergraduate education is well recognised within the Medical and Nursing professions. The career advice and support provided by Medical students during undergraduate training has been found to be fragmented, poorly resourced, and rated as less than useful by students.[75] In a survey undertaken across Allied Health students in South Australia 97% of respondents indicated support for the inclusion of specific information and sessions on career options, with over half indicating that formal career advice should be provided every year.[76] Such an approach would provide NSW Health with an opportunity to not only inform undergraduate students of the range of careers available but provide realistic and timely advice on where there is likely to be under and over supply.

Pastoral care mentoring and support for the health student/trainee across the training journey, in regards to promoting career options for both geographical settings and for speciality choice is important. A recurring theme within the medical training environment is the decline of pastoral care to support the student/trainee as they navigate through the training and employment choices available to them. The choice of training location, professional and speciality is largely left to individual choice. Pastoral care in this context is considered important for the following reasons:

- Maintaining links with the trainee or student creates and maintains a positive and supportive relationship which encourages the trainee to pursue careers in a particular geographical location or speciality
- It reduces the impact of peer pressure – anecdotal advice from general medicine physician and general practice trainees indicates that they face considerable peer pressure from other trainees and speciality supervisors to consider sub speciality careers. The availability of pastoral care in the form of clinical champions positively reinforces the trainee's initial choice.
- Acknowledgement that trainees will have interrupted health service careers – a number of health professions consider overseas and alternative experiences as a positive aspect of health training. However, few health training journeys accommodate these experiences within the training/employment plan. In Victoria, it was noted that the majority of Physiotherapists would undertake an overseas experience within 2-3 years of completing their training. Once this trend was acknowledged and accepted, the emphasis was not on restricting this movement, but ensuring that supervisors maintained contact with employees during their overseas experiences. This served as an incentive to the employee to return upon completion of the overseas experience. This was particularly successful for rural facilities as it maintained the relationship with the rural community. A similar initiative is currently being piloted in New Zealand to maintain medical postgraduate trainee links with service providers.

The use of **career frameworks or matrices**, such as the Canadian Health Informatics[77] COACH's Health Informatics Professional Core Competencies or the United Kingdom's National Health Service (NHS) Career Framework provides advice to both potential and existing workers on the range of career options available across a range of professions, and the key competencies, capabilities and education required to undertake different roles. Career Framework information is a way of improving career development and

Discussion Point Eight

i) **Would a structured career planning approach for new practitioners and for existing workers assist with retention?**

ii) **What are the most important messages to include in promoting Health careers?**

iii) **What is an effective way to provide mentoring and support across NSW Health?**

iv) **How can we best provide support and development to staff in rural locations?**

[75] Williams, M (2006) The Nature Of Career Advice Provided To Undergraduate Allied Health Sciences Students At The University Of South Australia. The Internet Journal of Allied Health Sciences and Practice, Vol 4 No. 4

[76] Williams, M (2006) The Nature Of Career Advice Provided To Undergraduate Allied Health Sciences Students At The University Of South Australia. The Internet Journal of Allied Health Sciences and Practice, Vol 4 No. 4

[77] https://secure.coachorg.com/publications/core_competencies.htm

job satisfaction, by encouraging individuals to learn new skills and take on extra responsibilities that enable them to progress within an organisation.

3.4 Leadership for the sustainability of the health system

3.4.1 Effective clinical leadership lifts performance: The evidence base

In the late 1990s, Kaiser Permanente Colorado was struggling with worsening clinical and financial performance and losing doctors to private practice. A new executive medical director made clinical leadership an explicit force for improving outcomes for patients. Defining the role of the clinician as "healer, leader, and partner," he revamped the leadership-development programs for doctors. Within five years, Colorado had become Kaiser's highest-performing affiliate on quality of care. Patients were significantly more satisfied, staff turnover fell dramatically, and net income rose from zero to $87 million.[78] The Veterans Health Administration, within the US Department of Veterans Affairs (VA) was performing so poorly in the mid-1990s that some prominent voices suggested closing it down. The new CEO, a doctor, sponsored an improvement program in which clinical leadership played a central part. The program introduced clinically relevant performance measures, with corresponding rewards, and new information systems. The VA soon became a leader in clinical quality. The satisfaction level of patients rose to 83 percent, 12 percent above the national average, even as the VA's patient numbers doubled over the following decade.[79]

These improvements happened because clinicians played an integral part in shaping clinical services. The expanded role of clinicians did not come about through one-off projects; nor were changes in formal job descriptions the primary driving force. What changed for clinicians was their professional identity and sense of accountability. All staff, whether clinicians or not, came to share a common aim: delivering excellent care efficiently. Doctors collaborated with administrators on important clinical decisions—such as how to expand or reconfigure services—in full knowledge of the trade-offs and resource implications.[80]

A growing body of research supports the assertion that effective clinical leadership lifts the performance of health care organisations.

3.4.2 Support and Supervision

Research showing that the development of staff is linked to an organisation's success in recruiting and retaining staff also suggests new healthcare graduates experience stress during the early phase of initial employment. Students reportedly often feel unprepared and unsupported in making the transition from student to confident practitioner. Structured support and a positive learning environment during this phase can make a difference to the confidence of the individual and contribute to and improve ongoing recruitment and retention.[81]

The role of senior clinicians in supporting and training the future workforce is an important one, and should not go unrecognised. The training system for health professionals is reliant on supporting new graduates in consolidating their theoretical knowledge in the workplace, and in many instances accreditation is reliant on periods of supervised "internship".

Flying Start NHS, Scotland[82] is a development programme

78 Mountford, J and Webb, C(2009). When Clinicians Lead. The McKinsey Quarterly. http://www.aemh.org/pdf/MacKinseyWhenCliniciansIead.pdf

79 Mountford, J and Webb, C(2009). When Clinicians Lead. The McKinsey Quarterly. http://www.aemh.org/pdf/MacKinseyWhenCliniciansIead.pdf

80 Mountford, J and Webb, C(2009). When Clinicians Lead. The McKinsey Quarterly. http://www.aemh.org/pdf/MacKinseyWhenCliniciansIead.pdf

81 District Health Boards New Zealand (2010). Allied Health New Graduate Toolkit.

82 http://www.flyingstart.scot.nhs.uk/mentor-area.aspxEvidence

which supports newly qualified practitioners during their first year of practice. It does this by assisting them to navigate to the Foundation gateway of the NHS Knowledge and Skills Framework 'Agenda for Change'.

3.4.3 Leading Culture

The Minister for Health has outlined the four core values of Collaboration, Openness, Respect, and Empowerment which will underpin the NSW Public Health System. Accompanying these values, and regardless of the motivation that an individual may have to work in the health industry, it is important to enshrine a commitment to the community as a core operating principle in health service delivery.

Perhaps the greatest barrier to the increased involvement of clinicians in shaping the future of patient care lies in the historical beliefs of clinicians themselves about the value of leadership and management. One way to address this issue is to be far more systematic about gathering stories, told authentically and compellingly by those who participated or observed, that highlight the value of great clinical leadership. By "making heroes" of clinical leaders of all types, both in formal management and in frontline roles, organisations can create a stronger bank of role models and also spark a sense of possibility.[84]

3.4.4 Leadership Development

Any effort to encourage clinical leadership has to include support for professional development. However, the best starting point is not to create or commission a training course. Health care organisations must first define what they want from their clinical leaders, what skills and attitudes they want to encourage, whether there are differences across professions or roles, and where the need to develop leadership is greatest. Efforts can then be targeted to where they can have the greatest impact.[85] The UK National Health Service has created a Leadership Framework that comprises seven domains that describe the leadership behaviours, knowledge, skills or attitudes expected.[86]

For clinicians, development programs with real work at their heart can help enormously in demonstrating how patients benefit when clinicians lead the improvement of services. A leadership program involving a dozen UK hospitals and both clinical and nonclinical staff focused on redesigning pathways for patients with stroke and hip fractures. The program, positioned as a quality-improvement effort rather

Revisiting the Hippocratic oath/Declaration of Geneva[83]

The declaration developed by medical graduates of the University of New South Wales made specific reference to: "My commitment extends beyond individuals to the health and wellbeing of the community." The Medical Board of Australia Code of conduct states that "Doctors have a responsibility to protect and promote the health of individuals and the community." Speech Pathology Australia Code of Ethics includes duties to clients and the community within their Standards of Practice. The majority of health professions note that in addition to patient care, they have responsibility for the healthcare of populations (communities).

If health professionals have a responsibility for population needs, should they also consider issues of affordability, quality of life and the health service impact within their management of individual patients?

An article in the Huffington Post in Canada (Silver Tsunami to Break the Health System's Bank, 6 January 2011) raises the issue that unsustainable health care spending is not just a product of an ageing population but is being driven by an increase in the overall utilisation of services across most age groups. The role of the health professional in contributing to the sustainable use of resources needs to be better understood.

Why is this relevant?

Sustainable use of health resources is not just about ensuring appropriate care but also ensuring that the ***most competent and cost effective workforce*** is delivering the service. This required a review of current service models to determine:

- What are the necessary competencies for performing this task?
- What level of training is required to undertake the task/function?
- Who is currently delivering this service/function?
- Is the training undertaken by the current workforce appropriate for the task/function?

[83] Source: Declarations made by graduating medical students in Australia and New Zealand Paul M McNeill and S Bruce Dowton http://www.mja.com.au/public/issues/176_03_040202/mcn10297_fm.html
[84] Mountford, J and Webb, C(2009). When Clinicians Lead. The McKinsey Quarterly. http://www.aemh.org/pdf/MacKinseyWhenClinicianslead.pdf
[85] Mountford, J and Webb, C(2009). When Clinicians Lead. The McKinsey Quarterly. http://www.aemh.org/pdf/MacKinseyWhenClinicianslead.pdf
[86] http://www.nhsleadership.org.uk/framework.asp

than a training or development course, had a remarkable impact on lengths of stay, mortality rates, and costs—all of which fell by up to 30 percent. It also created enthusiasm for leading service-improvement efforts more generally, with enduring benefits after the formal program had ended.[87]

Another recommendation of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals concerning the establishment of the Clinical Education and Training Institute (the Institute) was that it have as one of its functions "to design, institute, conduct and evaluate leadership training for clinicians to enable clinicians to become clinical leaders and also health system leaders" (recommendation 36(1b)).

Additionally, the Clinical Excellence Commission, which was established in 2004 to provide a comprehensive quality improvement and patient safety program across NSW, coordinates the Clinical Leadership Program for NSW Health. A primary aim of the Clinical Leadership Program is to transfer learning and tools into improving patient safety and clinical quality. Since the Clinical Leadership Program was launched in 2007 over 600 participants have completed either the executive modular or statewide format of the program. An integral component of the Clinical Leadership Program is the undertaking of a clinical improvement project designed to improve patient safety and clinical quality. Participants are supported in the development of their clinical practice improvement through workshops and through support from local Clinical Governance units.

Design and Structure of the NHS Leadership Framework

The NHS Leadership Framework is based on the concept that leadership is not restricted to people who hold designated leadership roles and that there is a shared responsibility for the success of the organisation, services or care being delivered. Acts of leadership can come from anyone in the organisation and as a model it emphasises the responsibility of all staff in demonstrating appropriate behaviours, in seeking to contribute to the leadership process and to develop and empower the leadership capacity of colleagues.

This model of leadership is often described as ***shared leadership*** and is especially appropriate where tasks are more complex and highly interdependent – as in healthcare. Not everyone is necessarily a leader but everyone can contribute to the leadership process by using the behaviours described in the five core domains of the NHS Leadership Framework.

The final two domains of the NHS Leadership Framework, creating the vision and delivering the strategy, recognise that a relatively small group of people do hold designated ***senior positional*** roles, and are required to act as leaders in formal hierarchical positions. These two domains therefore focus more on the contribution of individual leaders rather than the general leadership process.

Discussion Point Nine

i) **How can NSW Health create a culture that values the role of leader, preceptor and educator?**

ii) **What support programs are needed to develop an understanding of leadership roles?**

iii) **What education or workplace programs have been effective in developing leadership skills?**

[87] Mountford, J and Webb, C(2009). When Clinicians Lead. The McKinsey Quarterly. http://www.aemh.org/pdf/MacKinseyWhenClinicianslead.pdf

3.5 Health workforce planning

3.5.1 Linking workforce, budget and service planning

As noted earlier given the differential growth in age groups in the population the available pool of workers is growing more slowly than the growth of the aged in the population and there will be greater competition for scare workforce resources from all industry sectors. More information on these factors is available in the Technical Paper. Workforce redesign, role substitution and training more workers will not be enough to address the expected future health needs of the community. Workforce planning will need to be at the forefront of health service planning activities.

Workforce Service Reviews

Reviews of what the future health workforce in New Zealand will look like are underway in 12 specialties. The reviews are supported by HWNZ and led by small groups of clinicians who are developing a vision of the workforce of 2020. The reviews are tasked with thinking innovatively about how high quality services can be delivered for all New Zealand communities. This multi-disciplinary clinician-led and patient-focused approach has the potential to deliver some of the most significant shifts in how health services are delivered for decades.

This work requires courageous and innovative thinking from clinical leaders to develop scenarios and recommendations which are then scoped further with colleagues and analysed, costed and tested.[88]

Whilst much work has been done in NSW on clinical service design, the integration of service planning with workforce and budget planning and workforce redesign is at a relatively immature stage. Whilst it may seem apparent that these functions are critically inter-related for good planning, the integration of these activities is not always evident in practice. Health Workforce New Zealand (HWNZ) commenced service reviews through a series of processes including research, think tanks, data analysis, updates, evaluation, sector modelling, service planning and health policy development.

The NHS in the UK directs workforce planning processes to include accurate and reliable data and information at the centre of planning. In a method of collect, analyse and present data and information to support workforce planning, the NHS then uses its data to prepare workforce planning, assess workforce demand and supply, and develop, implement and review plans. The next stage in workforce planning includes partnerships and collaborative work; service change and innovation; resource management; equality, diversity and rights; and personal development).[89]

3.5.2 Identifying high priority areas for workforce planning

In NSW there is a need to identify the crucial areas where workforce and service reviews are required, either because of an expected increase in volume, such as in dealing with diabetes, or where a small but critical workforce is in danger of decline, such as Radiopharmaceutical Scientists. Radiopharmaceutical Scientists are specialist trained professionals involved in the diagnosis, treatment and monitoring of cancer patients requiring treatment involving radioactive materials. Radiopharmaceutical Scientists determine the amount of radioactive material required to conduct diagnostic scans such as Proton Emission Tomography (PET). The use of PET scans alongside CT or MRI scans provide the most in-depth anatomical and metabolic diagnostic information especially in diagnosing cancer. The information assists Oncology Medical specialists to determine the most appropriate course of treatment.

Radiopharmaceutical Scientists (RPS)

Of the 13 NSW public hospitals offering nuclear medicine services, 7 have 1 or more radiopharmaceutical scientists. There are currently 12 RPSs employed in the NSW public hospital system (as Hospital Scientists). Four of the current 12 RPSs are aged over 50.

Currently there is a global shortage of Radiopharmaceutical Scientists, as evident from comments noted by speakers and organisers at international conferences. Qualified professionals in this field have begun to move overseas (to US and Europe) or into the private sector to work in organisations with greater career opportunities and increased remuneration. Without the ability to attract and retain suitable graduates, a severe shortage will occur within 5 years, which will impact severely on the ability to provide medical care at a standard expected within Australia.

88 Health Workforce NZ (2011) Workforce Service Reviews Process Map, 2011

89 National Health Service (2005) UK Wide Workforce Planning Competence Framework. [online] http://www.healthcareworkforce.nhs.uk/

Discussion Point Ten

A skilled and able workforce is essential to the delivery of healthcare services. Service design with limited regard for the workforce can exacerbate workforce shortages

What improvements can be made to ensure that strategic workforce planning is an integral part of any service development/design initiative at the local and state-wide level?

3.5.3 Developing the capacity for planning at a local level

With the implementation of Local Health Districts (LHDs) and their responsibility for a broad range of human resources related functions, including local workforce planning and workforce strategy, recruitment, and skills development (supported by the Health Education and Training Institute) it will be necessary for the LHDs to have the skills and capacity to undertake this role. Local health Districts will also need to ensure that the collaboration of service, budget and workforce planning is occurring within their organisation.

3.6 Health workforce policy, funding and regulation

3.6.1 Employment Models

The world of work will evolve rapidly as we move towards 2025 and beyond. Technological advances and globalisation are both changing the way the workplace is structured. The changing nature of labour supply (with more older workers, people with care giving responsibilities, increasing feminisation in medical professions and increasing desire for work-life balance) will create greater demand for less traditional and more flexible working arrangements. Increasing numbers of employees, both highly skilled and low skilled will require non-standard work arrangements.[90]

The service delivery model, and how this impacts on availability of workforce, will require review, particularly in areas of workforce shortage. Models that are dependent on a single doctor being available 24/7 may not be attractive to the coming generations of medical staff. Service and workforce models that incorporate the range of relevant health professionals including doctors and nurse practitioners have a greater potential for long term sustainability to meet the requirements of patient care, particularly in regional and rural NSW.

An emerging issue highlighted by the earlier information on the contract nature of the medical workforce in rural areas is in the different employment models that are being used . There are a number of issues that need to be resolved in ensuring a more even distribution between metropolitan and rural locations.

- **Difficulty recruiting to permanent positions** – strategies to address this include targeted recruitment initiatives which package a training pathway with a career (guaranteed employment position) at the end of the training
- **Reliance on locums and agency staff** – impacts on the facility being considered a suitable teaching facility. Strategies to address this may include the establishment of a relationship with locum providers which results in a more stable locum cover, and greater engagement of this workforce to supervise and train. There may also be a need to encourage this workforce to enter into permanent contracts by, for example, placing time limits on locum opportunities to encourage long term locums to consider permanent employment.

There is also likely to be increasing demand for flexible working conditions. The health workforce is in the main female. Women workers bear a greater share of family and unpaid responsibilities. The participation of women aged between 25-44 years in the labour force decreases due to childbirth and childcare activities.[91] Research also suggests

> Increased demand for nurses means that the organisations that provide employee-friendly policies will gain a competitive edge in attracting and retaining a quality nursing workforce. An ageing workforce also means that the health service has to look at ways of encouraging older nurses to work for longer. This means providing flexible working hours towards the end of nurses 'working lives and pensions schemes that allow staff to step-down to lower grade jobs in the run up to retirement, while protecting their pension entitlement.[92]

[90] Department of Labour, NZ [online] http://www.dol.govt.nz/publications/research/forces-for-change/forces-for-change-06.asp

[91] Women's employment in the context of the economic downturn. prepared by: Angela Barns, Therese Jefferson, Alison Preston Women in Social & Economic Research (WiSER), Curtin University of Technology, for the Australian Human Rights Commission

[92] Spinning plates: establishing a work-life balance, Royal College of Nursing 2008

that women are less likely to consider rural careers.[93] The reasons for these are linked with the difficulty in accommodating the needs of health workers demanding greater work life balance within a health system which has been tasked with the provision of 24/7 care.

Issues such as opportunities to work part time for all professions (including postgraduate medical trainees) and a reduction in on-call demands need to be addressed to improve the attractiveness of rural careers. However these changes require a paradigm shift in the way health care is delivered and the way rosters are structured. The request for part time work and increasing work life balance can no longer be seen as the exception or the inconvenience but will increasingly become the norm.

Consideration of how shifts are organised and services provided can lead to work arrangements that better accommodate this desired flexibility and provide effective attractors for health professionals. Shift work enables the provision of 24/7 cover for service delivery and allows health workers to forward plan to accommodate their family responsibilities. It can reduce on call obligations as health providers are rostered across all shifts. This model may not be appropriate for all instances, but it may be a useful strategy for surgical, medical and radiology departments. Shift work can accommodate both 24/7 cover or the 16 hour hospital (as recommended by the Garling Commission of Inquiry into Acute Care in Public Hospitals).

3.6.2 Payment Arrangements

Australia's health payment/fee for service model encourages health as a series of transactions as opposed to outcomes. There is much debate about whether this model is conducive to effective long term management of chronic conditions. Critics believe the model provides perverse incentives to maximise the number of presentations, whereas a successful long term management system should ideally result in a reduction in the number of primary and acute presentations. Whilst consideration of other options for payments is beyond the scope of this discussion paper and the Workforce Plan, careful consideration of the impact of payment arrangements is required as all systems have associated unexpected outcomes, many of which influence career choices and work practices.

For instance the remuneration structure for medical practitioners in NSW Health can also impact on the preference of employment models such as visiting medical officer contracts compared to staff specialist employment options. Funding mechanisms and earning potential is also reported as major driver of career selection and is held up as being evident in the range of popular specialties sought after by medical trainees.

Influencing payment models is a medium to long term challenge that involves agreement nationally. It has been identified by Health Workforce Australia as a key priority as part the National Health Workforce Reform and Innovation Strategic Framework.

Discussion Point Eleven

i) **What employment models would assist NSW Health to create an attractive and supportive working environment for health professionals?**

ii) **What are the barriers to implementing those employment models, and how would they be overcome?**

[93] Nature of association between rural background and practice location: A comparison of general practitioners and specialists Matthew R McGrail, John S Humphreys, and Catherine M Joyce

Next Steps

The feedback gathered during the consultation period will be used to assist in the development of strategies and actions to be included in the Health Professionals Workforce Plan 2012-2025. Feedback can be provided via the NSW health Internet site at www.health.nsw.gov.au/workforce/hpwp. The consultation period will be open until Monday 14 November 2011

SHPN (WDI) 110236