National Health Workforce Innovation and Reform Strategic Framework for Action 2011–2015
Background Paper
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Background to the development of a National Health Workforce Innovation and Reform Strategic Framework for Action 2011–2015

Workforce planning innovation and reform is a priority focus globally for those interested in the sustainability and improved accessibility, quality and safety of health care. In every Australian jurisdiction, workforce planning innovation and reform is being addressed in different ways. At the national level, the foundation has been laid for a more coordinated approach in the creation of a national registration authority – the Australian Health Practitioner Regulation Agency (AHPRA) – and Health Workforce Australia (HWA) its particular mandate for innovation and reform.

HWA was established in 2009 as a body that can operate across the health and education sectors. It has jurisdictional responsibilities in health to devise solutions that effectively integrate workforce planning, policy and reform with the necessary and complementary reforms to education and training. HWA is a key source of advice to the Australian Health Ministers’ Conference (AHMC) on reform directions and on policy, regulatory or funding barriers to implementing substantive workforce change.

Its key functions are to oversee:

- improving the capacity and productivity of the health sector to provide clinical education for increased university and vocational education and training places
- facilitating immigration of overseas trained health professionals and continuing to develop recruitment and retention strategies
- system, funding and payment mechanisms to support new models of care and new and expanded roles
- redesigning roles and creating evidence based alternative scopes of practice
- developing strategies for aligned incentives surrounding productivity and performance of health professionals and multidisciplinary teams.

In 2010 the 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 (Framework). The purpose of the Framework is to support sustained national effort and to support and guide work at the jurisdictional and local levels.

The Framework seeks to:

- set broad parameters for the system as a whole recognising that HWA can only be one contributor to the necessary reforms of the health workforce
- provide a high level framework that encourages the development of new models of health care delivery
- facilitate inter-professional practice
- identify how to equip health professionals for current and emerging demands on the health care sector
- progress the new workforce models and reforms that are essential if we are to address workforce imbalances
- ensure Australia's health workforce can meet increasing demands for services resulting from factors such as an ageing population, increasing levels of chronic disease and community expectations.

Research to Inform the Development of the Strategic Framework

The following research has informed the development of the consultation draft of the Framework:

- A review of international and Australian peer reviewed literature
- National Health Workforce Innovation and Reform Strategic Framework: Alignment with National Reform Initiatives (Matrix)
- A mapping of Australian State and Territory health strategies and plans, as they relate to workforce innovation and reform
- A comprehensive bibliography of approximately 500 sources.

During the course of national consultations in April–May 2011, stakeholders provided additional references, case studies or draft research. A list of these additional references has been provided as Appendix A to the Background Paper in its final version.

Documents produced from these research approaches make up the Background Papers that informed the development of the National Health Workforce Innovation and Reform Strategic Framework for Action.
Brief overview of conclusions and their implications for the development of the framework

The health workforce supports and delivers services that have a major impact on the health, wellbeing, social inclusion, productivity and quality of life of individuals and their communities. The provision of these services accounts for increasing proportions of public and private expenditure and trends in population size, age and health are expected to have major implications for the delivery of health care over the coming decades.

In all OECD countries total spending on health care is rising faster than economic growth. In Australia health expenditure is rising faster than economic growth. The continued growth in health care expenditure in OECD countries is attributed to increasing longevity, the positive outcomes of previous health policies and advances in treatment and technology, the growing cost of pharmaceuticals and new technologies, increasing affluence and market forces creating higher levels of usage and higher expectations in developed countries.

Australia’s health expenditure in 2007–08 exceeded $100 billion for the first time. The $103.6 billion represented 9.1% of GDP, with 70% being paid for by government. Australia has an ageing and growing population that is escalating pressures on the health system with spending on the over 65s as much as four times more per person than on those under 65.

Currently, more than a quarter of Australian government spending is directed to health, age-related pensions and aged care, with rising health costs by far the largest contributor. At the same time, the workforce is ageing and workforce participation rates are falling as older people (including the health care workforce) retire or work fewer hours.

The current and forecast health workforce imbalances and service model imperatives are driven by a complex interaction of demographic, socio-cultural, clinical and professional factors that exert pressure on health care service delivery, and the supply, motivation and retention of the health workforce. These imbalances are not uniformly distributed, but vary by health profession, specialty, jurisdiction and geographical location. Imbalances in workforce numbers do exist in some places, but they can also manifest as over-supply in some disciplines at some times, skill imbalances among health workers that result in an inadequate mixture of skills to address patient need and consumer preference, as well as maldistribution (internationally and within countries). Addressing health workforce needs does not only equate to producing more workers. Re-balancing can be achieved by improving competencies, changing skills mix, and by augmenting productivity.

The current focus is on:

- increasing numbers in the workforce (increasing numbers of clinical training places, encouraging re entry, supporting retention)
- redesigning to support increased productivity (organisational and service redesign to increase engagement in direct patient care by health professionals)
- role redesign (efforts to ensure all professions work to full capacity and maximize return on investment in specialist training, creation of assistant roles to free higher skilled parts of the workforce from activities that require a lower level of skill)
- quality and safety efforts to reduce avoidable adverse outcomes and avoidable admissions and attendances at health services.

The evidence strongly suggests that this focus, though important, will be inadequate to address the many threats to the sustainability and appropriateness of health system organisation and the delivery of care. The rapidly changing extent and nature of population need requires a different order of change at national, regional and global levels. What is required is a paradigm shift in ways of thinking about health system and workforce design and planning, one that works backwards from outcomes for communities and consumers and population need, versus the current thinking that is generally focused on working forward from the base of existing professions and their interests and skills demarcations and responsibilities.

The task is to shape the new direction while supporting and improving the productivity of the existing system and workforce; attract and retain replacements for the retiring workforce; expand the size and nature of the workforce to care for the ageing population; and cope with the significant changes to health care delivery consequent on new technologies and advances in science and therapeutics.
Successful planning and implementation of non-traditional models involves micro-level initiatives, supported and guided by macro-level strategies. Micro-level initiatives can include redefinition of roles, inter-professional collaboration, enabling service provision to full scope of practice and creation of supporting technologies and information systems. Macro-level strategies include changes in educational approaches and changes in policy or regulation. The role of a national strategic framework in a federal system would therefore involve both enabling macro-level reform and supporting continuing micro-level initiatives. This support might consist of the joining up of local and jurisdictional level activities, disseminating lessons learned, facilitating the scaling up of proven initiatives, reducing duplication of effort and developing a more coherent and consistent approach to funding system reform (as proposed in the reforms arising from the National Health and Hospitals Reform Commission).

Meeting these challenges requires thinking from the starting point of the needs, circumstances and expectations of people and their communities; and then applying the results of this understanding to the workforce and workplace, and to new strategies for leading, training, managing and developing human resources for health. Innovation also involves identification of new ways of production. It is not just about ‘how many providers are required?’, but about ‘what type of providers are required?’ ‘how many?’ ‘to do what?’ ‘and how?’ ‘for whom?’ ‘under what circumstances?’

Importantly, making workforce planning part of health system planning and reform, and education planning and reform, will increase the likelihood that these reforms will gain traction and become successful and sustainable.

Many industries have recognised that the leadership and management styles necessary to promote quality improvement, efficiency and safety can have the unintended consequence of reducing the capacity for innovation and reform. Efforts to improve efficiency, productivity and safety promote adherence to policies, guidelines and procedures and thus reduce variation. The result can be that innovation is reduced and in some instances punished. The culture and leadership style required for innovation and change is different.

The current and forecast health workforce imbalances and service model imperatives are driven by a complex interaction of demographic, socio-cultural, clinical and professional factors.

HWA, with its mandate for advice on innovation and reform, can work with service providers across government, non-government and private sectors to seed innovation, build critical mass for change, identify and maximize the use of parallel work by others, and promote and support the type of leadership that can manage the full range of risks in the health system while allowing for and promoting real innovation and change.

The development of a Framework therefore, is an example of a significant change initiative where the intention is to steer a system in a major new direction, not just achieve narrow program or project outcomes.
An extensive search of the literature on health workforce issues has been conducted. This search has sought to be comprehensive for the relevant literature about such issues in Australia published over the past decade and has necessarily been selective for other countries. The scope of issues surrounding the health workforce has moved beyond planning for sufficient numbers of traditional occupations to encompass a much broader range of issues. Many of these issues arise from epidemiological and demographic transitions in population health, especially the increasing prevalence of chronic illnesses and an ageing population; and from new health technologies. Technological change has enabled the ‘routinisation’ of some clinical procedures to allow provision of care in community rather than clinical settings and by health care practitioners with more specific and appropriate skill sets. This recognition of skill set mix in patient care processes has challenged traditional occupational roles and boundaries between medical, nursing and allied health practitioners. It has also in some circumstance led to reviews of established care plans, clinical pathways and procedures. New health practitioner specialisations have arisen within practitioner groups and new occupations are also being created.

The methodology for our literature search strategy has been two fold, combining traditional bibliographic database, catalogue and Internet searching with a more focused strategy of following the citation trails within individual highly cited papers relevant to the topic areas. A search of Medline using the MeSH term ‘Health Manpower’ (defined as ‘the demand and recruitment of both professional and allied health personnel, their present and future supply and distribution, and their assignment and utilisation’) was supplemented with the key phrases ‘Health Workforce’ or ‘Health Care Workforce’, then combined and limited to English language journals and post 2000 publication. The resulting search set of 2657 items was reduced to 2492 with the removal of 162 duplicate records. This focused approach was replicated in the Cumulative Index of Nursing and Allied Health Literature (CINAHL) (n=1402) and for non-Medline Australian literature indexed in Australasian Medical Index (AMI) (n=203). A further 606 duplicate records were removed from the resulting Endnote Library of 3436 items.

However, within the scope of the project brief, these items were of mixed quality. Further searching of Medline to address broader workforce issues related to changing population need and changing clinical roles and work practices were attempted by exploding the broader MeSH headings of Health Occupations and Health Personnel limited to English language journals and post 2000 publication. Resulting search result sets were too large for serious analysis within the available timeframe, 308,000 and 110,000 respectively. A less sensitive but more specific search strategy was therefore developed, focusing on key Australian journals, book chapters, reports and monographs. The journal focus included the Medical Journal of Australia, Australian Health Review and Australia and New Zealand Health Policy. The traditional method of hand searching the references of relevant items was supplemented by prospectively following the citation trails of relevant highly cited papers and highly cited authors using the Scopus database.

While peer reviewed literature comprises a significant proportion of the health sciences knowledge base, much important information, policy documents and research papers are published in places other than peer reviewed journals. Consequently, in addition to the peer-reviewed literature, ‘grey literature’ in the form of major recent government reports, plans and strategy documents from Australian and international jurisdictions were examined for relevance to health workforce innovation and reform.

CINAHL and PsycINFO were particularly useful tools when searching for material that may be considered a part of the grey literature, as they both index publication forms other than peer reviewed journal articles, editorial and letters etc. These other forms include technical reports, conference papers and proceedings, dissertations, books, book chapters, systematic reviews, technology assessment reports, practice guidelines etc.
HWA research consultant, Siggins Miller, used web tools such as Google Scholar and Scopus to enhance access to scholarly literature published in sources outside the indexing scope of the bibliographic databases discussed above. Google Scholar provided a single access point to articles, theses, books, abstracts and court opinions, from academic publishers, professional societies, online repositories, universities and other websites and Scopus offered sophisticated tools to track citations both retrospectively and prospectively.

Searching the WWW efficiently required strategies to focus on the websites of known organisations active in the target field, such as government departments, clinical service providers, research institutes and university departments. Selecting domain limiters for specific countries or for specific website types and domains increased search specificity. However it was the combination of key words and key phrases in the natural language of the discipline that yielded the best results, together with a preparedness to scan several hundred pages of results.

The results of these searches ensured a more comprehensive coverage of the recent health workforce debates in Australia and relevant evidence and experience from other health systems published in the international literature. These results were combined with selected papers from the broader searches of Medline, CINAHL and AMI. A bibliography of more than 500 items was produced. All search strategies and search results were retained for future research.

The shorter list of references contained in the Background Papers includes those sources that were read and analysed in depth.

The scope of issues surrounding the health workforce has moved beyond planning for ensuring sufficient numbers of traditional occupations to encompass a much broader range of issues. Many of these issues arise from epidemiological and demographic transitions in population health, especially the increased prevalence of chronic illnesses and an ageing population; and from new health technologies.
DOMAIN 1

Health workforce reform for more effective, efficient and accessible service delivery

Reform health workforce roles for more effective and accessible service delivery models to better address health promotion, prevention, population and demographic needs and improve productivity.

Reforms of health workforce roles and service delivery models are generally regarded as micro-level or organisational initiatives, although they require macro-level strategies to enable their successful implementation and sustainability. Recent workforce innovations internationally have commonly involved either organisational interventions (changes to workflow, work load or work location to enhance efficiency, improve the ‘patient journey’ and increase access to health services) or changes to job content (including skill mix changes, job widening, job deepening, or the development of new job roles).

While there has been considerable activity at the State/Territory level, the pace of reform of health professional roles and service delivery models has been slower in Australia than in many other comparable OECD countries. New roles such as nurse practitioners, physician assistants, and lay health workers that are long established in other developed (and developing) countries have often faced barriers in Australia and continue to be the subject of debate, despite evidence of the effectiveness of these roles in achieving the same or improved patient outcomes. Protection of professional boundaries and the continued reliance on models of health service delivery and health education that are based on existing professional roles are seen by many as being largely responsible for this slow pace of reform.

In Australia, these organisational innovations are largely State/Territory based and are at different stages of development and evaluation. Overall, innovations like role re-assignment in the workplace are varying the work ‘little by little’ because of the constraints associated with professional demarcations, long training times and the pace and ability of education providers to respond.

Internationally, the amount and quality of research that evaluates these activities is regarded as insufficient. However, the available evidence indicates that factors promoting success in role and skill-mix changes include introducing treatment/service delivery models of proven efficiency, appropriate staff education and training; removal of unhelpful boundary demarcations between staff and service sectors; appropriate pay and rewards systems; agreed scopes of practice; and good strategic planning and management of human resources. Remuneration systems should be agreed in advance of the implementation, and should reward and not penalise health workers for making the required changes to their work practices. There should be clear lines of management and accountability established prior to implementation and incentives for management to support the introduction of the innovation.

There is considerable evidence that quality improvement (QI) and continuing professional development (CPD) strategies that aim to improve the knowledge, attitudes and behaviours of health workers (such as audit and feedback) can achieve on average a 10% improvement in performance; and strategies that focus on organisational issues, such as multidisciplinary teams (MDTs) and integrated care services, can improve patient outcomes.

Innovative models and work roles have largely arisen at the local level in response to perceived needs at the frontline. Introducing models that have been tested and proven elsewhere is an important factor for success, and the availability of proven innovations can guide and speed up implementation elsewhere, provided there is some room for local involvement in development and local adaptation.

The extension of successful local initiatives to a national level calls for co-operative activity between levels of government, guided by national overarching policy instruments. There will be an important role at the national level to maintain the quality of services, sustain the momentum of current reform in jurisdictions and enhance the efficiency of existing strategic workforce activity across the jurisdictions (e.g. in attracting, recruiting, supporting and developing staff), while at the local level supporting and enabling innovation and guiding macro-level national reforms.
DOMAIN 2

Health workforce capacity and skills development

Develop an adaptable health workforce – equipped with the requisite competencies and support that provides team-based and collaborative models of care.

Micro-level initiatives described in Domain 1 to design and implement new workforce roles and models of care will rely on additional macro-level strategic support for their success and sustainability. Reforms at the macro-level include strategies to ensure that the products of the education system meet the skill mix needs identified in micro-level initiatives. In addition, there is a pressing need for dialogue between health and education providers focusing on the requirements for the future workforce.

A Global Independent Commission has recently concluded that professional education has not kept pace with health workforce challenges, largely because of fragmented, outdated and static curricula that produce ill-equipped graduates. The Commission suggests that these systemic problems produce a mismatch of competencies taught to patient and population needs; inadequate team work; persistent gender issues within professional groups; and a narrow technical focus without broader contextual understanding.

To support workforce reform, much of the current thinking proposes a move to generalist health curricula, with common education platforms across occupational groups; inter-professional learning in both pre- and post-registration training; and a shorter time-frame for training. The literature suggests there is a need to move beyond multi-professional and towards inter-professional training and work practices. Several analysts make an important distinction: inter-professional learning is “where two or more professionals learn with, from and about one another to improve collaboration and the quality of care,” as opposed to (more commonly) multi-professional learning, “where two or more professionals learn side by side for whatever reason.”

Inter-professional learning has mostly emerged in post-registration training, but some argue that this is too late. There is evidence that the outcomes of reforms can be diminished by the difficulties senior practitioners have in supervising and supporting health workers outside their own professional group.

International and Australian literature affirms the need to focus on the skills and competencies required to meet the needs of patients and their communities, rather than on the professional qualifications required. Competency-based educational approaches offer a solution and have been championed as the way forward in health professional training for over two decades. The slowness of the move towards competency-based education however is a source of frustration to many, since the concept is not a new one – first proposed by Flexner in 1910. Consequently, it has been argued that we are “tinkering around the edges” of health educational reform.
Outcomes, rather than inputs such as the acquisition of knowledge and skills are the key drivers for competency-based education. While some view specifications of outcomes as reductionist, the trend in medical and in health science education is to specify outcomes in broad and inclusive terms. Such broad outcome oriented educational approaches provide a number of significant advantages.

- From an educational point of view they enhance curricular coherence and educational flexibility.
- Education and training providers can increase efficiency through reduction in training time while specifying common end points of training provides increased flexibility in the pathways taken to achievement and the types of education providers. Similarly health care organisations can increase training efficiency.
- Public accountability is enhanced by providing evidence of the competency of the health workforce, setting of transparent standards, articulation of agreed measures that can demonstrate quality, and determination of value for public money invested in health professional education.
- Objective information about workforce competencies assists system developers in the process of defining and redesigning roles.
- Regulatory and standard setting bodies can refer to outcomes in determining educational quality making decisions concerning fitness to practice and specifying criteria for continuing professional re-validation.
- Finally this provides an important way to articulate outcomes of various health education courses and curricula to enhance workforce flexibility.

The move to a competency-based approach, with a generalist oriented curriculum and increased focus on inter-professional learning, calls for a major overhaul of traditional education processes and content. It also has profound implications for the structure and content of current clinical training programs; and implications for industrial relations, since it will challenge professional boundaries and perceptions of status and reward. It will also have implications for registration authorities and professional regulatory bodies, since establishing unnecessarily high certification thresholds can limit those eligible for new roles.

Competency-based education and training involves careful specification of desired outcomes, a model of small group learning rather than didactic teaching and sound processes of appraisal and feedback on progress towards these outcomes. A competency-based approach also contrasts with a time-based education system, since completion of training is primarily linked to the demonstration of competence. This concept sits at variance with traditional training and health institution systems that are linked to employment contracts, rotations and 'time served.' Even within uniform time structures, some claim that, particularly for postgraduate medical education in clinical settings, the current system is not configured for an approach of training and feedback based on competency.

The ultimate goal is to make the needs of the patient and the community the starting point in identifying what skills, attitudes and behaviours health workers need to develop. We need to achieve more quickly and more cost-effectively a better prepared (work-ready), adaptable and sustainable health workforce to better serve the needs of the population. There are significant educational, status-based, remunerative, industrial, legislative and regulatory implications that need to be addressed if this depth and breadth of reform is to be achieved (see Domain 5).
Leadership becomes vital when an organisation faces the need to mobilise a workforce in a new way towards a vision, a set of values, or to changing work practices. Moreover, leadership can influence an organisation’s outcomes and the health and wellbeing of patients and staff in both positive and negative ways. Leadership and management are often confused. The purpose of leadership is to bring about movement and constructive change, while the role of management is to provide stability, consistency, order and efficiency. Problems may fall into the category of technical work (known problems solved through proven solutions) requiring a management approach; or adaptive work (unknown or uncertain problems requiring a new process to create solutions) which requires leadership.

Leaders will initiate and steer health workforce innovation and reform, and they will be needed at all levels of the health system – particularly at the local level on the frontline of service delivery. The challenges will be to achieve a shared understanding of what leadership is and who the potential leaders are. Investigations into major systemic failures in health systems inevitably identify weakness in leadership as a key contributing factor. Reviews of successful implementation of workforce change identify leadership (and continuity of leadership through the change process) as a crucial factor for success. Leadership which facilitates followership is critical for achieving change. In the health care industry employees are trained to think and act in the interests of their professional autonomy, which in turn is thought to be the cornerstone of patient safety. In this context leaders struggle to find followers no matter how they behave. In addition, employees who are working to full capacity in facilities where resources are stretched often become change weary as they are asked to once more adapt to a new structure or way of working.

Taken together, these two dynamics mean that any strategy to build capacity for clinical leadership has to be based on a firm understanding of the importance of building a culture of collaboration and engaging people in ways that promote the reciprocal nature of the leader/follower relationship. In the health care reform context, the role of the leader (clinical or otherwise) is to facilitate and support new ways of working; to provide others with access to the knowledge and skills required for change; and to provide an environment where change happens and where the risks of change are acknowledged and minimised.
The role of clinical leaders is receiving increasing attention owing to their ability to influence best practice, especially at the service level. Limited consensus exists for a universal definition of clinical leadership, but it has been differentiated from health care managerial leadership primarily focused on the overall needs of the organisation because of its proposed focus on enabling and championing best practice, progression towards best patient outcomes, and meeting service-level needs. Clinical leadership, like managerial leadership, can be predominantly technical in focus. For the purposes of this Framework development, a definition of clinical leadership that is relevant for steering major innovation and reforms could be:

- an ongoing process of engagement between a credible health care professional and fellow service providers and support staff, where the locally connected clinician champions the transformation of work to meet local population needs and deliver quality patient care at the service level.

The development of leadership competencies in clinicians, managers and a range of health services staff is necessary to create and maintain a culture within health services which upholds the fundamental values of patient safety and best practice, while remaining open to change and engaging with consumer, carers and communities to explore how best to meet their health care needs.

Added to the challenges facing health workforce reform are deeply rooted institutional and professional cultures, organisational structures and social dynamics that can act as barriers to adopting practices that produce best patient outcomes.

Leaders will initiate and steer health workforce innovation and reform, and they will be needed at all levels of the health system.

Leadership competency frameworks have been developed internationally, on the basis of empirical research. Not all competency frameworks are specific to leadership-for-change: some incorporate competencies associated with general health care leadership, such as administration, management, and executive-level leadership within health care and clinical leadership. Competency in leadership-for-change will need to be developed in all these roles and at all levels in the health system.

For workforce innovation and reform to succeed, leadership will also be crucial from within the education and training systems, and at the senior political levels in health, education, labour/industrial relations and finance. Senior levels within the health and education systems will need to support local leaders by minimising uncertainty, allowing some risk taking that will inevitably be associated with innovation and supporting them through a significant time of change management.
DOMAIN 4
Health workforce planning

Enhance workforce planning capacity, taking account of emerging health needs and changes to health workforce configuration, technology and competencies.

Planning for health services and the workforce to deliver them has relied largely on planning for existing occupational groups, existing service usage, illness-based models of care and population age projections. Such traditional workforce planning and modelling is now viewed as insufficient to support innovation and reform,\(^{15,16}\) and there is a view that it can perpetuate existing inefficiency.\(^{15,16}\) This is a global issue for workforce planning, and some suggest that it has led to oversimplified use of demographic projections and possibly incorrect conclusions that population ageing and ageing of the workforce are the dominant influences.\(^{85}\)

Policy levers developed in response to such planning models have traditionally included adjusting intakes for specific occupations, by adjusting the numbers of student places in education programs, based on planning models and projected workforce numbers. Policies for creating more graduates in existing professions have a long lead time and may have unintended impacts on other occupations,\(^{68}\) or on micro-level initiatives and new service delivery models that are developed in the meantime.\(^{19,35}\) Small gains in productivity (i.e. increased time spent on direct patient care, achieved through organisational initiatives) can address workforce shortages more quickly and more effectively than adjustments of education places.\(^{15,16,61}\)

Internationally, analysts suggest that current workforce planning does not adequately capture many factors that influence workforce supply: not only gender, marital status, child care responsibilities and ‘lifecycle’, but also other factors that will influence workforce behaviour and availability to the sector.

It is important to understand provider responses to changes in payment, practice organisation and income earning opportunities\(^{61}\) and to understand the reasons for workers’ decisions to leave, stay in or return to the health system.\(^{44}\) In addition, assumptions about hours of work have often been unrealistic\(^{51}\) and are premised on health service delivery in traditional institutions by traditional professional groups.\(^{52}\) Current planning may not adequately factor in the effect of policies of de-institutionalisation and the shift to community-based care, the increased role of the private sector and NGOs in providing health services, and the shift of work from paid workers inside institutions to more lowly paid or volunteer workers in the community.\(^{80}\)

On the demand side, models may not be sufficiently dynamic and may not adequately embrace the changing needs of population groups, and the improvements gradually achieved through other health policies.\(^{15}\) There is also limited use of dynamic planning models that simulate alternative policies and test policy mixes for their relative effectiveness or that model the impact of anticipated advances in treatment or technology.\(^{50,96}\)

INTERNATIONAL

Enhance workforce planning capacity, taking account of emerging health needs and changes to health workforce configuration, technology and competencies.
Some argue that the tools capable of undertaking more detailed analyses are readily available, but the current limitation is the available models and frameworks that make use of these tools. This brings the focus of strategic framework development to questions raised in the planning methodology literature: it is not just about ‘how many providers are required?’, but about ‘what type of providers are required?’ ‘how many?’ ‘to do what?’ ‘and how?’ ‘for whom?’ ‘under what circumstances?’

A shift to needs-based workforce planning models would derive requirements for providers directly from the requirements for services and therefore could be applied to a range of provider types. Requirements for services would be developed at the local level, through consultation with consumers, carers, communities and providers. “Skill-mix planning needs to start from this specific analysis of the patient population in question and their health needs in order to determine the type and mix of staffing required.”

In order to effect real change, workforce planning needs to provide a framework and models for identifying and planning the types of health roles that will best meet the needs of consumers, reflecting consumer preferences and new technologies. Such planning will reflect and plan for the emergence of new roles or the recognition of existing roles (such as ‘expert patients,’ lay health workers, peer support workers in mental health or unpaid health support workers in the home or the community). It will be responsive and adaptable, using richer sources of information to test scenarios that can be updated or modified with changes in technologies and treatments or community health needs. Importantly, it will also be available to local planners at the service level to inform the development of micro-level initiatives.

Effective innovation of workforce planning will support the implementation of major national health strategies in areas such as preventive health, chronic disease management, primary health care and mental health care reform.
**DOMAIN 5**

Health workforce policy, funding and regulation

Develop policy, regulation, funding and employment arrangements that are supportive of health workforce reform.

The Australian context provides decision and policy makers with a unique set of challenges and characteristics. These include the needs of underserved rural and remote Indigenous communities, inequity in health outcomes for Indigenous Australians and for people in rural and remote areas, a three-tiered system of government, and a mix of public, private, not for profit and Indigenous community controlled service delivery. These require specific social and political choices about access to and delivery of health care before appropriate methods can be used to derive requirements for providers and services in particular populations, locations and sectors. Many of these choices have been articulated by government in national health plans and priority areas for action and reform. Appropriate methods of identifying the service requirements of consumers, carers and communities have been suggested in the previous Domains of this strategy.

In the context of reform and innovation of health care provision, there is consistency of approach internationally. The steps taken by governments might start with developing and disseminating a national health plan (or plans) responsive to identified health needs of the population; then progress to configuring services and agreeing on models; and then formulating information technology, capital and workforce solutions. All these steps are underpinned by the availability of quality information that enables policy makers to evaluate the basis of and justification for decisions and priorities.

The principal policy levers available to governments to shape the health workforce include education, occupational regulation, and health care financing and organisation. These are macro-level activities that support micro-level innovations. To support fundamental changes in job design, scope of practice, professional demarcation and the creation of new roles, important industrial issues are also to be addressed. Public policy defines which employees are qualified to carry out which work in the health care system and which professions can determine access to the health care system (through the referral system and rights of first contact). Consistent, national occupational regulation is arguably further progressed in Australia than in comparable federated countries. However, regulatory boundaries can limit the opportunities for enhancing roles of health workers or substituting one type of health worker for another (including regulatory boundaries between the health and social care sectors) and can complicate providers’ abilities to redesign and re-allocate work. Ongoing effort will be required so that the regulatory process enables different professions to share overlapping scopes of practice, based on demonstrated initial and continuing competence; and so that all professionals are supported to provide services to the full extent of their current knowledge, training, experience and skills.

In terms of health care financing and organisation, decision-making should be informed by scenario modelling that reflects the dynamics of the health care system and the labour market. Health care financing decisions can unintentionally impede reform and innovation. For instance, the current system of publicly subsidising medical services and pharmaceuticals may provide incentives for consumers to seek medical interventions and drugs as solutions to health problems, when in many cases offering alternative services may provide a more effective and less costly solution, particularly for chronic problems. This pattern may be counterproductive when introducing new models of care and service delivery and new roles to support people with chronic disease. Careful consideration of the implications of any change in one part of the system, based on quality information and planning, will be essential.

Much of the current and suggested workforce reform in the health sector cuts across industrial issues and encroaches on traditional professional boundaries. Professional groupings in the health sector have strong industrial advocates in their professional associations or trade unions. Other health workforce groups are relatively fragmented and unrepresented.
There are considerable disparities in pay and conditions between jurisdictions for the same work performed inside institutions compared to in the community; or for a public, private or NGO employer; or for some professional groups, such as a private practitioner. Health workforce reform and innovation will take place against a backdrop of a complex, two-tiered industrial relations system. This system is itself undergoing reform under the Fair Work Act 2009, and is moving towards a national approach with fewer, simpler industrial instruments. These reforms potentially could support and facilitate the introduction of new roles and competency-based remuneration and career progression. At the same time, the reforms could increase the involvement of third parties, such as professional associations, in workplace change and thereby unintentionally increase complexity. A period of complex transition, consultation and negotiation lies ahead.

In a labour market where the public and private sectors are competing for workers, simple solutions will not be forthcoming. Most health professionals have work options, and reforms may have unintended negative consequences that will determine those options. Increasing pay in the public sector prompts increases in the private sector and immediately negates anticipated benefits. The effect of workforce reforms on salaried employees (perceived as work intensification, a loss of job security and broadening of job responsibilities) can be very different for those in private practice (who may have access to a range of benefits including the opportunity to work outside the bureaucracy of the public system; to see financial rewards for their work; to operate with increased autonomy, greater flexibility and opportunities for part-time work; and more choice in treatment approach).

There are lessons to be learnt from comparable countries about what remuneration, reward and pay progression systems may work, and how these might reflect any proposed changes in education programs, roles and career structures. A national approach should achieve consistency and reduce duplication of effort. Collaboration with relevant government portfolios and across jurisdictions and sectors, informed by the best evidence, will be crucial.

Strong links are needed between the education and health portfolios, and elements of the education and health systems need to align with each other and with patient needs. Education providers must respond quickly to changing needs in health workforce development, and then evaluate the effectiveness of their programs using indicators of practice outcomes. Education policies in any one period have serious implications for policies on health care provision in the future. At the academic research level, prompt translation of research findings into practice informs innovation and quality improvements.

In a context where public access to health information is increasing, and where public policy is shifting towards health promotion, illness prevention and community-based primary care, there is a continued predominance of hospital orientation at the expense of primary care, and the illness model of care continues to dominate. Health workforce reform will therefore be a crucial component of successfully implementing current and foreshadowed national reforms and health care priorities.

The national policy instruments to support local level innovation would need to include development of common frameworks for information collection and analysis that will support planning based on community needs and policy priorities (see Domain 4); speedier implementation of education and training programs that will produce the workforce required and support the current workforce through the change (see Domain 2); development of remuneration and rewards, registration standards and scope of practice frameworks that reflect levels of competence, regardless of professional group (see Domains 1 and 2). There are benefits to be gained from national facilitation of information sharing and diffusion of learning from local initiatives (Domains 1 and 3). These benefits could lead to a reduction in duplication of effort, more efficient use of resources and therefore the freeing up of resources, thinking and energy to be directed towards innovation and reform.
References

This list contains references to documents that are directly referred to in this concise Background Paper. A list of references and additional sources provided by stakeholders during the national consultation process for the development of this Framework can be found in Appendix A.


74 National Health Service (2010). Planning and Developing the NHS Workforce: The National Framework. UK.


93 The Healthcare Leadership Alliance (HLA) Competency Directory (2004). Developed by the HLA, United States.
94 The Medical Leadership Competency Framework (2008). developed by the NHS Institute for Innovation and Improvement, United Kingdom.
95 The National Center for Healthcare Leadership Competency Model (2004). developed by the National Center for Healthcare Leadership, United States.
100 Victorian Quality Council (2005) Developing the clinical leadership role in clinical governance: A guide for clinicians and health services
Appendix A

Additional references and sources provided to HWA by stakeholders during the consultation process.


Blacker N, Pearson L, Walker T. Redesigning paramedic models of care to meet rural and remote community needs 10th National Rural Health Conference.


Case study, MJA Careers in Indigenous Health issue, Medical Journal of Australia, 194(10), 16 May 2011.


Community Services and Health Industry Skills Council (2011). Environmental Scan 2011.


Healthy Horizons: A Framework for improving the health of rural, regional and remote Australians.


National Aboriginal and Torres Strait Islander Health Council (2008). Pathways into the Health Workforce for Aboriginal and Torres Strait Islander People: A Blueprint For Action.


National Rural Health Alliance (2008). Improving the rural and remote health workforce: A submission to the Department of Health and Ageing related to the audit of the rural and remote health workforce.


O’Mara, P. (2011). Our doctors making a difference: Aboriginal and Torres Strait Islander doctors walking in both worlds for the benefit of all Australians, in Indigenous Health issue, Medical Journal of Australia, 194(10).


Shortell SM & Casalino LP (2008). Health Care Reform Requires Accountable Care Systems JAMA, July 2, 300(1)

Simmons B (2009). Reforming health professions' education for a healthy nation: submission to the NHHRC.


World Health Organization (2010). Increasing access to health workers in remote and rural areas through improved retention: global policy recommendations.