Options for expanding the health workforce

Peter M Brooks, Lynn Robinson and Niki Ellis

Abstract

Health workforce reform remains a major challenge for Australia. The recent Productivity Commission report provided some guidance, but, sadly, few of the recommendations have been implemented. Health economies (and with them the health workforce) will continue to expand as the burden of disease increases. The important issue is to expand the current workforce but provide for a generalist stream that allows flexibility and retraining. The future health workforce needs to be able to provide patient-centred care, to have a focus on public health and disease prevention, use information and the new communication technologies, to be able to work as part of a team and partner with a range of organisations and to be dedicated to quality improvement within the health system.

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What is known about the topic?

The existing health workforce is not ill-structured to cope with the increasing burden of disease.

What does this paper add?

This paper discusses role extension and task substitution as potential solutions to the workforce issues.

What are the implications for practitioners?

The author supports the introduction of physician assistants and greater utilisation of nurse practitioners to address our workforce issues.

THERE IS LITTLE ARGUMENT that delivery of appropriate health care to an increasingly aged population with chronic disease and disability is a major challenge facing countries. Developing countries face problems with infectious diseases such as HIV, malaria and other tropical diseases, and have to cope with cardiovascular disease, diabetes and other health problems. All countries have issues with a shortage of trained health workers and the challenges of adapting their health system to cope with the 21st century.

Peter M Brooks, MB BS, FRACP, FAFPHM, FAFRM, MD, Executive Dean
Lynn Robinson, MB BS, Director, Centre for Health Innovation and Solutions
Niki Ellis, MB BS, FAFOM, FAFPHM, Director, Centre for Military and Veterans' Health; and Chair, Workforce Committee
Faculty of Health Sciences, The University of Queensland, Brisbane, QLD.

Correspondence: Professor Peter M Brooks, Level 1, Edith Cavell Building, Royal Brisbane Hospital, Herston, QLD 4029. **p.brooks@uq.edu.au**

Muir Gray[1] has defined the characteristics of modern health care as:

- Concern with health as well as health care (prevention as well as treatment)
- Concern with patient satisfaction and experience of care
- Evaluation of services in terms of effectiveness, appropriateness and of necessity
- Public involvement in health and health care policy making
- Commitment to continual quality assurance
- Emphasis on accountability.

The future of health care will be more devolved than it is now, technology influenced and with more community and individual participation.[2] Health workforce reform is high on the agenda in Australia, driven in part by the recent Productivity Commission Report — *Australia's health workforce* — which could serve as a blueprint for health reform in Australia and presents task substitution as one option in tackling what all acknowledge to be a very complex issue.[3] The Productivity Commission Report presents economic arguments for changing the way we practise. This is often an anathema to health professionals, but to suggest that providers of health services in the twenty-first century have no economic responsibility for what they do is unacceptable. The issue is not specifically

1 Principal recommendations of the Productivity Commission report[3]

- Enhancing the National Health Workforce Strategic Framework as a reference point for future reform and importantly a vehicle for promoting coordination across the policy areas that impact on the health workforce.
- Facilitating workplace innovation through the establishment of an Advisory Health Workforce Improvement Agency that would provide an independent assessment of the benefits and costs of workforce innovation opportunities, identify implications for education and training, accreditation and registration and the funding through both the public and private sectors.
- More responsive education and training requirements to better align the numbers of tertiary health training places with the health needs of the community and the workforce requirements of the service providers. There is also a need to ensure the clinical training capacity in many areas and to encourage new providers of health training through a range of organisations.
- Develop a consolidated national accreditation regime that would facilitate timely uptake of workplace innovations emerging from the proposed workforce improvement agency and interdisciplinary learning. This would also provide a platform for uniform national standards on which to base registration and to facilitate the development of a national approach for the assessment of the qualifications of overseas-trained health workers.
- Develop a consolidated national registration agency to promote a national uniform approach to the regulation of health workers and reduce barriers to the movement of health professionals within Australia.
- To provide improved funding-related incentives for workplace change which might include an expansion of MBS (Medicare Benefits Schedule) items including the development of delegated care models.
- Develop a more streamlined and focused approach to projecting future workforce requirements. This might be achieved by better use of resources available to undertake the projections and more transparency in relation to the impact of policy settings on future workforce requirements.
- A more effective approach to improving outcomes in rural and remote Australia.

about saving money; it is about using resources more efficiently to meet rising demand. The major recommendations of the Productivity Commission report, shown in Box 1, have been accorded only lip service by the federal government.

There is little alignment between the education sector (which provides the tertiary education training places) and the health jurisdictions which provide the clinical training positions. The continuum of education and training is fragmented, particularly medicine, between universities, health departments (postgraduate education authorities) and the specialist Colleges, with little incentive to disturb the status quo. Even the idea of national accreditation and registration authorities has become embroiled in debate on loss of autonomy of geographic (state) or professional groups. Another recommendation of the report, that the Medicare Benefits Scheme be expanded to encourage development of alternate models of health care delivery, including task substitution, has not been embraced by the current federal government.

Health workforce

It has been estimated that the health workforce in Australia constitutes just over 8.9% of the total workforce and is one of the largest workforce groups. The health workforce grew by 26% between 2000 and 2005; over twice the growth of other occupations (10.4%).[4] Robert Fogel (Nobel laureate) recently predicted that economies in the developed world would be driven by an expansion in health care, which will account for 20%–25% of gross domestic product by 2025.[5] With such issues as feminisation, changing attitudes towards working, the ageing population, chronic disease and increasing community expectations for health, we may need to have over 20% of the total workforce in health-related areas by 2025 if we are to maintain the delivery of services that we currently have.[6] There are obviously a number of options for meeting this increasing demand, which include:

- Appropriateness of existing health workforce in relation to current scope of practice
- Extending the role of existing health professionals (nurses and allied health professionals)

2 NHS Career Framework

Level	Role
9	More senior staff
8	Consultant practitioners
7	Advanced practitioners
6	Senior practitioners/Specialist practitioners
5	Practitioners
4	Assistant practitioners/Associate practitioners
3	Senior health care assistants/technicians
2	Support workers
1	Initial entry level jobs

- Creating new types of health workers (clinical/physician/surgical assistants)
- Improving efficiency of health workers by using information and other technologies more effectively
- Placing more emphasis on prevention and health promotion in the community with development of models of self-management
- Changes in models of training.

Role extension and task substitution can involve the creation of new autonomous roles (nurse practitioners) or roles in which non-medical practitioners (physician assistants) work under the supervision of someone else (usually a medical practitioner) — a delegated care model. Supervision may be in person (eg, a clinical assistant working in a primary care setting with a general practitioner) or remote (eg, nurses or physiotherapists who may be running minor illness or injury clinics using video links for their medical supervision). There is no doubt that nurse practitioners have a significant and increasing role to play in the Australian health care system, but although they have been around for a number of years, there is still significant resistance by powerful lobby groups such as the Australian Medical Association. Part of this may be the concern about "independent" practice but part is due to the continuing "siloed" approach from many health professional groups within the system.[7] The argument against nurse practitioners is not evidence-based, as studies demonstrate patient outcomes and satisfaction equal to or better than services delivered by general practitioners.[8,9]

We believe that in the implementation of role extension a combination of service redesign, the use of clinical practice improvement methodology and the development of progressive competency-based training is essential. Role extension needs to be based on the concept that generic health competencies can be developed which cross professional boundaries. The development in the United Kingdom of a generic health career framework (Box 2) provides a good example of this and has the potential for adaptation and testing in Australia. This model[10] provides a nine-level career framework commencing with supporting roles and then moving through a series of levels (Assistant, Senior Assistant, Assistant Practitioner, Qualified Practitioner, Senior or Specialist Practitioner, Advanced Practitioner, Consultant Practitioner) to quite senior posts. The advantage of this model is that it allows a wide variety of entry points into health care careers, encourages and recognises life-long learning and the acquisition of new skills, and is used in an environment that seeks both job satisfaction and service efficiencies by "delegating roles, work and responsibilities down the escalator where appropriate". This model of integrated practice could be utilised across a number of existing health professional groups (nursing, allied health) and should be trialled in the Australian context. The medical care practitioner/physician assistant is now being developed in the United Kingdom (both England and Scotland)[11] and also in a number of countries in Europe, and in Canada.

An argument for developing these new types of practitioners is that they will help to expand the workforce and not merely redistribute tasks within an already overloaded system. In the United States, physician assistants and nurse practitioners are a rapidly expanding group. In 2006 there were over 110 000 clinically active physician assistants and nurse practitioners making up about a sixth of the US medical work-

force.[12] Nurse practitioners and physician assistants in the US work in a diverse environment including individual and group practices, urban and rural areas, hospitals, correctional institutions, inner-city clinics, migrant worker clinics, emergency medical departments and doctors' offices. They constitute one of the fastest growing areas of the health care system with over 11 000 graduating each year. There are nearly 140 accredited physician assistant programs in the US, the majority of them associated with medical or health science faculties. This is important as it provides the opportunity for interprofessional and multidisciplinary learning at an early stage, so that the graduates from these programs already have the experience of working with doctors in the interests of patient care. Of particular interest is the fact that the majority of the physician assistant programs in the US are generalist based and all physician assistants are required to pass a general examination every five years to continue their state and national registration. This is certainly a benchmark that other health professionals in Australia might look at. The importance of a generalist training is that it allows much more flexibility of the physician assistant pool as, even though they may develop a speciality pathway and work in a focussed area, they can be rapidly retrained if the need or desire arises. This provides a significant flexibility to the health care system which is not apparent if physician assistant programs are specialty based from the start.

In an excellent review of the literature and of the development of extended practitioners in the UK, Buchan, Ball and O'May[13] identified issues related to their introduction into the health system. These include scope of practice, legislative and regulatory requirements, supervision and working relationships and remuneration. Despite these issues, a number of US-trained physician assistants and others have been employed in pilot projects within the National Health System and several universities are developing training programs. These new health professionals are known by various terms (medical or surgical care practitioners, or in some cases physician assistants). They are deployed in roles across the health sector, but already benefits in the primary care setting are being realised, such as reduced waiting times and improved access, better management of increasing workloads and improved job satisfaction.

As we continue to introduce the concept of physician assistants in Australia their training options need to develop. This will best be done (as in the US) within Faculties of Health Sciences where they can train with other health professionals with whom they will work after graduation. Given that much of their work will be in the area of chronic disease this training should espouse the five basic competencies required of the future health workforce outlined recently by the World Health Organization.[14] These include:

- Patient-centred care
- Partnering
- Quality improvement
- Use of information and communication technology
- Adoption of a public health perspective.

There is significant and growing interest in the development of physician assistant programs in Australia but also pressure to develop speciality models of training driven in part by interests within the private sector. While we applaud the enthusiasm of this sector in embracing opportunities for workforce change it is our strong belief that the generalist model will serve Australia better in the long term and does not preclude the development of specialty interests once general competencies have been achieved.

Conclusion

The health workforce needs significant expansion to cope with the service demands of an ageing and chronic diseased population. Future models of health care delivery require a reorientation of the current workforce and development of new types of health workers. The recent report[15] that nearly two-thirds of patients with non-urgent musculoskeletal conditions referred by GPs to an orthopaedic outpatient facility could be appropriately assessed and managed by physiotherapists is

a good example of the type of "task transfer" study that should be researched.

Similar projects where radiographers might report on x-rays in a delegated model have also been proposed,[16] but have of course been opposed by powerful self-interest groups.[17]

These new models of health care delivery should be trialled and assessed in the Australian context, and if clinical outcomes are equivalent or better they should be implemented, even though they might disturb the status quo. The introduction of physician assistants and nurse practitioners (particularly in the US) has been an important innovation within the health care workforce. Their emergence has stimulated review of health workforce policies and assumptions of care delivery that might otherwise have not been addressed, and their presence in the system has promoted new opportunities for organisational efficiencies.

As Australia faces significant challenges in health care reform there is an urgent need to explore the role of physician assistants in the Australian context and to evaluate them appropriately. The opportunity exists to experiment with various models of task substitution through education, service delivery and consumer partnerships which would add significantly to our knowledge. If we are going to seize the opportunity to provide, in this country, learning-centred health education, patient-centred health care and a consumer-focussed but provider-friendly health system,[18] then we need to work together to ensure its success.

Competing interests

The authors declare that they have no competing interests.

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