Health Workforce Innovation Conference

Peter M Brooks and Niki Ellis

We need to create a range of new health practitioners who can deliver patient-friendly care

On 22 and 23 November 2005, some 200 health professionals, including doctors, nurses and other health professionals, met in Brisbane to discuss education and training issues for the future health workforce. The meeting, sponsored by the University of Queensland and Queensland Health, accepted that providing health care for an ageing population afflicted with chronic disease requires a health workforce that is more flexible, mobile and multiskilled than our current one, and this will require creative thinking about future workforce requirements. Key issues addressed at the meeting included:

- What will be the health care requirements in 2010–2020?
- Who is going to deliver these services, and how?
- How are these health care practitioners to be trained?
- What are the issues of accreditation of these practitioners?
- How are we going to pay for these services?

William Doe (Dean of the Faculty of Medicine, University of Birmingham) discussed some of the changes that are occurring in the United Kingdom's National Health Service (NHS). These relate to the National Practitioner Program, which tackles traditional and longstanding barriers to change, such as professional boundaries, team structure, hierarchies and existing care processes. The program involves expanding the depth and breadth of roles and creating new job descriptions so that different health professionals at similar levels of responsibility can share a number of care competencies in addition to those unique to their own role. An important enabler in the NHS has been the establishment of a generic competency-based skills escalator, involving all non-medical health professions. This framework has eight steps, beginning with a Junior Assistant and ascending to a consultant Health Professional Practitioner. Foundation degrees allow a broader range of people access to health careers, commencing in the newer roles lower on the skills escalator.

New roles described by Doe include the Medical Care Practitioner, which is based on the physician assistant model in the United States and will have a skill and knowledge base to deliver most generalist diagnoses, treatment and care within general medical and family practice. Science graduates, NHS staff and armed health services staff are the expected source of recruits, and there are plans for a 2-year university degree course, developed with input from universities and royal colleges. This course will lead to a statutory registered qualification and registration, probably on the health professions register. Although there will be considerable autonomy for Medical Care Practitioners, they will work under the supervision of a qualified medical practitioner.

Surgical Care Practitioners will tend to be drawn from nurses and other health care practitioners, and will assist in delivering surgical services to patients under the supervision of a consultant surgeon. Again, this role is being developed in collaboration with the Royal Colleges of Surgeons and Nursing.

Anaesthesia Practitioners will perform pre- and postoperative assessment care, maintain anaesthesia and, under direct supervision of a specialist anaesthetist, conduct the induction of and emergence from anaesthesia.

Debra Humphris (Director of the Health Care Innovation Unit at the University of Southampton) described significant changes that are occurring in southern England in relation to the delivery of primary care. She noted that patients' needs may be much simpler than what we wish to provide. The new models of care increasingly reflect the importance of effective teamwork, collaboration and real role change, coupled with improvements in productivity, but can only be developed through a close relationship between the academic institutions, local policymakers, service providers and patients. Jane Barnacle (Health Care Innovation Unit, University of Southampton) described the development of a new role: Community-Based Rehabilitation Assistant. This role is level 4 on the NHS skills escalator (Assistant Practitioner). The role was designed after a task analysis of the delivery of post-hospital care at home showed that 80% of the care delivered was not discipline-specific, was poorly coordinated (in one case by 17 different providers) and of poor productivity, with much time spent in driving. The training required is a foundation degree, developed in close association with local employers, which includes a generic first year and more specific second year, and emphasises structured competency-based training in the field.

Bonnie Sibbald (Chair of Health Services (Research), University of Manchester) presented data on nurse practitioner experience in the United Kingdom. Nurses are increasingly working alongside doctors in primary care, assisting doctors in tasks ranging from blood sampling or syringing ears to more advanced roles in health care promotion and management of patients with stable chronic conditions such as asthma, diabetes, cardiovascular disease and arthritis. Sibbald also presented the details of a Cochrane review of nurse practitioners.[1] The review showed the same or better outcomes for patients in services delivered by nurse practitioners or by general practitioners, and showed that nurse practitioners are well accepted by patients. Issues that need to be carefully addressed in using nurse practitioners include continuity and coordination of care, which may be an issue particularly if the team becomes too big (greater than 10). There may be significant initial capital costs in terms of producing nurse practitioners and, of course, the nursing profession is as much in short supply as the medical profession.

Rod Hooker (Associate Professor, Department of Physician Assistant Studies, University of Texas, Southwestern Medical Center Dallas, Tex) presented the US experience with physician

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assistants. There are now some 65 000 physician assistants in the US, graduating from some 130 programs, mostly attached to Faculties of Medicine or Health Sciences. The physician assistants cover a vast range of tasks from anaesthesia, acute care, public health, surgery, pathology, radiology, chronic disease management and primary care. He presented data that suggest that physician assistants take up about 10% of the time of the supervising doctor but can address 85% of the caseload of the physician in most situations. The educational programs run for around 24 months and the cost of educating a physician assistant is about 20% of that of a medical practitioner. It was felt that physician assistants could address a number of the problems currently facing the Australian health care system, particularly in primary care, chronic disease, some procedures (colonoscopies, etc), and in rural and remote Australia.

Amanda Adrian (Health Care Consultant, NSW) discussed the issues of nurse practitioner legislation in Australia and pointed out some of the complexities of the legislative process for health practitioners (the Productivity Commission recently noted that there are more than 90 registration bodies for health practitioners in Australia[2]) and the difficulties for health practitioners in moving between jurisdictions. She highlighted that much legislation can be disabling (rather than enabling), and this may be why so few nurse practitioners are actually working in Australia.

Tony Austin (Head, Defence Health) presented the final formal presentation. He noted that the military has a long tradition of innovation in health care delivery and gave particular emphasis to the important roles of medics (medical assistants). One feature of the military medic group is their variation — to meet the differing needs of the three Services (Army, Navy and Airforce). A major concern at the moment is the lack of articulation for medics with the civilian community. Although there is some scope for this with paramedics and nursing, there are also significant limitations. The development of a physician assistant program in civilian life would provide a valuable opportunity for army medics on discharge from the Defence forces.

Peter Brooks then gave a brief overview of the Productivity Commission's draft report,[2] emphasising its recommendation for the establishment of an Advisory Health Workforce Improvement Agency to facilitate workplace innovation, and the possibility of shifting the primary responsibility of funding from the education sector to the health sector to allow more responsive education and training arrangements. The report discussed the need for a consolidated national accreditation regime and the establishment of uniform national registration standards and improved mutual recognition. The report also recommended the establishment of an independent review body to advise on services to be covered by the Medicare Benefits Schedule and on referral and prescribing rules. In addition, the report recognised the importance of an adequate database on workforce and of creating better solutions to the problems of rural and remote areas and groups with special needs. Discussion took place in relation to the importance of addressing remuneration for health services and particularly a revisitation of the Relative Value Study with a redistribution of funding away from procedures and towards the "considered opinion".

Wide-ranging discussion on Day 2 of the conference covered areas supporting the development of integrated care models, the importance of getting general practitioners more involved in preventive care, and a focus on health professionals and creating meaningful work environments for these individuals.

The meeting reflected a groundswell of feeling within the Australian health system that change must happen and that we, as key players in that system, must help to drive that change. We need to create a health system (not an ill system, as we currently have), continue to develop partnerships to break down the professional silos, and create a range of new health practitioners who can deliver care in a patient-friendly fashion.

Many participants considered that a key to workforce innovation is a back-to-basics review of what consumers want and what services should be provided. It was proposed that a key question is the level of skill required of the person providing the initial assessment in primary care. Is it someone who should be able to handle 100% of conditions presenting? Or is someone who can handle 70% and refer the other 30% acceptable? There was general support for the concept of a wide range of delegated care, especially physician assistants and nurse practitioners. The associated changes to the Medical Acts which this would require were felt to be an important area of reform that needs to be urgently addressed. Delegated payment systems, where payment could be made to a practice rather than an individual, were preferred. Many speakers supported streamlining of the regulatory processes and the development of a competency-based modular education system. There was support for a better aligning of the health and education sectors, particularly in regards to policy. Although there was support for the Productivity Commission's draft document, some participants that felt that it would be difficult to implement many of the suggested changes. There was strong support for local action to introduce appropriate innovations, and a sense that this could and should be done, with or without central reform.

Participants were keen to continue the health workforce innovation agenda in the future.

Competing interests

None identified.

References

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2 Australian Government Productivity Commission. Australia's health workforce. Position paper. Canberra: Productivity Commission, 2005. Available at: http://www.pc.gov.au/study/healthworkforce/positionpaper/index.html (accessed Dec 2005).

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