

Occupational Change & the Allied Health Workforce: Future Scenarios for Allied Health & the Rural Remote Sector

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Overview

- Overview the policy environment on workforce reform
- State of play in AHP workforce
- Critical workforce questions:
 - New roles – substitutes & support
 - Clinical training & placements
 - Medicare funding
- One suggestion for the way forward

Health Workforce:

- Critical to prosperity of nation states & regional economies
- A global resource
 - Market forces vs ethical strategies
- Critical to personal health
- Critical to political success
 - ➔ Increasing intervention / planning

Health Workforce Action:

- Chronic interest in medical workforce issues
- Cyclical interest in nursing workforce issues
- Emergent interest in allied health & health science workforce issues
 - For government
 - For the professions themselves

Policy Activity

- Productivity Commission Reports on Health Workforce:
 - Referred to the Commission by the Treasurer – not the Health Minister
 - COAG responses to the Productivity Commission
 - Excellent summary in the latest SARRAH newsletter
- WHO Health Workforce Report 2006

Workforce & Allied Health

- No country has a viable base on which to confidently plan in terms of the allied health profession workforce
 - ❖ No systematic investment in data gathering
 - ❖ Sources of data are not compatible
 - ❖ Negligible research capacity
 - ❖ AHP is the weak link in shifting to inter-professional workforce planning methodologies

Rural & Remote Sector

- Has been the most influential in workforce development for allied health in Australia
- Professions continue to push profession-centered agendas

Reliant on the expertise of SARRAH to set the agenda and lead change in workforce

Drivers for Workforce Action:

Specific drivers:

- Political sensitivity
 - Inter-professional planning methodologies
 - Specialty focused planning
 - (eg. cardiac services)
 - Planning for settings / locations
 - Development of “allied health”
- Increasing sophistication required

State of Play – Growth 1996-2001 (ABS)

Allied health occupations	+ 26.6%
Nursing occupations	+ 5.4%
Medical imaging workers	+ 25.0%
Medical scientists	+ 16.8%
Medical occupations	+ 12.6%
All health occupations	+ 11.4%
Population Growth	+ 6%

Growth for AHP was even greater in 1991-1996

State of Play – Growth

Per cent increase in selected countries

Professions	Australia (1991-2001)	England (1995-2003)	USA (1990-2000)
Dietetics	+ 53%	+ 46%	+ 57%
O T	+ 46%	+ 43%	+ 71%
P T	+ 44	+ 42%	+ 41%
S P *(+ Audio)	+ 72%	+ 46%	+ 86% *

State of Play

Supply growth in AHP has been significant.

Critical Question:

Why does the skills shortage register of the Australian Department of Employment and Workplace Relations show that eight of the 12 health professions were from allied health? (2004)

Workforce Options - Simplified

- Get more new workers
- Get more out of existing workers
- Change the way we work:
 - ◆ Skills, roles – of individuals
 - ◆ Structurally – of system

Workforce Options:

- Increase new entrants
- Retain workers for longer
- Inspire the non-working to return
- Release capacity of under-employed
- Import international workers
- Implement support workers → extend service
- Cross-train others in professional roles
- Advance existing roles in new settings
- New skills → New roles

Critical Questions

While work goes into developing data frameworks and rigour for AHP workforce planning methodologies – what is the crucial workforce development issue that AHP must ensure their voice is heard on NOW ?

Critical Questions

Answer:

- The stimulation of medical student numbers.

Why?

Because doctors stimulate demand for AHP services

- Workforce policy development for both groups must go hand-in-glove to prevent greater downstream under-supply issues for AHP

Selected Critical Questions

- New roles – substitutes & support workers
- Clinical training & placements
- Medicare funding models

One suggestion for the way forward

Critical Questions & Concepts: Substitutes & Support

- About access not so much saving \$
- Job redesign vs substitution strategies
 - ◆ Using existing skills in new settings
 - * AHP led clinics (role advancement)
 - ◆ Training to include a new skill set
 - * pharmaceutical prescribing rights
 - * not be viewed as substitution but a role redesign
- Focus on the outcome for health status

Substitutes & Support

- Notion of skills escalators is popular
- Generic & discipline-based advanced practice support workers
 - ◆ Can amplify your service reach
 - ◆ Must be actively supervised
 - ◆ Must be regulated
- Impact on graduate professionals?

Critical Questions & Concepts: Clinical Placements & Funding

Intense efforts at the moment to lobby about increasing the funding quantum for student education

- ◆ Inequity between medical-nursing-allied health funding levels
- ◆ Argument is that it poor \$ → poor placements
- ◆ Is it being done at the level of 'allied health' ?

Is this (\$) the main game? No

Clinical Placements & Funding

Is getting more \$ the main game? No

Why?

Because unless the \$ are quarantined to address clinical placements you still won't get to see the effects of those \$ at the level of the student & clinical supervisor in your health services

Clinical Placements & Funding

How clinical education is organised is the most important question

- How will the \$ be received?
- Infrastructure:
 - ◆ Agreed best practice organisational models
 - ◆ Embedded in the system
 - ◆ Important opportunities or rural & remote

Clinical Placements & Funding

Opportunities for rural & remote sector:

Premised on the idea that:

- (1) the clinical placement experience is the most important form of anticipatory recruitment
- (2) \$ flow into organised infrastructure

What infrastructure can be developed?

Clinical Placements & Funding

What infrastructure can be developed?

Leading regional centres, particularly those with a university campus nearby should be setting up Allied Health Academic Research, Training & Education Centres based in the health service.

- ◆ Ballarat Health Services (2006)
- ◆ Headed by an Associate Professor Allied Health jointly appointed with a university
- ◆ Models to suit different contexts
- ◆ Learn from nursing

Critical Questions & Concepts: Medicare Funding Extension

Productivity Commission recommended a “delegation” model not a “referral” model.

- services billed in the name of the “delegating” practitioner (ie. GP)
- services paid at a lower rate

COAG – new Medicare item (2007) for practice nurses, nurse practitioners and registered aboriginal health workers, for and on behalf of general practitioners – chronic disease

Medicare Funding Extension

Delegated Models vs Referral Models

- inconsistent with the autonomous practice models which are at the heart of allied health professional's modes of practice
 - ◆ First contact practitioner status in mid-1970s
- epitome of the exercise of medical dominance – medically-focused service rather than community health focused models
- Political / policy landscape not receptive - not yet!
- “allied health” is not ready to win this argument

The Way Forward ?

What can SARRAH do to take leadership in health workforce reform further?

One single thing?

The Way Forward

SARRAH submissions to Productivity Commission should be reworked as your strategic framework for workforce renewal and sustainability in rural and remote allied health services

- ❖ map it to the *National Health Workforce Strategic Framework*
- ❖ governments need blueprints
- ❖ AHP clinicians & managers need policy leadership
- ❖ Strategy leads to organised action. It's a way of harnessing the impatience of those who will come after you

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