Stakeholders' perspectives on health workforce policy reform

Valerie A Hepburn and Judith Healy

Abstract

We administered an electronic survey in October–November 2006 to gauge stakeholder perspectives on Australia's recently adopted health workforce policies. Nearly all of the 41 survey respondents (65% response rate) ranked workforce as very important to overall health policy. Respondents identified decreasing health disparities and rates of disease and mortality as top goals, and identified improved quality and safety and more professionals in rural areas as priority measures for success. Lack of coordination between the governments and insufficient long-range planning were seen as threats to the success of the new workforce initiatives. The survey results suggest the need for clear goals and measurable outcomes. Although they represented different organisations and perspectives, the health workforce policy opinion leaders that participated in this survey reflected remarkable commonality in goals, measures, alternatives, and potential threats.

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What is known about the topic?

Although there are efforts underway to address Australia's current and projected shortages of health professionals, the policy goals and performance measures for these initiatives are unclear.

What does this paper add?

This article presents results from a survey of stakeholders in health workforce policy, highlighting the broad opportunities for policy consensus while recognising structural and organisational challenges.

What are the implications for practitioners?

Health workforce policies need clearly stated agreed outcomes if they are to enhance the standard of health services and the quality of life across Australia. Agreement among key stakeholders, necessary for successful policy reform, may not be as difficult as is often thought, and recent initiatives provide an opportunity to engage stakeholders in goal setting and performance monitoring.

THE RECENT Productivity Commission Report on the health workforce[1] and the policy initiatives adopted by the Council of Australian Governments (COAG)[2] have intensified focus on and investment in the health workforce. Australia, like the rest of the world, is facing health workforce shortages. The growing and ageing

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population, continued geographic dispersion, opportunities posed by technological innovations, the burden of chronic diseases, and new and re-emerging infectious diseases are forecast to substantially increase future demand for health professionals.[3-6]

Australia has had a strong economy over the past decade. This financial stability has allowed the Australian Government and the states and territories to invest in a range of health system enhancements, global recruitment efforts and educational inducements with hopes of meeting current health workforce supply and distribution needs. Yet workforce shortages remain and policy leaders have recognised the need to undertake forward planning to address the challenges that are certain to be imposed by future health resource needs and consumer demands.[1,7,8]

Health care is labour intensive. The many groups in the well-educated and well-organised

labour force are stakeholders to changes in workforce composition and functions. Policies that aim to bring about structural change in the workforce must enlist the support of a complex mix of occupational groups and trade unions, recognising that these sectors can facilitate or block efforts to improve access and services.[9] Any attempts to address health workforce supply must consider organisational constructs, professional identity and financial arrangements.

When considering health workforce policy, Australian health researchers point to financial and human resource problems posed by a health system lacking coordination and focused predominantly on inputs and processes.[10-17] Australian policy makers should spend more time engaging stakeholders and the community in goal setting and outcome monitoring. A recent report to Parliament from the House Standing Committee on Health and Ageing notes that uneven accountability and the financial "blame game" impede action in addressing health workforce shortages.[18] Successful health workforce policy requires clear understanding among all parties of "workforce to what end" and the measures by which the performance of workforce policy will be evaluated.

The Productivity Commission proposed structural changes and policy measures designed to enhance efficiency and effectiveness and, ultimately, to impact health workforce supply and demand. Following a review of these recommendations, in July 2006, COAG adopted a number of proposals related to the health workforce, namely:

- Increasing the number of medical school and nursing higher education placements and expanding medical specialist trainee positions;
- Creating a single national registration scheme for peak health professionals and one national accreditation strategy for health education and training that could be cross-professional in nature;
- Minimally expanding access to Medicare benefits for certain mid-level practitioners working on behalf of a general practitioner; and

- Establishing a new body to direct health workforce planning and analysis.

The COAG communiqué speaks to the need to strengthen the health workforce and to establish structures to support reform and more effective use of the workforce.[2] With implementation for these initiatives underway, including the April COAG decision to set up a consolidated registration scheme with a new national board for each of the nine health professions, the need to clearly articulate "workforce to what end" is essential. The significance of establishing consensus goals and outcome measures to monitor goal attainment is well recognised in the health policy and research literature.[16,19-23] The current landscape of expectations and outcomes is an important starting point.

While visiting as a Packer Policy Fellow from the United States, the principal author interviewed policy leaders and experts representing more than 60 Australian organisations involved in health services, education and advocacy, who expressed a broad range of perspectives on health workforce policy approaches and their potential impact. These stakeholders spoke of lack of capacity in the education system to respond to increased training demands and the need to develop new professional tracks to facilitate task sharing or transfer. Many expressed concerns about limited long-view thinking, using the recruitment of overseas-trained doctors as an example. Others noted coordination problems between the Commonwealth and states/territories and concern for the needs of rural communities. Through the course of these interviews, it became clear that inadequate organised conversation about goals and performance measures was underway in the stakeholder community. Stakeholders agreed on the need for more health workers but most had given limited consideration to the desired result. Moreover, they conveyed an individual sense of altruism but expressed significant scepticism about the perceived vested interests of colleagues in education, government and the health professions. Stakeholders reflected that past workforce initiatives often were undertaken without clear goals or measures of success.

In issuing its report the Productivity Commission noted that, "Successful policy reform requires agreement among key stakeholders on: the problems with the current arrangements that must be addressed; the objectives of the reform program; the strategies to be implemented; and a pre-agreed evaluative framework to assess the level of success and any need for strategy modification"[1] (p. 307). We decided to act on this message and seek quantifiable feedback from stakeholders on problems, objectives, strategies, and evaluative measures.

Methods

A short survey was developed to identify themes held by stakeholders. The survey was designed to seek insights on aspirational goals with limited attention to the challenging aspects of implementation. Questions focused on the Productivity Commission's recommendations and the recent related COAG initiatives relating to the health workforce, with particular attention to the projected impact on the health system broadly, identification of policy goals, articulation of outcome expectations, and potential threats to workforce supply. The survey was administered electronically. The instrument was reviewed and piloted with a representative from each of three stakeholder groups: education, government and advocacy. Ambiguous items and confusing terminology were revised accordingly. The final survey consisted of twelve items which contained twenty variables and took about 10 minutes to complete.

The survey was distributed electronically to a sample of 63 health workforce policy experts and stakeholders, accompanied by a short explanation of the purpose and process of the survey. All responses were treated anonymously and considered confidential. The sample included state and territory government officials (13), health professions education leaders (13), advocacy organisations (13), professional societies (15), and other policy leaders (9) representing organisations throughout Australia. Australian Government officials directly involved in COAG health workforce policy were excluded. The survey was administered during October and November 2006. The data were analysed using SPSS Version 12 (SPSS Inc, Chicago, Ill, USA) and, given the small sample size, limited to descriptive statistics.

Results

Forty-one completed surveys were received, representing a response rate of 65%. Respondents identified themselves in the following stakeholder categories: education/university (25%), advocacy (12%), non-governmental organisations (28%), state/territory government (22%), and clinical and other professional category (13%). Of those responding, 98% indicated they were familiar with the causes and potential impacts of health workforce shortages. Some 90% said they were familiar with the Productivity Commission's recommendations and the related COAG proposals on health workforce. Respondents (83%) overwhelmingly perceived workforce policy and planning as very important for overall health policy concerns for Australia.

Respondents were given a list of the COAG health workforce initiatives and asked to designate the one they expected to have the greatest impact on workforce supply. Over two-thirds (68%) thought that increasing the number of university places for health professionals would have the most impact on workforce supply. Several respondents (15%) saw the expansion of Medicare coverage for services in rural and remote areas as most important, but otherwise few respondents identified the other COAG initiatives as having any major influence on health workforce supply.

Using a Likert scale, respondents were asked about the potential impact of the COAG health workforce initiatives on health system quality, cost and accessibility. Most respondents thought the COAG initiatives would have positive impact on accessibility, and a majority expected a moderate positive impact on quality, but they were uncertain about the impact of the initiatives on health system costs, with a nearly equal split

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1 Expected impact of the recent COAG health workforce initiatives on aspects of Australia's health system

Response	Quality, no. (%)	Cost, no. (%)	Accessibility, no. (%)
Significant positive impact	2 (5.3%)	4 (11.1%)	6 (15.8%)
Moderate positive impact	21 (55.3%)	10 (27.8%)	24 (63.2%)
No impact	14 (36.8%)	10 (27.8%)	7 (18.4%)
Moderate negative impact	1 (2.6%)	11 (30.6%)	1 (2.6%)
Significant negative impact	0	1 (2.8%)	0

Includes valid percentages only. Missing data ranged from 3 to 5 observations across the categories.

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2 Approaches which should be used to address health workforce shortages in the future (respondents could select up to three)

Optional approach	No. (% of valid cases)
Improve efficiency of existing workforce (eg, using technology and information systems)	25 (64.1%)
Expand preventive and population health programs	23 (59.0%)
Expand Medicare payment options for services not currently reimbursed	15 (38.5%)
Create new health professions for task transfer	13 (33.3%)
Consolidate administration of all government funding for health services	12 (30.8%)
Decrease demand for health care services	7 (17.9%)
Other	6 (15.4%)
Expand private health insurance coverage	4 (10.3%)
Increase reimbursement payments to providers	2 (5.1%)

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across the categories of positive, negative and no impact. Ultimately, few saw the COAG proposals as having significant positive or negative impact on the health system broadly (Box 1).

Over half of the respondents (54%) thought the most important policy objective should be improving the health status of the population overall. With respect to the desired long-term goal of an increased supply of health professionals, respondents prioritised decreasing rates of disease and morbidity (38%) and decreasing health disparities (33%). When asked to select up to three measures of performance which should be used to track the impact of workforce policies over the next 5 years, stakeholders identified increased rates of professionals in rural and remote areas (53%) and improved quality and safety within the health system (50%) as priority indicators. Other measures identified as impor-

tant were increasing the total number of health professionals and lowering the percentage of overseas-trained professionals.

Recognising that increasing the supply of professionals is only one means of addressing health workforce shortages, respondents were asked to consider other possible approaches. The results are displayed in Box 2. Improving the efficiency of the workforce (64%) and expanding preventive health programs (59%) ranked as the top two approaches. There also was some support for reducing the medical monopoly by expanding Medicare payment options (38%) and for creating new professions for task transfer (33%).

All respondents identified at least one factor that could threaten sustained success in efforts to increase health workforce supply and overall distribution. Box 3 outlines the potential threats identified by respondents. The top concern, iden-

3 Factors posing the greatest threats to sustainable increased health workforce supply and distribution (respondents could select up to three)

Factors posing threats	No. (% of valid cases)
Lack of coordination between Commonwealth and states/territories	25 (62.5%)
Insufficient long-range planning for health systems needs and resources	19 (47.5%)
Ageing of the health workforce	16 (40.0%)
Specific interests of the various health professions	12 (30.0%)
Insufficient funding for the health system generally	10 (25.0%)
Lack of capacity and resources in the education system	10 (25.0%)
Other	9 (22.5%)
Inadequate regulatory infrastructure	4 (10.0%)
Inadequate performance measurement systems	2 (5.0%)
No threats anticipated	0

tified by nearly two-thirds of respondents, was lack of coordination between the Australian Government and states/territories. Other priority concerns were insufficient long-range planning for health systems needs and resources (48%) and the ageing of the health workforce (40%). Vested interests of the various health professions (30%), insufficient funding for the health system generally (25%), and lack of capacity and resources in the education system (25%) also were identified as potential threats by respondents.

Discussion

This survey aimed to capture the high-level perspectives of an impressive cross-section of opinion leaders in the health workforce field to stimulate and contribute to a much-needed and important policy debate. Certain consistent themes clearly emerged around goals, performance measures, alternatives, and threats.

Stakeholders singled out, among the COAG proposals, the expansion of training places as the measure most likely to increase the supply of health professionals. The COAG initiatives are expected to positively impact health service access and quality but the impact on health system costs is less clear. Since respondents recognise that the ability to increase health workforce supply is at some level finite, they also identified parallel initiatives to improve workforce efficiency and to expand preventive and population health programs. Combined approaches, coupled with corresponding focus on the work environment and retention issues, could serve to reduce demand for health care while improving overall health. Moreover, equitable workforce distribution is at least as important as increasing supply. As new programs are initiated, policy makers should critically analyse whether increasing the flow of resources will in fact produce the desired outcomes of better health system access and quality for all Australians. As the impact of the new workforce initiatives are uncertain, keeping a watchful eye on health system quality, costs and accessibility will be important. Performance measurement is critical to monitor progress and to improve results.

Stakeholders place high value on health status improvements (ie, decreasing health disparities and rates of disease and morbidity) as the priority goals which should result from health workforce supply enhancements. While these goals are consistent with efforts to increase the supply of health professionals, the cause and effect relationship is not linear. It cannot be assumed that improved health will naturally result from "more" health workers or "more" health care. Training and performance of the workforce, combined

with its quality, distribution and support within the broader health system, is likely to do more to influence health status than the number of health professionals alone.

In selecting improved health status as the primary metric for evaluating the impact of the health workforce, respondents identified a laudable standard for a long-range goal. To monitor early progress on workforce initiatives, stakeholders selected more proximate measures of supply and consumer wellbeing, specifically more professionals in rural areas and improved safety and quality in health systems. The challenge, of course, is that the means to routinely collect and analyse such measures are not firmly in place. Centralised registration and accreditation systems could be important policy tools in promoting better information systems. As the push to expand educational placements continues, it will be imperative to develop evaluative systems to ensure the stability and quality of training programs. Constructing patient safety and health quality measurement tools[24,25] accompanied by robust health status indicators such as amenable and avoidable mortality[26] would provide a means to showcase system performance and pinpoint areas in need of improvement.

Measuring improved health status requires much more than calculating rates of doctors and nurses to population and scoping the rise and fall of hospital waiting lists for elective surgery. In government, in business and in health (to quote the oft-used aphorism from Mason Haire), "What gets measured gets done."[27,28] Devising and implementing mechanisms to link health resource inputs, such as workforce and capital, to outputs (eg, immunisations, hospital readmissions, emergent care) in the near term, and outcomes (eg, quality and health status) in the long range are under design across the globe and receive regular attention in Australia.[29-32] Funding mechanisms should be linked to performance benchmarks to further encourage and reward the success of workforce initiatives.

As with all policy initiatives, there are potential threats to sustained and successful results. Top concerns among stakeholders are: lack of coordi-nation between the two levels of government and insufficient long-range health systems planning. These concerns echo the findings of *The blame game: report on the inquiry into health funding,* recently released by the Standing Committee on Health and Ageing of the House of Representatives of the Australian Parliament.[18] Whether real or simply perceived, policy leaders and program managers should give attention to these potential threats. Achieving consensus about desired outcomes and performance objectives could help to unite government officials and stakeholders in their collective thinking around common, long-range goals. Health workforce initiatives should be strongly anchored in an encompassing and visionary perspective of the Australian health system.

In considering the domains of consensus and omission identified through this survey, several points merit attention. First, goal cohesion does not easily translate into the finer points of implementation. Secondly, stakeholders' minimal focus on barriers, such as vested interests of health professionals, may simply reflect resignation to the perceived intractability of the problem. Finally, health workforce policy and the market place in which it functions is complex. Solutions to supply, demand, access, and quality concerns will require confronting and resolving conflicts in long-held beliefs about power relationships, professional scopes, service design, system priorities, and health equity.

Conclusion

Health workforce policies need clearly stated and agreed upon outcomes to enhance the standard of health services and the quality of life in Australia. Successful public policy undertakings require goal setting and ongoing evaluation to promote goal attainment. Engaging health workforce experts and key stakeholders in the identification of goals and the establishment of performance objectives is a critical first step. As the Productivity Commission and others[10,33,34] have noted, dialogue should commence before the implementation phases of any policy initiative. Admittedly,

achieving high level consensus will not ensure desired results; the reality of implementation challenges is always looming. However, the inability or unwillingness to achieve goal consensus before policy commencement will nearly always ensure failure.

Observers of health policy note that health system goals are difficult to establish and even more difficult to achieve, in part because of competing interests among stakeholders.[13,35,36] This survey found remarkable consistency and commonality of themes across a broad spectrum of providers, educators and professional organisations. Moreover, we find health system and workforce policy stakeholders are generally focused on program strategies and outcomes that inure to good health, quality and access for the population overall. Survey responses indicate little support for parochial approaches such as increased reimbursement or professional turf guarding. The COAG health workforce initiatives provide an opportunity to debate and develop a broader vision of health policy, one which focuses on "measurement and improvement of outcomes rather than a preoccupation with process and structure."[33] (p. 37)

Both the structural challenges of the health enterprise and the contextual barriers to consensus in health workforce policy must be acknowledged and respected. Clear goals and consensus measures about workforce policy have the potential to move Australian officials and stakeholders beyond the "blame game" and onto results, while providing more precise answers to the question of "health workforce to what end?" Agreement among key stakeholders on policy objectives, necessary as a first step for successful reform, may not be as difficult as is often thought.

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Competing interests

The authors declare that they have no competing interests.

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