Disrupting the present to build a stronger health workforce for the future: a three-point agenda

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ABSTRACT

The health professional workforce in high-income countries is trained and organised today largely as it has been for decades. Yet health care professionals and their patients of the present and future require a different model for training and working. The present arrangements need a serious overhaul: not just change, but disruption to the institutions that underpin training and work organisation. This article outlines a three-point agenda for this, including: the need to reorganise workforce and care systems for multimorbidity; to reorient workforce training to build genuine inter-professionalism; and to place primary care at the apex of the professional hierarchy.

KEYWORDS: Health workforce; health professionals; medical professionals; disruption; institutions

The academic literature is awash with research into and discussions of the challenges confronting today's health-care systems. To recite these, our populations are ageing, chronic disease is increasing, and multimorbidity will be the new normal; these characteristics describe the 'patient of the future'.[1–4] Studies discuss the importance of integration, of using best treatment evidence and of engaging patients more closely in the treatment and condition-management process.[5–7] The configuration of the health workforce also receives attention.[8] Mostly, the pointers are to multidisciplinary team work, shifting scopes of practice, differing professionals such as nurses taking on work traditionally performed by doctors, and emphasising different areas of training, such as medical generalists and hospitalists.[9] Alongside this, the challenges are routinely highlighted. These include maintaining a full complement of health professionals, sufficient to meet patient demand; of retaining professionals in a global marketplace that many, especially developing but also developed countries including the UK and New Zealand, struggle with;[10,11] and of ensuring that areas such as generalism and primary care are attractive professional choices when consultant speciality medicine is considered more prestigious and is ubiquitously better remunerated.

Reading between the lines of the research, and at the various meetings and discussions that many readers of this and the numerous other academic journals publishing on related topics attend, one point is clear. This is, that the traditions around how professionals are trained, regulated and practise, and the institutions undergirding these, require fundamental reorientation. The concerns, of course, are common across the developed world, and relate mostly to medical professionals, so this is the primary focus of this perspective piece. The developing world, for its part, has a separate set of challenges around building a stable and sufficient workforce, although it too would undoubtedly benefit from a reorientation of conceptions of health workforce training and organisation.

This article argues that three changes are needed, involving disruptions to the underlying institutions behind health systems, if professionals are to cope with patients of the

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future. First, workforce and care systems need to be redesigned for multimorbidity. Second, inter-professionalism should be the focus for workforce training structures. Third, primary care should be repositioned at the apex of the health professional hierarchy. The next section describes the role of institutions in health systems and need to disrupt these. The three-point agenda is then outlined.

The problem with institutions

Health systems – how we organise funding and services – have been reformed and re-reformed in many countries over the past few decades.[12,13] Remarkably, the institutions that underpin care delivery itself have remained largely persistent, creating considerable barriers to 'integrated care' and other aims of policymakers and services providers.[14] By institutions, I specifically refer to the rules and traditions around how health professionals are trained and practise, particularly medical professionals; in other words, institutions refer to '*how we do things around here*'.[15–17] Institutions have considerable influence and effect on performance, and have been variously accused of protecting specific interests to the detriment of broader society and services. Institutions have also been pinpointed as creators of barriers to innovation and change.[18]

It is no secret that how we train health professionals largely mirrors how health services have been organised for the last century or so. Doctors sit at the apex of the health professional hierarchy, and such a hierarchy most definitely exists. The professional power of doctors has been under scrutiny and threat in recent times, via the increase in patient rights, patient-centred care, lapses in regulatory standards and service quality, and the growth of the internet, but doctors continue to reign among professionals.[19] A full complement of doctors, qualified and well-regulated, is pivotal to a high-performing health system, and the clinical contribution and importance of the medical profession should never be discounted. The medical profession in many countries has continued to reflect on the challenges faced and introduced new methods for ensuring high standards and adequate review of professional practice.[20]

Yet, the way the medical profession and its various training and regulatory bodies are organised has remained largely untouched for many decades.[21] Whether this is a good or bad thing, and whether such consistency is important to health systems, in the context of the challenges outlined above, are important questions. Debate on these questions is overdue. At one pole is an argument that stability of such institutions is important, given that other parts of health systems seem perpetually under reform. Patients and professionals themselves can at least be confident that, despite ongoing reorientation of the location of 'commissioning' or introduction of 'alliance governance' in a system, the professionals, medical in particular, will continue to do what they have always done in terms of training and organisation of medical services delivery. In contrast, institutional persistence suggests that patients of the future will need considerable assistance or education in how the system is structured and functions if they are to navigate the various different services and systems they will need to interact with.[22]

If one takes a patient-centred view, then something is seriously wrong here. Patients should not need to be skilled in system navigation, or in how the institutional arrangements are structured and function. There is a demand to rethink these arrangements. There is a need for the medical profession in the broadest sense to consider itself a 'management system' that should orient its organisational models toward a patient view of the system and the broader organisational fabric of the health system. The traditional model, by contrast, is largely founded on a professional and professional educators' view of the system, in that services tend to be designed around how medical professionals organise their professional lives; patients must mould their needs around, or adapt to, the structures and schedules of professionals.

The current institutional arrangements provide limited capacity for responding to a patient view of care delivery. This is because they are designed to support, first, the regulation of professionals and their practice and, second, specialisation and its associated structures. The latter poses a particular challenge in that medical consulting speciality colleges, such as surgery, medicine, paediatrics, radiology, pathology and ophthalmology,

have significant control and influence over specialist practice within their zone of influence, over the supply of the health workforce and of the organisation of care. Very importantly, they have largely failed to lead a dialogue around how to structure care for patients of the future. This must be frustrating for health professionals who see the gaps between the different professional systems.

Institutions for the future

One of the key challenges for the health workforce is the demand for health professionals, especially doctors.[23,24] This focus on workforce production, however, provides an opportunity to also look at transforming the institutional arrangements. By transform, this refers to complete remaking of how health professionals work; in other words, a disruption to existing arrangements. Transformation should be considered in contrast to change, which refers to simply adjusting arrangements while maintaining the broader focus on 'how things have always been done'.[25] The remainder of this perspective outlines a three-point agenda for health workforce transformation.

Organisation for multimorbidity refers to perhaps the single most important disruption required. As noted, many patients now and more into the future will have several co-existing health conditions, each requiring individual condition specialist input. Consultants themselves need to lead discussion on how such patients should be served. Key questions for consideration include whether one professional consultant should be the lead provider of care and coordinate care for patients, or whether a generalist or primary care doctor should be the patient's lead carer. While not a new conundrum, depending on who is the lead provider will still mean a patient may need to see several professionals. For example, a primary care doctor will need to periodically refer to specialists; specialists may see some patient needs as being outside of their expertise, or so complicated by the co-existence of other health problems that overall care is better handled in primary care. In the context of current institutions, there are no easy answers.[26] Hence, the need for the second disruption.

Tertiary training institutes and speciality colleges are pivotal to making the health system fit for the purpose of providing health care for patients of the near future. Inter-professional training must be the focus, along with creation of team-based approaches to care delivery.[27] Inter-professional training should occur from the first day in medical, nursing or allied professional school and continue through vocational training and continuing professional competency updates. The role of each profession in a patients' pathway through the health system should be clear and team work natural, so that all health professionals readily work in genuine partnership; patients, of course, need to be the focal point of the team. Professionals should be always looking to the team and identifying their contribution to treating, managing and working in partnership with patients. Again, debates around this are ongoing, with various studies pointing to such a need.[9,28] Yet, trainers have largely failed to date, to transform curriculum design, despite the fact that, for the most part, they make an important and significant contribution in producing highly skilled and qualified graduates. A key question is whether traditionally separate training schools should be merged, with complete curriculum redesign and students naturally training together.

Beyond basic professional training, especially in medicine, the role of speciality colleges is critical. Suffice to say there is a strong argument that their self-regulatory role, with colleges largely separated along speciality lines, serves individual speciality areas well in terms of upholding standards. However, the model fails the basic test of ability to traverse professional boundaries and progress discussions on how patient care of the future should be modelled and delivered. The cynics would suggest self-protection is the key influence on the current model. Another explanation is simply that strong institutions endure, often due to path dependency, not necessarily for the greater good.[16] Today's world and its challenges require collaboration and a different model of organisation.

Finally, there is no shortage of discussion around the need for strong primary care in health systems and a focus on treating patients as close to their home as possible, in community

locations.[29] One constraint on the potential for this is the need for more primary care doctors. The challenges to providing these doctors that future patients need include their relatively low income compared with medical specialists, for often difficult work with a myriad of patients who come with any range of conditions.[30] This is not helped by siloed medical curricula in many medical schools, continuing rapid expansion of medical technologies and consequent expectation of teaching faculty as well as student anticipation, that graduates should naturally progress to keeping up-to-date with more about less (as in consultant medicine) rather than more about more (as in generalist medicine). This will not change without disrupting how we conceive different areas of medical service. The adherence to traditional notions of higher status around specialism is long outmoded. In many ways, primary care doctors truly are the ultimate specialists for the fact that they must have a strong grasp of all conditions and medicines, and for this reason are deserving of the highest-status pedestal. Professional colleges have an obligation to consider how to reframe their relative positions in the medical hierarchy, if indeed there should be a hierarchy. With this needs to come a discussion on how to rebalance incomes in favour of general practice, and consideration of how to redesign how primary care operates in the broader health system.

Conclusion

Many discussions today are focused on what is needed for patients of the future, with no shortage of suggestions. Mostly, such discussions centre around adjustments to current service delivery arrangements. This means that underlying institutional arrangements will remain largely uninterrupted, albeit subject to incremental changes over time. Disruption, however, is required for building health systems and a workforce for the future. Adjusting current arrangements is akin to constantly patching a leaky roof.

This article outlines three components of an agenda for disruption that reveals a series of questions for professionals, their trainers and colleges to consider. The three-point agenda is centred around need for health workforce and care systems to be reorganised for patients with multimorbidity; for workforce training to reorient towards inter-professionalism; and for primary care to be shifted to the pinnacle of the professional hierarchy. The opportunity to transform the institutions underpinning today's health systems around this agenda cannot be dismissed. A key issue is whether the questions in this article or a different set of questions is most relevant. What is clear, at least to this author, is that the time is now, more than ever, to take up the debate.

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COMPETING INTERESTS
None.