Coming in from the interprofessional cold in Australia

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Abstract

In Australia, implementation of interprofessional education (IPE) has been slow compared with peer countries. One cause is an apparent uncertainty about where and how to situate IPE at policy levels. Without a clear articulation of related needs, vision and purpose, IPE has largely remained isolated from the strategic planning and funding cycles necessary for implementation as "core business" across various sectors, systems and levels. This paper draws on international developments and research to emphasise the need to complement innovative IPE practice with supporting policy, specifically to optimise the quality of future health care delivery. Major forces for change are identified, as well as some residual barriers and possible strategies to bring IPE "in from the policy cold" in Australia.

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What is known about the topic?

There has been growing international recognition that health professionals need better preparation and support for effective collaborative practice. This corresponds to the development of a broad evidence base linking interprofessional education with the development of a range of professional competencies associated with effective interprofessional practice (IPP), as well as growing evidence that better IPP will improve health care for a range of conditions.

What does this paper add?

This paper outlines the lack of interprofessional education (IPE) and IPP practice in Australia and, using Kotter's change model, outlines some possible steps to advance IPE implementation.

What are the implications for practitioners?

The author suggests the need for policy and funding support for IPE implementation.

BOOSTING INTERPROFESSIONAL education (IPE) to improve interprofessional practice (IPP) is not a new idea (for preamble on definitions, see Box 1). Evidence of IPE as an explicit area of study stretches back more than three decades (for example, see Harsh, Fewell and Casto[3]). Gilbert and Bainbridge[4] refer to IPE efforts in Canada from nearly 40 years ago. These are not isolated examples: the World Health Organization (WHO)[5] is often credited with initiating the IPE movement in 1973, claiming that IPE would improve job satisfaction and encourage a more comprehensive and integrated approach to patients' needs. This has been followed up by numerous studies and projects, for example "Learning together to work together for health".[6] Nor is IPE, as suggested by some,[7] easily dismissed as a passing fashion or fad. For example, since 2001, the National Health System (NHS) in the United Kingdom has mandated that IPE be a compulsory and core feature in the training of all health professionals.[8]

In recent years, other countries such as the United States, most Scandinavian and many European nations, South Africa, Canada and New Zealand have also made long-term commitments to develop IPE programs to improve IPP. These developments are a positive response to the change forces demanding IPE as a mainstream course component. Such forces relevant to the Australian context are identified in Box 2.

Interjurisdictional networks are used to enable collaborative research and education initiatives. For example, there is now a European Interprofessional Education Network (EIPEN)[9] and an International Association for Interprofessional Education and Collaborative Practice (InterEd).[10] These developments herald interna-

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1 Preamble on definitions

Interprofessional education (IPE) tends to take on a variety of meanings, among different contexts and groups. Lack of clarity of key terms can hinder shared meaning and implementation efforts, so it is important to agree on operational definitions. CAIPE (The UK Centre for the Advancement of Interprofessional Education) provides one of the most widely accepted definitions for IPE:

> Interprofessional education occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care.[1]

CAIPE adds further qualification and proposes an inclusive definition that includes all related learning in academic and work-based, pre- and post-registration settings, and also involves purposeful interaction with service users and carers. This last inclusion is particularly important with respect to moves towards more patient-centred approaches that place a priority on "concordance",[2] or collaboration between practitioners and patients.

The term IPE has largely replaced what used to be referred to as "multiprofessional" education, which now usually refers to situations in which two or more professions may simply be collocated, without deliberate and systematic interaction — for example, students from different disciplines sitting alongside in lectures. The inclusion of work-based learning is also noteworthy: a defining feature of effective interprofessional practice is positive interdependence, where health professionals learn from each other as they provide their respective and sometimes overlapping areas of care and expertise. In this sense, IPP is a subset of IPE.

2 Change forces for IPE and IPP

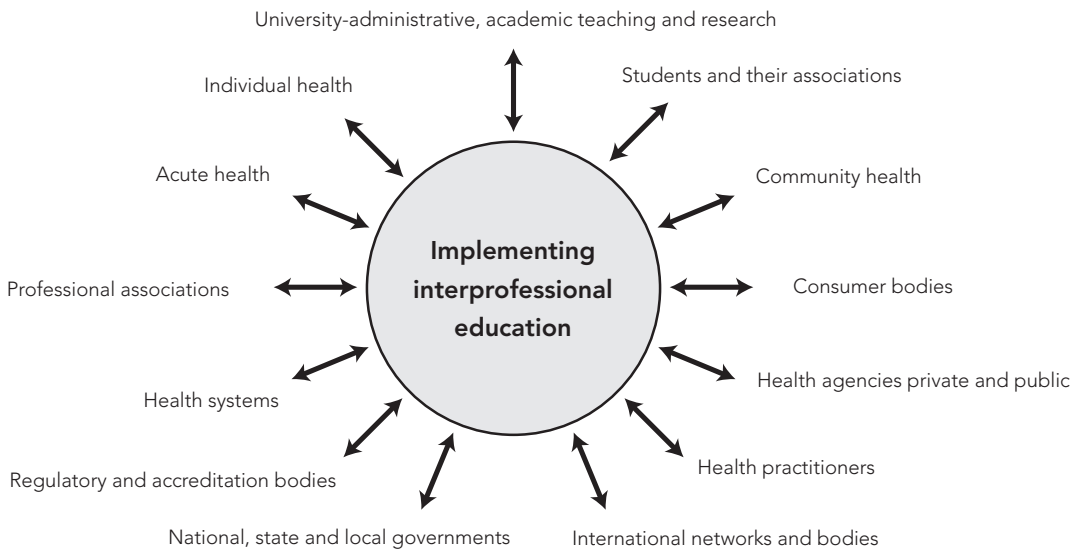
- The ageing population, associated health costs and the need to provide more health care in the home
- Devolution of some health care responsibilities (traditionally the domain of GPs) to nursing and allied health professionals
- A major proportion of health care moving from acute to community-based/ambulatory settings
- Chronic disease, and its self-management, now demanding the greatest proportion of health care resources
- The shortage of GPs and other health professionals in rural and outer-urban areas
- The "professionalisation" of nursing and allied health disciplines
- Improvements in information and communication technologies, medical/health research, enabling patients to be more active partners in their health care
- Increased recognition of the importance of preventative approaches, health promotion and related education
- Recognition of benefits of IPP for patient health outcomes and health professionals' job satisfaction
- Increased accountability and demands by patients/public for greater transparency, quality and safety in health care
- Need to maximise efficiency in public and private spending — reducing duplication of health treatments and procedures
- The necessity in rural and remote areas for non-medical professionals to perform a wider range of "medical" procedures
- Societal trends towards greater democratisation and egalitarianism in workplaces
- Recognition of the need for greater continuity of care versus episodic intervention
- Fragmentation of various health system levels, responsibilities and processes
- Need to improve cost effectiveness by identifying common learning/ training needs, sharing resources and teaching expertise

tional affirmation of the need for better collaboration and communication among health professionals, both in health service and education delivery. In these international contexts, this need is being addressed through mainstream education and training policy initiatives and substantial government funding commitments to facilitate associated program and curriculum redevelopment. As yet, however, such an awakening is barely nascent in Australia.[11,12]

While the concepts of collaboration and teamwork are not new, there is now a widespread realisation that such IPE-related learning simply does not "just happen".[13] It requires explicit, carefully planned sequences of formally assessed learning experiences that enable systematic development of related abilities. IPE and IPP should therefore be recognised as necessary responses to pressures for greater efficiency and effectiveness of team-based, interdisciplinary health care delivery.

There is now a substantial and rapidly growing base of research evidence that shows that improve-

3 Complex systems involved in implementing IPE



ments in interprofessional practice in a wide range of health care contexts can lead to significant improvements in health outcomes.[14,15,16] This literature highlights the benefits of better collaborative skills and attitudes for workplace issues such as recruitment, retention and job satisfaction. The benefits are apparent in areas that are poorly addressed within traditional, monodisciplinary, and solely biomedical-oriented models of health care delivery. Of particular importance, these areas include conditions that are chronic and complex, such as the management of diabetes, asthma, cardiovascular and pulmonary disease, emergency procedures, rehabilitation, aged care, indigenous health, and mental health.

This does not imply an assault on the biomedical model which clearly continues to serve well for a specific range of purposes.[17] It does, however, point to limitations when used alone to deal with complex interactions within and across dynamic social systems.[18] Box 3 illustrates some of the main levels, stakeholders and sectors involved in this interplay of complex systems.

Improving IPP has been shown to increase the effectiveness of interprofessional communication and reduce the prevalence of miscommunication, conflict and preventable adverse events associated with clinical error.[14] As mentioned above, IPP is also seen as an effective response to a range of workforce issues, for example, by reducing preventable workplace stress and increasing job satisfaction. Such beneficial effects are particularly pertinent in areas of sociodemographic disadvantage, where perennial workforce shortages are also commonplace, such as rural and many outer-metropolitan contexts.

Australian experience in IPE

In 2005, a health professional development event (getGP[19]) in East Gippsland, Victoria (south-eastern Australia), highlighted the strong potential benefits of interdisciplinary training and regional collaboration. Boosting interprofessional, in-service education (or learning) opportunities was recognised as a practical, achievable and much-needed response to help address the perennial issues of rural recruitment and retention. This anecdotal observation is complemented by a range of research that supports the intuitive

notion that effective IPE and IPL can improve both patient health outcomes and workplace satisfaction.[20]

In Australia there has been little policy and sustained funding commitment to IPE.[21] Despite significant international developments, here there have only been a relatively small number of pilot IPE initiatives, involving relatively small numbers of students. Examples include Smith and colleagues[22] and McNair et al.[23] These are typically isolated, often rural-based, short-term initiatives that in themselves have limited scope to effect the lasting, systemic change that is needed.

These innovations offer a basis for IPE models to be integrated into mainstream health professional undergraduate and postgraduate education. However, their short-term funding means these projects rarely translate into ongoing programs. This means momentum, continuity and expertise are lost, and research output is also limited. This presents a "catch 22": policy makers often demand evidence that IPE will eventually lead to better health outcomes, but without up-front policy support and sustained funding such longitudinal investigations are impossible. In addition, because it relates to such a wide raft of health education, promotion and delivery areas, responsibility for implementing IPE is especially prone to political and institutional buck passing.

Within the international IPE community, Australia is in danger of acquiring a reputation for being an "interprofessional backwater"[12] (p. 81). Thistlethwaite[11,21] was surprised that Australia, which prides itself on progressive approaches to health care and related education and training, has allowed such a costly oversight to continue. Although Australia may be seen as a traditional importer of education and health care innovation,[24] this hardly seems an excuse to keep ignoring IPE.

Recently, there have been some positive signs that suggest cause for modest optimism. The most notable was initiated by ACT (Australian Capital Territory) Health. In collaboration with the University of New South Wales and local service providers, ACT Health recently secured substantial Australian Research Council funding to conduct a 4-year project to "interprofessionalise" the ACT health system.[15] This was only made possible by their far-sighted commitment to spending the time and resources to establish strategic relationships with all stakeholders. This multilateral partnership model offers a working example for state and Commonwealth policy makers of what is needed to implement IPE as core business.

Another auspicious example is that, for the first time, a national conference recently focused squarely on "Interdisciplinary learning for interprofessional practice",[25] including more than 30 sessions on a range of projects and initiatives from across this country, as well as some from abroad. This conference revealed that a number of universities are trying to establish interprofessional teams to support IPE and, in the longer term, the development of IPP competencies within and across different health discipline departments. However, their mission will be extremely difficult, if not impossible, without consonant policy development at both state and federal levels and related funding bodies.

Another potentially supportive development is the Productivity Commission's recent position paper and report[16,26] on Australia's health workforce, which recognise the substantial but preventable risks and costs of continuing to maintain such a highly fragmented health care system. One recommendation is to consolidate national health profession regulation and accreditation frameworks. Related initiatives are underway and, if successful, may allow and encourage IPE to be built in at system level to support emerging IPE practice on the ground. By incorporating "IPE-enabling" components to course accreditation and professional registration arrangements, education and service providers will have curricular space to foster the development of essential IPP competencies. Thus, one of the dominant factors that constrain health profession course designers appears to be moving towards a more supporting role.

Implementing IPE

Ultimately IPE needs to be addressed within all phases of policy development cycles.

Waller et al identified policy neglect as a major barrier to implementing IPE in Australia.[21,27] In a global evaluation of the Australian IPE situation, the areas that need most attention include:

- While there appears to be widespread agreement in terms of "values and beliefs" underpinning IPE and IPP at the level of education and service providers, they are not apparent at institutional and government levels.
- The problems or issues have largely emerged in relation to aged care and chronic disease management, care delivery moving from acute to community settings and the associated workforce issues.
- There is a vast wealth of knowledge development and research in the international arena, but relatively little specific to Australian contexts.
- Public awareness about the need for IPE and IPP appears to be extremely low and constitutes a major need.
- Political engagement has thus far been piecemeal: although there are scattered examples of support for some small scale initiatives, along with considerable rhetoric that is supportive of IPE and IPP, little has permeated key policy documents and discussions.
- Interest group activation is in the early stages but offers high potential to engage the many educators, service providers and researchers who are committed to IPE and IPP. Emerging rural, student and national IPE networks are examples.
- Public policy deliberation and adoption present the aspect of the cycle most resistant to influence.
- Regulation, experience and revision are not yet evident; these aspects rely on policy and funding support, including research programs.

As with all models, there is a risk that these components cannot represent the dynamism and complexity of the multiple systems that interact in unpredictable ways. Circular models imply a neat, closed system or number of sub-systems, whereas the reality is inevitably much more chaotic. This model is adapted from the work of Tarlov,[28] whose original approach may also be useful to consider (Box 4).

The original model does not confine the elements and dynamics to a closed loop. It may therefore better reflect the complexity of applied contexts in which unpredictable forces and events often arise. It also seems to more clearly delineate the need for parallel public awareness and advocacy to advance (in this case) IPE. In addition, Tarlov offers four public policy frameworks to improve population health; one is useful for IPE, which inherently involves multiple complex systems:

> Linear effects models and multiple independent effects models fail to yield results that explain satisfactorily the dynamics of population health production.
>
> A different method (complex systems modeling) is needed to select the most effective interventions to improve population health. (p. 281)

We could easily substitute "IPE" for the words "population health". Clearly then, implementing IPE requires accepting greater levels of complexity and uncertainty than normal change management.[29] Expecting relatively simple, linear (or circular) approaches to achieve significant gains may condemn such endeavours to be dismissed as failures when they do not (and probably cannot) deliver what appears to have been promised. Complex, however, does not mean "too hard" — there is a rich and deep range of literatures that can assist us, including work already contextualised in the IPE and IPP fields, for example Headrick,[30] Clark[31] and Cherry.[32]

Change to boost IPE and IPP clearly requires both top-down and bottom-up approaches.[33] Without significant policy renovation and funding support, the activities of the many "IPE-friendly" teachers, academics and clinical supervisors will, necessarily, remain out in the cold. While there are some networks that have self-organised to support IPE in Australia, for example the Rural Interprofessional Education Network (RIPEN),[34] these largely rely on individual

4 Tarlov's Public Policy Development Framework[28]

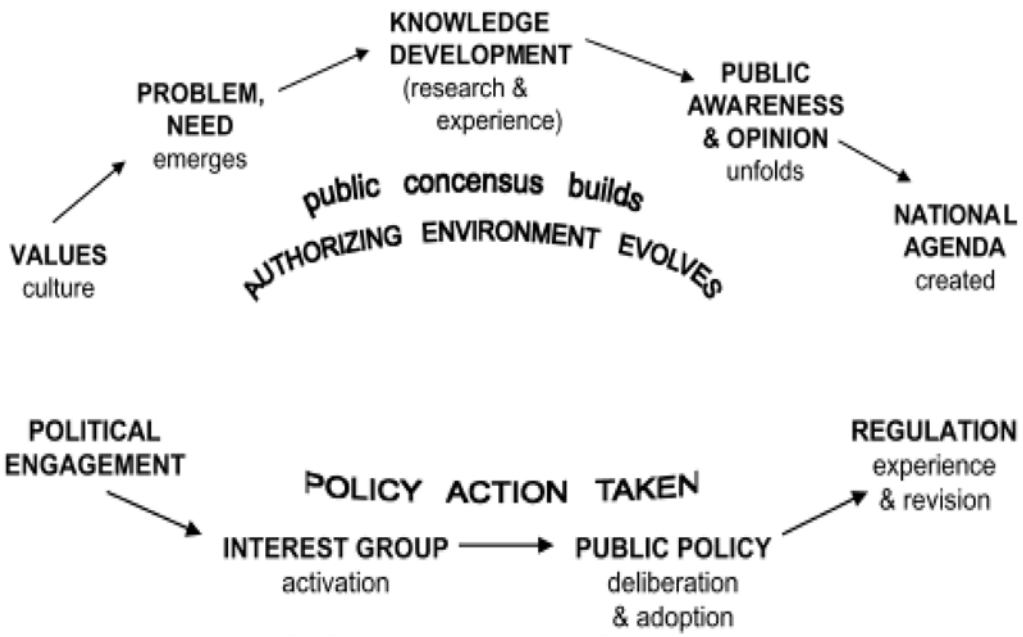


Figure reproduced with permission from Blackwell Publishing.
Tarlov A. Public policy frameworks for improving population health. *Ann N Y Acad Sci* 1999; 896: 281-93. Figure 2. Conceptual framework for the two phases of the public policy development process: public consensus/national agenda building, and political/public policy actions taken (page 286).

interest, goodwill and professional commitment. They are typically initiated and sustained on top of the members' workload and therefore are likely to have limited impact. With universal workload intensification, such momentum cannot be sustained without policy and funding commitment.

Embracing IPE may seem like a "journey of courage".[35] However, far from adding further layers to overworked professionals, IPE and IPP represent a more effective and efficient way of addressing the widely agreed health care priorities of patient-centred care, student-centred learning, quality and safety, reflective professional practice and a focus on collaboration to ensure the best use of available resources. Australian health care and associated education systems seem well-poised to promote interprofessional education and practice. To mobilise these assets we need sustained commitment to implement IPE and IPP as core system features from politicians, professional bodies and other senior decision makers.

IPE change management

Kotter's eight change phases[36] model (Box 5) has dominated the change management literature and may therefore be useful in summarising what we need to do to advance IPE in Australia.

The first phases involve "creating a sense of urgency". In the UK, a sense of urgency to implement IPE was assisted by community outrage at the findings of the Bristol Royal Infirmary inquiry.[37] A substantial portion of the preventable errors were found to stem from institutionalised poor interprofessional communication and respect. In Australia, we have recent episodes, such as the Bundaberg Hospital scandal,[38] which suggest interprofessional

5 Kotter's eight change phases

- Establish a sense of urgency
- Create a coalition
- Develop a clear vision
- Share the vision
- Empower people to clear obstacles
- Secure short-term wins
- Consolidate and keep moving
- Anchor the change

From Kotter J, 1996.[36]

problems. However, a reactionary approach is questionable, compared with the longstanding needs identified in Box 2.

The second phase involves "building a coalition". We have some fledgling national "coalitions" such as the RIPEN network mentioned above, and an Australian chapter of Inter Ed[10] is on the drawing board. Members of RIPEN were active in the most recent (9th) National Rural Health Conference, attended by about 1200 stakeholders. Out of 250 conference recommendations, a short list of 18 was compiled. At number seven was:

> The Department of Education, Science and Training and the Department of Health and Ageing should develop budget weightings for universities (including University Departments of Rural Health) to boost curriculums and training programs that are modeled on interprofessional education for health practitioners. This approach should also be taken by State governments in relation to training undertaken within their jurisdiction, including in hospital settings.[39]

Strong support for IPE by educators, academics, students and service providers has been evident for a number of years now, but any influence on related policy is not yet visible. Looking at the third and fourth phases, "developing and sharing a vision", a related vision has been offered by some early adopters, but needs to be formulated and shared as much as possible by all stakeholders. We have many inspiring examples from overseas developments to draw on.

Kotter's remaining phases (empower people to clear obstacles; secure short-term wins; consolidate and keep moving; anchor the change) are contingent on the first phases, which rely on appropriate policy and funding support. Kotter warns against starting with the latter phases as a quarter of a century of leading research and practice allow him to identify why transformation efforts fail.[40]

Conclusion

IPE in Australia is an example of action within a policy vacuum. In addition to all the pressures, needs and trends identified above, ACT Health's leadership will hopefully help other governments to take on the challenge. Their example should show, above all, that it is necessary to develop and maintain constructive working relationships with a range of key stakeholders. This does not necessitate political or ideological isomorphism, rather a durability to withstand the turbulence associated with electoral cycles and other relatively short-term constraints.

We have enough international "proof of concept" or research evidence for national and state authorities to explicitly support and fund the necessary change management processes. More research to address key questions will always be needed, particularly to link relationships between IPE and improved health outcomes. If such an act of leadership can evolve at the national level, IPE will be able to build badly needed long-term capacity within the health workforce. IPE offers an excellent opportunity for all levels of government to start progressing out of "the feral state of buckpassing"[41] in the interests of more efficient, effective and safe patient-centred care.

Competing interests

The author declares that he has no competing interests.

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