Victorian Healthcare Association
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Submission

16 March 2020

Consultation response: National Medical Workforce Strategy

About the Victorian Healthcare Association

The Victorian Healthcare Association is the peak body supporting Victoria's public health services to deliver high-quality care. Established in 1938, the VHA represents the $20.3b Victorian public healthcare sector including public hospitals and community health services.

The VHA provides exceptional access, influence and scope for a unified advocacy and policy development voice to State and Federal governments and other key stakeholders. In addition, the VHA supports its members with the implementation of major system reform and strategic business support and provides networking opportunities through topical and informative events on vital issues.

This paper

This paper offers feedback on the sections of the National Medical Workforce Strategy (NMWS) consultation pre-read which are directly relevant to the operations and strategic objectives of public health services and community health services across Victoria, including:

- Section one: Coordination between medical workforce planning stakeholders
- Section three: Reliance on registrars to meet health service needs
- Section four: Geographic maldistribution and inequity of healthcare access.

VHA response to potential solutions

Section one: Coordination between medical workforce planning stakeholders

The VHA strongly supports efforts to improve coordination and reduce fragmentation between medical workforce planning stakeholders. Given the scale of the challenge, the need for systematic and integrated approaches to medical workforce planning is critical.

The NMWS consultation pre-read does not, however, make reference to the way in which the strategy will interface with efforts across other health professions and disciplines to ensure a holistic approach to health workforce planning. Significantly, there is no single comprehensive national health human resource strategy that considers innovative ways to address both current and emerging issues, joins up existing initiatives and policy areas, or considers future changes that will impact the health workforce such as future population health needs, advances in technology and medical breakthroughs.

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The ongoing focus which silos professions and disciplines across the acute, primary and community care settings does not adequately address the complex arrangement of structures, legislation, policies and programs that govern, accredit, regulate and develop the workforce and influence workforce planning.

Recommendation: That the Department of Health lead a program of work aimed at joining up the national medical workforce strategy with workforce planning efforts across the healthcare continuum to strengthen health workforce planning, modelling and policy development at the national level.

Section three: Reliance on registrars to meet health service needs

Potential solution 7: Reduce the number of tasks for which hospitals require a middle-grade workforce by improving practices, systems and processes

Junior doctors and doctors, like all health professionals, would like to spend more time in clinical duties. Feedback suggests that many health professionals are spending increasing amounts of time dealing with paperwork. This challenge is multi-faceted and should be tackled more broadly than merely focussing on reducing the amount of time the 'middle-grade' medical workforce spends on administrative tasks.

Often, the burden of paper work is out of the control of health services. There is an increasing amount of regulatory and legislative red tape that health services must navigate to ensure they meet their legal, safety and quality requirements not only for funding purposes but to ensure high-quality patient care and outcomes.

To improve practices, systems and processes the strategy must acknowledge that multiple stakeholders, outside of the health service, are responsible for or influence the number of inefficient tasks and administrative requirements including commonwealth and state governments and departments, regulatory and accreditation bodies, and electronic health record vendors.

Recommendation: That the Department of Health work with the Medical Workforce Reform Advisory Committee, health services, health service representative bodies and health system regulators to map and streamline current health service administrative and regulatory requirements to improve practices, systems and processes.

Furthermore, what appears to be missing from the framework is how digital innovation, technology and information can be better leveraged to augment the work of health professionals and reduce administrative burden. New digital technologies will significantly reduce repetitive work of health professionals and has the ability to automate some traditional administrative tasks. For example, Telstra Health's Drs App gives clinicians secure access to real-time patient information via their mobile device. Drs App helps avoid the pitfalls and effort associated with paperwork with digital information, helping reduce administrative burden and associated costs.

Recommendation: The framework should consider how health services can be funded to invest in these innovations and make recommendations to establish mechanisms that support the scaling of best-practice initiatives across the system.

Potential solution 8: Ensure scopes of practice for non-medical personnel are maximised where they can reduce the reliance on a middle-grade workforce.

The VHA strongly supports full, expanded and advanced scopes of practice roles that ensure the full range of available workforce skills and competencies are deployed across the system. Ensuring scopes of practice are maximised could provide a more flexible, sustainable, accessible and responsive workforce while maintaining the quality and safety of care.

While progress has been made towards improving the flexibility of the health workforce, there are a number of systemic barriers to the long-term success these efforts including:

- protectionist attitudes towards roles and responsibilities that persist across the health system creating significant barriers to establishing new ways of working for example, the attitudes of doctors towards the role of nurse practitioners
- the prohibitive cost to health services to employ allied health professionals and nurses in advanced practice roles, which are often supernumerary to ratios
- the availability and supply of nurse and allied health professionals with advanced practice qualifications
- national registration and accreditation arrangements
- funding restrictions on the types of health professionals that can access reimbursement for MBS and PBS items.

While it is positive that in this section the strategy is looking beyond the medical workforce, it is disappointing that this potential solution considers only how tasks can merely be 'transferred' from medical to non-medical staff. Instead, the strategy should address how roles and skill mix, including those of medical professionals, will need to evolve to meet the changing needs of patients.

If we continue to ignore the relationship between professions including the influence of scopes of practice and changing models of care we will be unable to address workforce issues across the system, now and into the future, to ensure high-quality patient care.

Recommendation: That the Department of Health identify opportunities and introduce targeted system-wide strategies to implement redesigned workforce models and innovations across the system that look beyond merely reducing the burden for medical professionals but rather consider the changing needs of the community and ensure equity of access and outcomes.

Section four: Geographic maldistribution and inequity in healthcare access

Potential solution 12: Develop a mechanism to support the portability of employment benefits, enabling doctors to work across different employers, regions and/or health services throughout their careers.

For a number of reasons, the VHA does not support this potential solution. Portable leave arrangements already exist in the Victorian public health, allowing doctors and other employees to take their leave entitlements with them as they move employers within and across the sectors. While the potential solution is a positive step for doctors outside of the public hospital setting, who do not currently have portability provisions, the proposed solution imposes a significant burden on public services which will be required to contribute to two sets of long service leave entitlements.

The development of a mechanism to support the portability of employment benefits, particularly through the establishment of a third party portability fund, would duplicate an entitlement already in place for the public health workforce. This approach essentially requires health services to redirect funding away from patient care or other organisation requirements such as facilities management or staff training and development.

On 27 March 2018, the Victorian Government introduced the *Long Service Benefits Portability Bill 201*8 (the Bill) to provide for the portability of long service leave benefits for employees in contract cleaning, security and the community services sector to parliament. Like the public health system, community health services are already signatories to enterprise agreements that provide employees within the sector long service leave portability. The Bill introduced a portable long service leave scheme for community health services to be funded by a levy paid by employers to a third party, the new *Portable Long Service Benefits Authority,* while also accruing for the enterprise agreement entitlement.

While the VHA supports schemes that target the recruitment and retention of doctors in rural areas, as we have seen in the community health sector, the proposed solution will impose an additional cost burden on a sector already facing significant funding challenges; challenges that are most acutely felt in rural health services, the very providers that this recommendation targets.

Recommendation: That the proposed solution to support portability of employment benefits not be pursued due to detrimental impact on rural health service viability and sustainability.

Potential solution 13: Develop pooled or block-funding models for MM4–7 areas that offer greater flexibility

The VHA strongly supports block funding arrangements to ensure the provision of services in small rural and remote areas by simplifying funding and accountability mechanisms and by providing a more flexible, co-ordinated and cost-effective framework for service delivery.

Recommendation: Given small rural health services are already block funded, the VHA is seeking further information regarding which sources of funding are being referred to in this potential solution.

Potential solution 16: Expand outreach, network models and telehealth models that provide continuity of care and are attractive to doctors
Potential solution 17: Ensure all rural communities and doctors have access to 24/7 specialist clinical support.

The VHA considers that for both of these proposed solutions the role of technology, notably telehealth and virtual care, have the biggest potential to meet the needs of rural doctors and communities. There are a number of good practice examples of virtual care across the country including the Victorian TeleStroke Network and the Western Australia Country Health Service telehealth service.

Recommendation: That the Department of Health initiative a rolling program to evaluate, consolidate and scale existing telehealth to maximise their potential and drive efficiencies, improve equity and access to quality of health services and create a more sustainable approach to telehealth.

Potential solution 23: Ensure all programs undergo outcomes based evaluation
Potential solution 24: Establish mechanisms for communities to share learnings on what makes programs successful
Potential solution 25: Enable new and existing programs to more effectively address critical barriers and drivers for attracting doctors to rural careers

To date, little effort has been made to evaluate the impact of various workforce programs and projects across the system. The VHA considers that new and existing programs must be needs-based, outcome-directed and responsive to changing service delivery and evaluated on an ongoing basis. This approach would ensure that maximum value is being gained from government funded projects.

Like other jurisdictions, experiences of Victorian public health services show that it is possible to improve service delivery through workforce innovation locally, but more needs to be done to ensure that the benefits are adopted, implemented, sustained and scaled-up to ensure service innovation is distributed across the system. Queensland Health's Improvement Exchange is an example of a centralised virtual platform that shares innovative work being undertaken across the system.

Recommendation: That the government and industry work together with other relevant partners to establish a mechanism to overcome these challenges which enables health and care providers across the health continuum to share learnings on what makes programs successful.

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