Interprofessional Health Education in Australia:

The Way Forward

L-TIPP (Aus)

LEARNING AND TEACHING
FOR INTERPROFESSIONAL
PRACTICE, AUSTRALIA

The University of Sydney

UNIVERSITY OF
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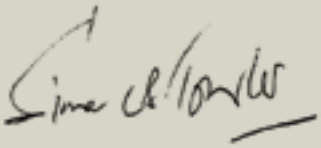
Foreword

Right across the world health systems are under review as the full impact of population growth, intergenerational change and new technology bring both challenges and opportunities in the provision of health services. What is becoming clear is that traditional models of patient care will not be able to meet the demands of the future or ensure that those who live away from major population centres have access to services of the same quality. In order to address these pressures the health workforce of the future will need to be more adaptable and be able to work effectively in teams.

Reform programs under the WA Health Networks have now documented new models of care – many emphasise enhanced community roles and greater cooperation between health professionals. Concurrently, a series of recently completed health service research projects under the auspices of the Western Australian "State Health Research Advisory Committee" have demonstrated the impact of changes in service design that emphasise shared roles in patient assessment and management. In these settings leading health professionals regularly provide education to trainees in all health professional groups embedding the interprofessional learning model into redesigned clinical practice.

It is in this emerging environment that having health professionals train together at both undergraduate and vocational levels will facilitate and enhance new models of patient care. The focus on interprofessional learning and education through the L-TIPP proposal is taking the lead in this regard.



Dr Simon C Towler
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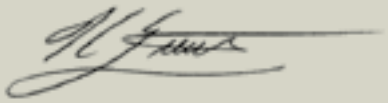
Effective interprofessional health education challenges many educational norms and traditions. Many health education and training institutions claim to prepare the best health practitioners in specific professional disciplines. In many cases this narrow view of the preparation of a health professional is based in the discipline bias, and indeed the discipline based structure, of health education institutions. Few claim to provide a health graduate able to work effectively in the delivery of quality integrated health services through interprofessional health practice.

I commend this proposal to you because it investigates how interprofessional health practice can be improved through adjustment in the education and training environments, including work experience, in our universities. In particular, it will examine how the discipline silos of traditional health education can be made more "porous" through curriculum, pedagogy, work experience or structural arrangements that promote both openness to the contribution of, and capacity to work harmoniously with, all health professionals in the provision of quality health care for all.



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Contents

Definitions

- **Interprofessional education (IPE):** Occasions when two or more professions learn from, with and about each other to improve collaboration and the quality of care.
- **Interprofessional practice (IPP):** Two or more professions working together as a team with a common purpose, commitment and mutual respect.
- **Interprofessional learning (IPL):** Learning arising from interaction between members (or students) of two or more professions. This may be a product of interprofessional education or happen spontaneously in the workplace or in education settings.

Freeth, et al. (2005, pp. xiv-xv)

I would see it (an interprofessional approach) as one that … enables you to maintain and develop your own core disciplinary skills, (and) also the capacity to work and understand other health delivery professionals, their activities, their approaches, and the way in which you interact … understanding your own approach in greater depth, and understanding the practices and approaches of others, and how they intersect, (will) give … improved health service delivery.

Interviewee

Executive Summary

Interprofessional practice (IPP) capabilities have been identified as essential for delivering health services that are safer, more effective, more patient centred and more sustainable. They are the building blocks of effective team-based practice and assist health professionals to make the best use of their professional knowledge and skills in a team environment and to understand and work with other health professionals to deliver better care. Accordingly, the graduation of health professional students who have well developed IPP and interprofessional learning (IPL) capabilities is now identified as an urgent national workforce development task to be addressed by the higher education sector.

Building a health workforce that is more adaptable and more able to work effectively in teams and across discipline and sector boundaries is a critical enabling element in many health reforms currently being initiated by the Australian federal, state and territory governments. The current Council of Australian Governments (COAG)-initiated National Registration and Accreditation Scheme process makes this report particularly timely, but also creates a sense of urgency, as it is important that the scheme be informed by the outcomes of the actions proposed in section 6 of this proposal. This project and proposal is a response to this national reform context.

The national consultation undertaken in this project – Learning and Teaching for Interprofessional Practice, Australia (L-TIPP, Aus) – revealed many examples of innovative and successful interprofessional education (IPE) initiatives developed across the Australian higher education sector. However, health and higher education stakeholders interviewed consistently told us that these initiatives tend to be local, developed in isolation, driven by and dependent on the concerted efforts of a few local 'champions', and existing on the margins of health professional curricula and health professional practice.

What these same stakeholders also told us, and what was confirmed by our review of the national and international literature, is that current approaches to IPE within the Australian higher education sector are neither sustainable, nor will they be successful in building a national health workforce that is equipped to utilise collaborative and team-based models to address contemporary health care challenges.

To bridge the gap between what is required nationally and what is actually occurring, the proposal initially identified from stakeholder interviews and the literature, eight recommendations for action that would establish the research and development directions required for building an Australian health workforce with well developed IPP and IPL capabilities. These recommendations, listed in Appendix 1, were then widely circulated for comment and reaction. Respondents gave strong support to all of these recommendations but also identified clear priorities and made suggestions for implementation.

Working with the findings of the national consultation, we have refined those recommendations to establish an agenda for national development. However, what has been less well specified and what, we believe, is an urgent matter for national and local consideration, is the identification of appropriate mechanisms and processes through which this national agenda can be progressed. This is the challenge of moving from conceptualisation to successful national development.

The *national agenda* identifies the need for development in four interrelated areas:

- *informing and resourcing curriculum development*
- *embedding IPP as a core component of health professional practice standards and where appropriate, in registration and accreditation processes*
- *establishing and implementing a program of research to support and inform development*
- *establishing an IPE/IPL/IPP knowledge management system.*

Section 6 of the proposal identifies four national development areas, eight associated actions and two enabling strategies.

Section 1

Health system crisis and reform: The case for interprofessional education

Section 1 identifies key dimensions of health system crisis and key directions in health system reform. IPP is identified as a central and enabling strand of health workforce reform. Recent Australian health workforce reforms are identified, in particular the National Registration and Accreditation Scheme. The critical role of the higher education sector in addressing the need for differently skilled health professionals is discussed.

1.1 Challenges and solutions

Health systems, both in Australia and internationally, are under increasing pressure because:

- patient and community expectations of greater partnership in health care decision-making and of improved health care outcomes are increasing exponentially
- the ageing of Australia's health workforce will, as outlined in the *Productivity Commission's Issues Paper on Australia's Health Workforce* (2005), exacerbate already existing workforce shortages, particularly in terms of service provision to rural and remote areas, to Indigenous communities, and in areas of special need, such as mental health, aged care and disability
- already existing workforce shortages will be exacerbated, particularly in terms of service provision to rural and remote areas, to Indigenous communities, and in areas of special need, such as mental health, aged care and disability
- the increasing incidence of chronic illness and life-style diseases is placing ever-greater demands on already stretched health services
- within the area of patient safety, a recurring theme identified in many patient care inquiries, is that ineffective teamwork is an underlying cause of many adverse events, for example inadequate understanding of and respect for the contributions of other health professions (Hindle et al., 2006).

The challenges that such developments pose for health systems, health provider organisations, health professionals and health professional education providers are immense. Health systems and health professionals are required not only to deliver high quality, safe, patient-centred, knowledge-informed, efficient and sustainable health services, but also to be flexible, contextually responsive, innovative and engaged in a constant process of learning – learning that is career long and system wide.

However, inadequate coordination between governments, planners, educators and service providers; fragmented roles and responsibilities; inflexible regulatory practices; perverse funding and payment incentives; on top of entrenched custom and practice, are all cited as barriers to the development of innovative, flexible and efficient models of care (Illiffe, 2007).

Four overarching reform directions or reform tasks are consistently identified in the literature as required for negotiating current challenges and developing a health system that is effective and sustainable:

- improved systems of governance, accountability and funding
- increased responsiveness to Australian demographic and geographical circumstances
- new models of interprofessional and team-

based care that deliver health services that are patient and situation responsive, effective and sustainable. Particular emphasis is placed on prevention; early engagement through well developed and accessible primary health care; partnerships and collaboration; service integration across the continuum of care; collaboration across professions; and the active participation of health consumers

- the establishment of an Australian health workforce that has well developed professional and interprofessional capabilities, a workforce that works together and learns together.

1.2 Working together, learning together – Interprofessional practice and learning

In response to the above challenges health systems and higher education providers are increasingly emphasising the critical importance of improved and enhanced levels of interprofessional team-based, inter-disciplinary and collaborative practice: that is, health professionals working together in teams to manage complex practice situations that require a systematic and informed collaboration between different professions and professional specialties. Such requirements are increasingly articulated in workforce and professional education policy and development initiatives, as is the need to develop a health workforce that is capable in the areas of IPP and IPL.

Within the health reform literature IPP is contrasted with more traditional forms of service delivery and professional practice, frequently termed 'uniprofessional practice'. Uniprofessional practice is often identified as less flexible, less able to respond to the complex needs of patients and their carers, less engaged with and skilful in team-based practice, more prone to generate adverse events, less efficient and less sustainable (Canadian Health Services Research Foundation, 2006).

McNair (2005), in her discussion of health workforce reform and the value added to uniprofessional practice capabilities by the addition of IPP capabilities, refers to the National Institute of Clinical Studies (2003) review of the literature on factors that support high performance in health care.

The reviewers concluded that *the potential of health care teams was not being realized because of lack of effective communication and team working practices* (NICS, 2003, p. 15). There is evidence that interprofessional teamwork is an important contributor to positive health outcomes through the improved communication, efficiency, cost-effectiveness, and the patient-centredness of the health care team. Effective teamwork also improves the working environment for the health provider, by creating higher levels of respect between team members, better understanding of roles, collaborative skills and improved job satisfaction (McNair, 2005).

1.3 The Council of Australian Governments (COAG) and health workforce reform

In taking forward the workforce reform agenda, the Council of Australian Governments (COAG) in 2006 agreed to a significant national health workforce reform package to enable the health workforce to better respond to the evolving care needs of the Australian community, while maintaining the quality and safety of health services. Importantly, the COAG package included the establishment of the National Health Workforce Taskforce (NHWT) to undertake projects that inform development of practical solutions on workforce innovation and reform. The NHWT Strategic Framework encourages collaboration among stakeholders so that:

> Future health care demand is expected to change in line with anticipated changes in the burden of disease facing the community. This will fundamentally effect the models of care employed in service delivery, the number and types of health care workers that will be required, and the development of multidisciplinary approaches to care.
>
> *Productivity Commission, 2005, p. 18*

Australia will have a sustainable health workforce that is knowledgeable, skilled and adaptable. The workforce will be distributed to achieve equitable health outcomes, suitably trained and competent. The workforce will be valued and able to work within a supportive environment and culture. It will provide safe, quality, preventative, curative and supportive care that is population and health consumer focussed and capable of meeting the health needs of the Australian community (Health Workforce Australia, 2008, p. 1).

As part of a broad based and expansive national reform agenda developed following the election of the Rudd Labor Goverment in March 2008, COAG initiated one of the most significant, complex and challenging workforce reform initiatives, a *National Registration and Accreditation Scheme for Health Professions*:

This agreement will for the first time create a single national registration and accreditation system for nine health professions: medical practitioners; nurses and midwives; pharmacists; physiotherapists; psychologists; osteopaths; chiropractors; optometrists; and dentists (including dental hygienists, dental prosthetists and dental therapists). It is anticipated that the new arrangement will help health professionals move around the country more easily, reduce red tape, provide greater safeguards for the public and promote a more flexible, responsive and sustainable health workforce (Australian Health Ministers' Advisory Council, 2008, front page).

Whilst the aims and scope of this initiative are broad and contentious, its focus on defining the nature and standards of contemporary health care practice provides an important opportunity for national debate and discussion in relation to:

- the requirements of contemporary health professional practice
- new approaches to defining the boundaries of professional practice
- the relationship between uniprofessional and interprofessional knowledge, practice and education
- the utility of graduate attributes as a way of defining and educating health students
- national approaches to capability assessment
- the requirement for and implications of new forms of collaboration between the health and higher education sectors for career-long professional learning.

As a further step in the development of this initiative, on the 13th August 2008, the Australian Health Ministers' Advisory Council launched the first of five national consultation papers, *National Registration and Accreditation Scheme for Health Professions.*

[We] need to use our existing health professionals more effectively. I envision less rigid divisions between disciplines, more flexible training and service delivery, widespread use of interdisciplinary teams – and new roles for care providers.

In a speech to the Catholic Health Australia National Conference, 26th August 2008, the Minister for Health and Ageing, Nicola Roxon captures well the core directions of workforce reform.

1.4 The critical role of the higher education sector

The above developments, with their significant implications for health professional students, come at a time when the Australian higher education system is also undergoing significant and sustained reform, with a particular emphasis on the need to integrate more effectively with the changing needs of industry and the professions. For example, most recently, the *Discussion Paper of the Review of Australian Higher Education* currently underway, known as the *Bradley Review* (Bradley et al., 2008), stresses once again the need for more effective partnerships with the professions, in order to develop graduate attributes that are relevant to changing professional practice.

New forms of educational thinking and practice aimed at developing interprofessional capabilities in the Australian health workforce are increasingly stressed within the policy and practice literatures. The influential report, *National Patient Safety Education Framework* (Australian Council for Safety and Quality in Health Care, 2005),

> In the past most training and education in health care has been delivered using the learning objectives of a particular profession or occupation. This segregated approach is not appropriate in today's health care system where complexity, technology and specialisation are the norm ... Health care workers who are educated and trained to work together can reduce risks to patients, themselves and their colleagues...
>
> *Australian Council for Safety and Quality in Health Care, 2005, p. 6*

identifies interprofessional education and learning and the development of interprofessional practice capabilities across all sections of the Australian health workforce as essential for enabling effective collaboration, effective teamwork and increased levels of quality and safety.

Developing similar themes, the *Productivity Commission Research Report on Australia's Health Workforce* (Productivity Commission, 2005) noted the 'lack of coordination between the education and health areas of government, leading to mismatches between education and training places and service delivery requirements' (p. xxiv), and the ways in which longstanding practices tended to act as a barrier to the exploration of 'better ways of educating and training the future health workforce' (p. xxiv). One of its key recommendations was to call for a national and systematic dialogue on health education and training to:

Facilitate consideration of education and training issues on an integrated rather than profession-by-profession basis. Amongst other things, this could provide greater scope to identify common education and training requirements across particular professions, and consequent opportunities to further develop inter/multi-disciplinary training approaches (Productivity Commission, 2005, p. 94).

1.5 Workforce reform: IPE/IPL – what's happening on the ground?

At the policy level, the achievement of system wide IPL/IPP is consistently presented as an essential and urgent necessity. What is, however, also well documented in the literature, in reports and research developed from the experience and findings of various workforce reform initiatives, is the enormity of this undertaking, the degree of its complexity, and the many implications and challenges that need to be addressed to move from policy articulation to workplace reality.

In Australia, in contrast to the international situation, there has been relatively little documentation of the problems of implementing system wide IPL/IPP. The broader L-TIPP (Aus) project, of which this proposal is the main outcome, has sought to address this knowledge deficit.

The next two sections provide a brief summary in relation to the Australian situation.

Section 2

Interprofessional health education: a brief historical overview

Section 2 provides a brief overview of the development of IPE in Australia from the 1970s to the present day. Whilst there have been significant and successful projects, these have tended to be local, on the margins of the curriculum, dependent on the efforts of champions and, therefore, vulnerable. Initiatives have rarely been sustained, with learning and outcomes rarely published. More recent developments led by the Australian Capital Territory, Western Australia and projects funded by the Australian Learning and Teaching Council hold out the hope of a more systematic and coordinated approach to IPE within Australia.

2.1 Methodology

The content reported in this section is developed from the findings of a comprehensive review of the Australian and international health policy reform and IPE health education and learning literature. A more detailed report on the content of the literature review will be available in early 2009 (refer Professor Alison Lee, Alison.lee@uts.edu.au).

2.2 Early initiatives

IPE/IPL within Australia is not a new concept, with early reports of IPE/IPL programs dating back to the early 1970s. Davidson and Lucas (1995) describe two programs at the University of Adelaide. The first, *Working in Health Care*, focused on concepts of primary health care and the potential contributions of the different professions to the health system's functioning and effectiveness. The second program, *Community Practice Workshop*, was an elective for final year students and focused on translating community health principles into practice. Like many IPE innovations, which are not part of the core curriculum, these two programs ceased when grant funding ended in the mid-1990s (an issue consistently raised in our stakeholder interviews).

Piggott (1975) reported on a community-focused program developed in the 1970s and implemented through the Community Care Teaching Unit of Royal Prince Alfred Hospital, Sydney. This differed from the University of Adelaide programs in that it was based within a community setting, allowing students the opportunity to become part of a student multi-professional team in planning the health care management of some members of the community. Despite these earlier promising starts, published accounts of Australian IPE activity within the 1980s and 1990s are sparse.

2.3 Recent initiatives

Practice-based

Over the past decade, details of Australian IPE/IPL initiatives, many focusing on rural health care practice, have increasingly been published. Within the rural sector, the *Rural Interprofessional Education (RIPE)* project generated optimism as a successful and sustained initiative (McNair, et al., 2001, 2005; Stone, 2006). However,

once funding was withdrawn, the project was discontinued. In Tasmania, published accounts of activity within rural settings suggest more promise for sustainability (Albert et al., 2003; Dalton et al., 2003). A rural placement project in Queensland focuses on medical students learning from existing health professionals in the workplace (Young et al., 2007), offering another approach to interprofessional learning.

Reports on the development of metropolitan and acute care IPE programs are less frequent. Nisbet et al. (2008) describe an IPE/IPL program implemented within the acute care hospital setting in Sydney. As with the early program reported on by Piggott in the Royal Prince Alfred initiative, students formed their own interprofessional student teams in managing patients within a ward environment. However, as noted by Nisbet and her colleagues, curriculum and organisational barriers prevented the further expansion of this program.

Campus based

Published accounts of campus based IPL activity can be found from Moran et al. (2007) and Rodger et al. (2004). Moran and colleagues report on *The Health Care Team Challenge,* an extra curriculum IPL activity which provides student teams with a case-based simulated approach for 'real life' practice in team-based problem solving. Using a case scenario approach, Rodger and colleagues report on a workshop aimed at enhancing teamwork skills amongst allied health students. Both Moran and Rodger are based at the University of Queensland.

2.4 National activity profiling

During the past few years, accounts of IPE/IPL activity across the Australian higher education sector – national activity profiles - have begun to appear. Thistlethwaite (2007), in her editorial in the *Journal of Interprofessional Care*, highlights other areas of IPE/IPL activity across the country. Results of a 2005 survey of Australian universities (Thistlethwaite & Nisbet, 2006, unpublished) indicated that a number of universities offered campus based IPE/IPL opportunities, particularly in qualifications for entry level practice programs. Many of these programs, however, tended to focus on broad based content areas rather than specific IPL/IPP objectives; for example, Indigenous studies and research methodologies. There was little indication that IPE/IPL was an embedded component of curricula. Although two thirds of the courses had been evaluated, only three studies had been published, highlighting both the need for more formal program evaluation and a far more active approach to disseminating findings and learning.

A 'snapshot' of IPE/IPL activity across the nation was provided by ACT Health (ACT Health, 2006). This report indicated an increased range of IPE/IPL activity, including clinical placement programs, particularly in rural settings; the establishment of IPE/IPL clinical educator positions; IPP professional development; projects to address workforce recruitment and retention and the utilisation of simulation skill centres for enhancing IPL/IPP. Many of these programs were in their early stages of planning or implementation, and had not been formally evaluated. The report highlights that although there are pockets of IPE/IPL activity across Australia, there is very little co-ordination of, or communication about these programs.

EXEMPLARS OF IPL

The Health Care Team Challenge has been held annually at the University of Queensland. Modelled on an IPL activity developed at the University of British Columbia, Vancouver, this initiative is going from strength to strength and is being expanded to a state-wide challenge, and possibly a national competition in the future. Three teams of mixed health professional students (including medical, nursing and allied health) develop and present a management plan for a real patient with whom they have interacted. They are judged by a panel of experts including the patient, with assessment criteria including patient-centredness and team collaboration.

2.5 IPE/IPL and the health professional curriculum

The existence of IPE/IPL programs within health care education curricula is not, as yet, a universally accepted practice within Australia. A number of Australian higher education and health providers have initiated innovative IPE/IPP capability building projects, particularly in the area of rural health care practice. However, the scope, scale, knowledge underpinnings and level of coherence and coordination of these initiatives fall far short of what will be required to achieve an Australian IPL/IPP capable health workforce within the short to medium term.

2.6 Leading the way: State based and Australian Learning and Teaching Council funded initiatives

During the past few years, the Australian Capital Territory and Western Australia have taken the initiative in developing more ambitious cross-sectoral IPE initiatives.

The Australian Capital Territory Health (ACT Health) has brought educators, clinicians and government bodies together to establish strategic relationships to design and implement IPE/IPL at both the entry level and within the workplace (Chesters & Murphy, 2007). A substantial Australian Research Council Linkage grant underpins this work.

There has been progress in recent years.
… Many health professionals have begun to appreciate the limitations of narrow clinical approaches, for example, to cardiovascular disease. As a result there has been a welcome blurring of the traditional boundaries between curative care, preventive medicine and health promotion.

World Health Organisation, 2008, pp. 45-46

The Department of Health Western Australia has established an *Interprofessional Learning Working Group* through its *Health Education and Training Taskforce.* Similar to ACT Health, the Working Group is comprised of stakeholders from the education and health sectors. The initiative arose in response to recommendations from the *Reid Report, A Healthy Future for Western Australians* (Reid, et al., 2004), which called for greater emphasis on collaborative approaches to address workforce education and training issues across qualifications for entry level practice and post-graduate training. The IPL Working Group will address recommendations that arose from that report as well as those from a Clinical Senate meeting on IPL which brought together for the first time representatives from Health and Education sectors (Playford et al., 2008; WA Department of Health Clinical Senate, 2006). Of particular significance for a more system wide approach to IPE/IPL, this initiative includes developing an IPE/IPL framework for implementation across Western Australia.

The Australian Learning and Teaching Council has funded teaching and learning fellowships and projects that directly or indirectly address the national development of IPE/IPL across the higher education sector.

A joint Fellowship *Developing a model for interprofessional learning during clinical placements for medical and nursing undergraduate students* aims to provide solutions to sustainability and other problems experienced in establishing IPE/IPL in acute health care settings. Another Fellowship, entitled *Application of clinical staff development model (Teaching on the Run) to allied health and multi-professional audiences and to rural and remote settings*, recognises that health care should be delivered and therefore also taught in multidisciplinary groups.

A project led by Griffith University *Developing cross-disciplinary leadership capacity for enhancing the professional education of multidisciplinary mental health workers* aims to develop leadership frameworks for university learning and teaching that will enhance the professional preparation of the multidisciplinary mental health workforce.

Section 3

Interprofessional health education: Australian stakeholder perspectives (Dec 08–Mar 09)

Section 3 provides comments from the stakeholder interviews. The themes of finding common ground; drivers, enablers, constraints and challenges; and an emerging and urgent research agenda are identified and discussed. Discussion of these themes is supplemented with commentary drawn from the comprehensive literature review.

3.1 Methodology

The content reported in this section is developed from an analysis of 27 interviews and two focus groups with key stakeholders involved in higher education, health and government health policy and workforce development. The identification of national stakeholders was undertaken through consultation with the project's Reference Group of key stakeholders from the Australian health and higher education sectors, together with international leaders in IPE from the UK, Sweden and Canada. Interviewee comments are supplemented with commentary drawn from the comprehensive literature review. A more detailed report on the content of the stakeholder interviews will be available early in 2009.

> It's very hard to get all the universities together to talk something through .... such as how can we progress interprofessional learning and education. That's partly because there is a sense of competition between the universities and (a need for) product definition to distinguish themselves from each other.
>
> *Interviewee*

3.2 The importance and challenge of establishing common ground

Interprofessional learning and education for health professional practice was identified as being located at the intersection of two key public policy sectors in Australia; higher education and health. In addition to the policy and funding complexities of both sectors, health professional pedagogy and health professional practice were identified as two competing, diverse and occasionally oppositional perspectives. The difficulty of finding or achieving common ground both within each of the sectors and between sectors was a common theme.

Competition not collaboration

Higher education reforms were presented as being underpinned by a framework of competition between universities. To enhance their reputation and position, universities are required to compete to attract international students and research funding.

Complexity, complexity and complexity

Whilst interviewees identified a strong policy and organisational emphasis on reform, there was a view that rather than diminishing existing organisational and funding complexities, such complexities were likely to increase. The complex multiple jurisdictions within Australia added a further challenge to finding common ground.

It is in this complex environment that the further development of interprofessional health education, learning and practice is situated.

A rich tradition of sharing

In contrast to the above, a number of interviewees commented on the long-standing and enduring partnerships developed between the two sectors. Universities, hospitals and health care facilities were identified as enjoying a shared and rich tradition of health professional education.

Building common ground – top down and bottom up

A common theme discussed by interviewees was how to establish common interests and collaborative activity. Various views were presented on how this could be achieved. Some interviewees focused on the need to develop a national reform agenda in health professional education in response to changing Australian demographics and changing patterns of illness (a top-down approach); others suggested multiple, targeted initiatives aimed at achieving incremental change via collaboration (a bottom-up approach). Most interviewees identified the need for both.

Curriculum redesign and developing research knowledge

Within the higher education sector, leadership in curriculum redesign and the development of collaborative health service research between staff in the health and higher education sectors were identified as key sites for the development of common interests and collaboration.

3.3 Drivers, enablers, constraints and challenges:

Changing demographics, changing policy and adverse events

Interviewees identified a number of drivers for change that had led to the development of local IPL/IPP initiatives: changing demographics, changing patterns of illness, the need for greater equity. Health system critical incidents and preventable patient deaths were also identified as having catalysed a rethinking and re-conceptualisation of health service delivery.

Policy initiatives, such as the COAG National Registration and Accreditation Scheme, and the current strong focus on prevention and primary health care were all seen as important aspects of health system reform, necessitating the further development of IPE.

Team-work and collaboration

There was a strong recognition identified by interviewees that in addition to the more general movement toward increased team-work, far more extensive 'team-work' and 'collaboration' were essential for meeting the particular health needs of many communities in Australia. Indigenous and rural communities were particularly identified.

Funding, vision and support

Common enablers mentioned were 'vision, money (dedicated money), support, resources and local champions.' Particular emphasis was given to 'dedicated funding.'

One interviewee recounted an experience of disruption to a successful but still tentative IPE program:

It has struggled to achieve that objective again because of … the distractions the university has encountered in that it underwent a major funding crisis and that diverted a lot of attention to that rather than to look at progressing interprofessional learning (Interviewee).

Preparedness for change

The importance of system wide preparedness to change was also identified as critical to developing and sustaining change. Many of the interviewees referred to the critical importance of 'attitudes' and 'mind-sets' for making (or constraining) development in IPE. Providing IPE focused training to educators was identified as important.

It's an advantage that the facilitator doesn't come with assumptions that might be associated with specific health disciplines (Interviewee).

continues p. 18

What the literature says

Stronger partnerships between health and higher education

The need for the health and education sectors to develop more extensive and sustained collaboration – finding common ground – to progress IPE, and health professional education in general, is a strong message in the literature.

Internationally, the call for interprofessional education as a means of enhancing interprofessional teamwork and collaboration is not new. Baldwin (1996) provides a comprehensive summary of North American programs dating back to the 1960s (e.g Szasz, 1969). In 1988, The World Health Organisation report *Learning together to work together for health* (WHO, 1988) called for closer links between education and health systems to ensure that health professional education and health professional graduate attributes were responsive to the changing needs of health systems and patients/communities.

More recently, the global health workforce shortage has been the impetus for a further WHO study group on interprofessional education and collaborative practice, (Yan et al 2007). Influencing factors include the need for greater creativity and flexibility in health professional education, the need to educate for new approaches to health system effectiveness and sustainability, and new career structures.

Learning together for working together

Within a number of countries, in particular, the UK and Canada, there exists a clear policy direction to incorporate IPE/IPL into health and social care curricula.

In the United Kingdom the Department of Health publication *Working together – Learning together*, emphasises:

Core skills, particularly communication skills, "undertaken on a shared basis with other professions, should be included from the earliest stages in professional preparation in both theory and practice settings" (UK Department of Health, 2001, p. 25).

In Canada, the 2003 First Ministers Health Accord identified that changing the way health professionals are educated was a key component of health system renewal (Health Canada, 2003).

New Zealand – partnerships in primary health care

Within the Australasian context, New Zealand has established strong collaborative relationships between district health boards, primary health care organisations and the university sector with an explicit focus on improving primary health care delivery (New Zealand Workforce Taskforce, 2008). In its terms of reference for the *Building and Enhancing Interprofessional Teams* project, the NZ Ministry of Health calls for the creation of opportunities:

For tertiary education providers to collaborate with health services so that the teaching and learning experiences are aligned with the present and future needs of consumers and communities within the primary health care sector (Boyd & Horne, 2008, p 1).

Core skills, particularly communication skills, *"undertaken on a shared basis with other professions, should be included from the earliest stages in professional preparation in both theory and practice settings"*

UK Department of Health, 2001, p. 25

Enabling practices

Interviewees provided many examples of Australian initiatives that demonstrated enabling practices:

- the development of rural placements as fora for IPE and IPP development
- the use of team simulations
- the development of innovative post-graduate modules, such as in public health (the latter modelled and partnered with a similar initiative in Canada)
- the use of case-based learning
- the development of common modules in the first year of university across several professions.

It was noted that sustaining new educational initiatives requires the willingness of all governments, institutions and communities to invest in the change process.

Digital technologies and flexible delivery

Interviewees also reported on what they saw as important developments in the flexible delivery of health professional education, particularly via distance education and digital technologies. Such developments were identified as particularly important for the development of IPE/IPL in practice settings.

Interviewees identified a number of significant constraints and challenges associated with the development, implementation, and sustainability of IPE/IPL and IPP.

Cultural constraints

Cultural constraints and barriers were seen as major influences that limit the kind of systemic and paradigmatic change required to relocate IPE/IPL and IPP into the mainstream of higher education and health care practice.

Creating an environment where new models of health service delivery and education can be adopted poses a significant challenge to both the traditional methods of professional practice and to health professional education.

I think some of the current conversations about clinical change roles and clinical role substitution and all those things are almost in one sense a risk at the moment because it is making people less receptive of collaborative action… The push nationally to embed the reform changes on us too quickly may in fact be one of our biggest risks. (Interviewee)

Some stakeholders commented on their experience of 'interprofessional' education as still being strongly influenced by uniprofessional traditions:

Even though it was interprofessional it was still a very medical dominated medically led experience. (Interviewee)

Local champions but …

Strong leadership in the area of IPE was identified as a critical factor in leading cultural change

… you have to have very strong leadership within organisations to actually ensure that there's communication, there's collaboration, there's interprofessional practice, and education actually works. (Interviewee)

It was also noted that strong leadership was not in itself enough. Relying on individual champions alone to sustain change left promising projects vulnerable when champions left.

The role of regulatory bodies

A number of interviewees commented on the fact that where IPE/IPL/IPP has been successfully incorporated into health education and health professional practice overseas, one critical factor has been that professional regulatory bodies have required it for accreditation. It was noted that within Australia there has been hesitancy in regulatory bodies taking this step.

An interviewee discusses the hesitancy of regulatory bodies embracing IPP: *Well, the barriers are because professionals like to see themselves as professional (uniprofessional) and they can see interprofessional education as denuding their profession, downgrading their profession* (Interviewee), and *It requires them to move outside their existing paradigms of being particular practitioners to being part of a health service delivery system*. (Interviewee)

continues p.20

What the literature says

The barriers and challenges to the implementation and sustainability of IPE initiatives are well documented (e.g. Davidson et al., 2008; Gilbert, 2005; Hall, 2005; Harris et al., 2003; Headrick et al., 1998) and align closely with the range of challenges identified by interviewees in this study.

Accreditation standards and incentives to change

At the macro level, Gilbert (2005) argues that without the inclusion of IPE in professional accreditation standards, universities have no reason to include it in academic programs. Harris and colleagues (2003) suggest that the hierarchical and silo nature of academic institutions hinders the progression of IPE. The fear that interprofessional practice will lead to a loss of status, a loss of professional identity, and a dilution of the role of individual professions in patient care (Headrick et al., 1998) is a strong and frequently identified barrier that will need to be addressed if IPE is to move forward.

Professional and interprofessional – a necessary and synergistic combination

Within the UK context, Barr (2005) draws on a report in 2000 by the Committee of Vice Chancellors and Principals to affirm that *Team working, integration and workforce flexibility could only be achieved if there was widespread recognition and respect for the specialist base of each profession.* (p. 7)

Recognising and addressing significant cultural change

Meads (2007) suggests the sustainability of IPE requires significant cultural change which requires a move away from territorial and professional rivalries and a 'bottom-up' approach to development. Stone argues that within Australia (at the time of writing 2007) there has been a national policy void when it comes to IPE and that this has contributed to Australia lagging far behind developments that have been occurring in other countries (Stone, 2007).

Addressing pragmatic constraints

At the level of implementation, differing expectations between key stakeholders (including students) as to the goal of IPE are consistently identified as generating difficulties (Harris et al., 2003; Headrick et al., 1998). These difficulties are exacerbated by structural differences between professional programs and in curriculum design that inhibit interprofessional education opportunities (Thistlethwaite & Nisbet, 2007; Harris et al., 2003). In a systematic review of interprofessional clinical education, not surprisingly, a lack of timetabling alignment between programs was identified as the most common barrier to implementation, with the second most commonly identified cause of implementation failure being a lack of funding (Davidson et al., 2008).

Although less well researched, the lack of preparedness of facilitators for IPE program implementation has been identified as posing a barrier to success. Practitioners and educators may feel apprehensive and lack confidence in their ability to facilitate programs that include students from other professions (Nisbet & Thistlethwaite, 2007). Staff development programs that include facilitation skills for IPE may help this situation (Steinert, 2005).

Negotiating cultural constraints

Stakeholders identified an approach to change that emphasised the need for the inclusion of all relevant stakeholders; a bottom-up and evolutionary approach to change; a knowledge led approach to development, in particular, the sharing of local knowledge - an approach typified by learning together; and an enabling of and investment in sustained change. At a more practical level, interviewees identified a range of issues.

Timetabling and clinical placements

Clinical placements were identified as important, particularly for discipline specific placements. IPL opportunities in the clinical education setting were seen by most to be under utilized and less valued than profession specific placements.

Planning and logistical problems

Without a clear directive or driver from an authorising body there are many logistical and planning difficulties which can frustrate those involved in IPE. In addition to timetabling complexities, obtaining the relevant support and involvement from members of faculty and clinical educators from health can be challenging and time consuming:

That (our program) ran into problems in that it became very difficult for the university to schedule curricula in each of the schools to coincide with clinical placement times (Interviewee), and
… if you say that we want to introduce a one week interprofessional education (unit) all … responsible for curricula say that this is impossible; we can't lose one day, we can't lose one hour… (Interviewee)

Differing levels of readiness

Even when there is agreement between professions about implementation, timing is an issue.

So you can have this terrible situation where one group has suddenly decided it's going to be ready to be interprofessional, to share and to work collaboratively. Another group isn't, and then the first group can go off the boil while the other group comes up with its new ideas. (Interviewee)

3.4 An emerging and urgent research agenda

One of the strongest and most well developed themes within the stakeholder interviews related to the gaps in knowledge about the impact and outcomes of IPE/IPL and IPP, and the urgent need to address these gaps through well developed collaborative research.

The effectiveness of IPE – a provisional position

There was broad agreement from stakeholders that there is some evidence for the efficacy of interprofessional education. Key stakeholders believe that the identified benefits of IPE/IPP need to be more rigorously evaluated and integrated into improved models of care and a credible educational pedagogy. There was a strong and consistent view that more evidence is needed to support a commitment from the Government to IPE.

… this government; they want evidence to put more money in, or to undertake significant political changes (Interviewee), and

EXEMPLARS OF IPL

Monash University Department of Rural & Indigenous Health (MUDRIH) has developed the *Health and Social Care Interprofessional Network (HSIN)*. HSIN was launched in Gippsland in October 2007 and has spread through all five rural Victorian regions during 2008 attracting a broad range of clinicians from a wide variety of disciplines. The goals of HSIN are to assist clinicians and educators develop or enhance their skills to effectively function in an interprofessional learning and practice environment; to share IPL resources and skills and to identify potential student clinical placements that are not currently utilised. In total there have been eleven HSIN meetings across rural Victoria with a wide variety of interprofessional guest speakers and participants attending. HSIN is supported by a newsletter, the *HSINVicNews*. HSIN was initially funded by MUDRIH but attracted a small Victorian Department of Human Services grant in 2008. In 2007 and 2008 HSIN has been raising awareness about IPL but in 2009 the focus will shift to building sustainable 'local' IPL capacity through the enhancement and support of sub-regional HSINetworks. The sub-regional networks will be well placed to take on local IPE and IPP projects.

I'd need a business case as to why it was more effective … I'd need to have evidence to say this actually does make a difference in practice. (Interviewee)

Directions for future research

Five main areas in which further knowledge and research are required were consistently identified:

- a patient focus: evidence as to patient outcomes
- a student focus: evidence as to student opinion and satisfaction
- a health professional focus: evidence as to the impact on skills, job satisfaction, recruitment and retention
- a higher education system focus: evidence as to economic benefits/cost effectiveness
- a health system focus: in particular, evidence as to economic benefits/cost related to effectiveness.

Interviewees suggested key areas where impact and improvement in relation to patient care might be identified as 'safety and quality' and 'patient satisfaction'. There was also a suggestion that differential team functioning related to educational experience could be a useful area to explore the impact and outcomes of IPE – the performance of health professionals who had participated in IPE programs, compared with health professionals who had not participated in such programs.

Patchy publication and the need for a longer-term view – longitudinal studies

Interviewees noted that while information that could be used to explore the impact of IPE participation on the student experience is being collected from program and placement evaluations, data collection is both 'patchy' and not widely available in the public domain as published data.

It was also pointed out that even when there are good evaluation processes in place and robust data collected, the results are rarely published. There was a strong consensus that more robust and longitudinal data is required.

We're looking at some longitudinal data…but that's going to take a long time (Interviewee), and *We need to be able to decide on what the evaluation is and what outcomes we want to be able to demonstrate about how IPL improves the quality of the product that comes out of the uni[versity].* (Interviewee)

Data fragmentation – the need for a coordinated approach

A further issue limiting the aggregation and analysis of larger data sets was that each institution tended to develop its own particular approach to evaluation and, as a consequence, identify its own data items and collection methods.

Researching workforce retention and satisfaction

Given the extensive health workforce shortages and the national policy emphasis on workforce development, a number of interviewees identified the urgent need to develop research into the relationship between IPE and job satisfaction and retention, in particular in rural and remote areas.

A cost/benefit perspective

To influence policy, cost/benefit data would be required in relation to a number of matters, in particular the cost of progressing IPE as a core component of the health education curriculum juxtaposed with a valid and reliable measure of benefit – patient care, staff satisfaction, retention.

The governments aren't all that interested in the educational finery, they're interested in something that will solve their workforce problem. (Interviewee)

The overall message from stakeholders was that existing evidence needs to be synthesised in ways that are meaningful to policy makers and senior health and higher education managers. Developing long term evaluation of the outcomes of IPE/IPP and how these impact on patient care and staff retention/development is critical.

What the literature says

Systematic reviews – promising indications and design challenges

In a quest to demonstrate the effectiveness or otherwise of interprofessional education, a number of systematic reviews have been conducted in recent years. A report commissioned by the Canadian Interprofessional Health Collaborative provides a synthesis and useful comparative summary of these reviews (CIHC, 2007).

The most recent systematic review, a Cochrane Collaboration review of 2008 identified that four out of six studies that met its inclusion criteria demonstrated positive behavioural or patient outcomes (although two had mixed outcomes); and two studies had no impact. All the above studies were conducted in workplaces with qualified practitioners. Most studies, however, did not have IPL as a primary focus but rather, focused on team based practice as a quality improvement initiative. Behavioural outcomes included changes to referral practices, improved documentation and work patterns. Patient care outcomes related to patient satisfaction and reduced clinical errors. No studies were identified at the level of qualification for entry to practice (Reeves et al., 2008).

Hammick and colleagues (2007) in a systematic review that broadened its inclusion criteria and outcome measures identified 21 papers for inclusion in the review. In contrast to the Cochrane review, most of the included studies (15) evaluated IPE delivered to students seeking qualifications for entry level practice. Although the majority of studies still focused on learner attitudes, skills and knowledge, there were a handful of studies from the qualification for entry to practice setting that addressed behaviour changes and patient care outcomes (e.g. satisfaction with care).

From the above systematic review there is strong evidence that students perceive IPL to be beneficial within curriculum and welcome the interactions with students from other health professions (e.g Kilminster et al., 2004). Studies also report that attitudes can be shifted through IPE (e.g Carpenter, 1995; Tunstall-Pedoe et al., 2003) and that students gain an increased understanding of professional roles and teamworking (e.g Cooke et al., 2003; Ponzer et al., 2004).

What is less well known is whether IPE at a pre entry to practice level can impact on behaviour and whether these changes can transfer into practice on graduation. Kilminster and colleagues (2004) report on a workshop for medical, nursing and pharmacy students which focused on professional roles, team working and communication skills. Students reported an increased level of asking for advice from other health professionals and asking more questions about medications after attending the workshop. Although this study is a notable attempt at measuring behavioural change, perception of practice may not necessarily translate into actual practice. Cooke and colleagues (2003) have addressed this somewhat. Through observations of students during a 'breaking bad news' workshop for nursing and medical students they found that nursing students became more involved in the patient consultation as the workshop progressed. This suggests that the workshop assisted in developing confidence within these students, which impacted on their practice within the interprofessional environment. This study however, did not report on longer term impact and whether these changes were maintained in the workplace.

Measuring the impact of IPE on patient outcomes and service delivery is even more of a challenge. Unsurprisingly, the systematic review by Hammick and colleagues (2007) only identified two such studies at a pre-entry to practice level (Dienst and Byl, 1981; Reeves and Freeth, 2002). The previously mentioned 2008 Cochrane review failed to identify any studies in this category. Reeves and Freeth report an increased level of satisfaction from patients in an interprofesional training ward compared with a comparative ward. However, as pointed out by the authors, these patients received more attention from students, and IPE facilitators contributed to higher than usual staff levels during the intervention, thus making direct comparisons with the comparative ward somewhat problematic. Dienst and Byl (1981) suggest that IPE can enhance numbers of patients seen and the comprehensiveness of that care. This outcome was demonstrated in a community based IPE program involving senior year students.

The individual studies mentioned in this section highlight some of the challenges researchers face in evaluating IPE beyond the knowledge, skills and attitudes level. However, as pointed out by many of the interview stakeholders, there is a need to develop tools and methodology to gather this data. Freeth and colleagues (2005 a; 2005b) provide some useful resources to assist with this.

Section 4 Looking to the future: building IPE capacity and capability – a national approach

Section 4 draws together interviewee comments regarding – where to from here? Three national development trajectories are identified: scaling up of IPE activity; managing cultural change and repositioning and reconceptualising IPE.

4.1 National development trajectories

Three national development trajectories for IPE and, more broadly, health professional education, were identified:

- from IPE being located on the periphery or margins of health professional curricula, to IPE/IPL being located as a core component of the health professional curricula
- from IPE being developed and communicated at the local level, to IPE being developed and communicated as part of a coherent and connected national agenda
- from health professional education and learning being developed almost exclusively within distinct and frequently disconnected uniprofessional frameworks, to health professional education and learning being developed within curriculum frameworks that connect and integrate professional knowledge and practice with interprofessional knowledge and practice.

All of the above directions reflect a common theme identified by interviewees: the critical need to scale-up from local activity to build national IPE/IPL capacity and capability. As outlined in section three, there is an increasing number of Australian academics making worthy contributions to the interprofessional literature. However, as one informant commented, there is currently no 'national conversation' within Australia about the importance and development of IPE/IPL.

As noted previously, interviewees recognised the degree and scope of change involved in progressing the above development trajectories. The need for change and change management was discussed in relation to policy change, institutional change, cultural change, educational change, identity change and change in the area of professional practice. The concepts of a 'paradigm' change and a change in underpinning 'mindsets' were used to reflect this, as were the terms 'horizon' and 'blue-sky' thinking.

In terms of achieving such changes, interviewees identified the need for a significant re-conceptualisation and redesign of fundamental elements of health professional education. Interviewees identified the need for a re-conceptualisation in the following areas:

- contemporary professional practice: seeing professional practice not from the perspective of a single disciplinary position, but rather as a complex, team based, interprofessional and patient focused activity
- what is required to graduate an effective health professional? Engaging with this more complex view of contemporary professional practice requires a re-conceptualisation of what is required to graduate an effective health professional
- professional knowledge and a sole reliance on professional education and learning are identified as incapable of equipping health professional students for contemporary practice. Re-conceptualising the professional curriculum is required.

A major issue identified as constraining the development of IPE/IPL was the view that IPE/IPL and IPP were about replacing discipline based practitioners with generic health workers. An alternative view was expressed by interviewees. IPE/IPL was identified as adding to and enhancing disciplinary professional knowledge and practice and was also identified as a contributing to the delivery of more patient focussed and effective health care.

One of the most consistent, arguably defining themes identified by interviewees, was the need for a far stronger, better developed and sustained partnership between the higher education and health sectors in the development and delivery of health professional education. The need for a coherent and consistent view and approach to education and learning implemented across academic and clinical settings was identified as critical, with the lack of such coherence and consistency being identified as one of the major constraints on further development.

EXEMPLARS OF IPL

The *Teamwork in Health* module, now in its third year of implementation for health and social work students at The University of Sydney, introduces students to key concepts of team-work and its relevance to the health care setting.

Designed as a foundation step in the continuum of interprofessional learning, module focus and assessment is strongly weighted towards reflection on team process. The module is divided into three parts: preparation and introductory lecture; a team building workshop to allow students to develop teamwork skills in a supportive environment; and a team based project where students can apply the skills developed to a real situation.

To date, close to 1000 students have completed the module. Student evaluations indicate the module to be relevant to their education and future practice, as well as helping them to develop not only practical teamwork skills, but also insight into how they perform within a team.

Section 5 Testing the recommendations: a process of national consultation

Section 5 reports on findings from a national consultation process. Relevant stakeholders, organisations, networks and individuals were sent the initial proposal – *Interprofessional Education in Australia: a proposal for future research and development* – for national consultation and asked to provide feedback on each of the recommendations (Appendix 1).

5.1 Responses to the National Consultation, December 2008-March 2009

There were 64 individuals or organisations that provided a response through the online response system. In addition, a further 16 written responses were received.

Of the total 80 responses, 20 (25%) came from organisations and the balance from individuals. More than half of the responses (60%) came from health providers while 40% of respondents were in the educational sector, mostly universities. The respondents categorised themselves as: 30% were involved in 'all areas of health provision', 22% in nursing, 18% in allied health and 30% were in other areas of practice. In both the online system and in the written submissions, respondents did not always give their position in respect of each of the eight recommendations. Indeed, a number commented that the first two recommendations ought to be the focus of further development. Recommendations 3 to 8 were, to many individuals, and especially to many of the organisations, actions that should follow further down the development path. Consequently, many online respondents did not specifically respond to the later recommendations.

Thus, the number of respondents to each of the recommendations varies significantly. Nonetheless, it can be seen from the following table that there was considerable support for the thrust of the proposal's recommendations.

The overarching tenor of responses provided to the recommendations was of a keen commitment to further developing the IPE/IPP research and development agenda, and this was often accompanied with comments such as 'this proposal is long overdue and very welcome'. However, there was also a strong element of scepticism and concern about the capacity of the system to achieve these goals. Many respondents noted that there is a long history of attempts to reform the health system and that, without great care and careful preparation, many have failed.

Some significant players such as the Medical Deans Australia and New Zealand and the Australian Medical Council (AMC) took a stronger position that any change should be 'evidence-based'. Both organisations indicated that they were 'generally supportive', but the Medical Deans Australia and New Zealand cautioned against 'proceeding with the initiatives other than on an 'evidence-based framework'. The AMC was supportive of the idea of further investigating how IPE could be developed: *the AMC acknowledges the need for more evidence to support the linkage between interprofessional health education and improved health outcomes. Further exploration is also required to establish the optimal times and settings in which to embed interprofessional health education in learning and teaching programs.*

This concern for the development of a greatly expanded knowledge base was equally expressed by many of those who enthusiastically endorsed the expansion of IPE/IPP. Their view was that this development is too important to risk by rushing in with a major change agenda. For example, the network Services for Australian Rural and Remote Allied Health (SARRAH) says of Recommendation 2:

This recommendation is supported in principle. However, SARRAH does not believe that there is sufficient national coordination within the IPE/IPL movement as yet to be able to develop a national response to the National Registration and Accreditation Scheme within the timeframe available prior to the Scheme's implementation. Notwithstanding coordination issues the competencies relating to IPP must be incorporated into the competency standards for all health professions as part of accreditation and registration.

These competencies are shared across the health professions. The lack of nationally accepted IPP health professional attributes and practice capabilities creates a barrier to the development of a national response.

As SARRAH indicates elsewhere in its submission, this does not imply any lack of urgency in progressing an Australian move to embrace IPE/IPP. Rather, it represents a strategic approach, in which it is necessary first to, identify clearly what IPE/IPL/IPP entails, and to further develop both the evidence base and the network of those committed to IPE/IPL/IPP in both universities and the health workforce.

Most respondents recognised that considerable activity in this area is underway. However, many were also aware of past failures to develop and mainstream the notions of interprofessional work. For most respondents the key is achieving commitment and this, they recognise, is no easy task, and is likely to take some time to develop.

Respondents proposed two key strategic approaches that could be taken from this point. One group – a mixture of those engaged in higher education and those engaged in health service delivery — supported an approach that builds upon the existing experience and knowledge through an intensive national R&D agenda. For some this was a matter of trying to identify an area where the greatest impetus could be developed. For example, Prof Dawn Forman commented:

The National Research agenda may well be more quickly agreed and achieved than the development agenda as collaboration between HEIs and practice for research purposes whilst difficult, if funded could be achieved quite quickly.

Others saw the starting point as being the workforce agenda. In their view, there has never been a more pressing need and a more willing climate for change. As an approach, Lesley Bainbridge of the University of British Columbia noted that:

In Canada, federal funding has been provided to bring together 6 key professions (medicine, nursing, physical therapy, occupational therapy, social work and pharmacy) to develop principles to guide the development of accreditation standards for IPE. … The intent is to embed IPE accreditation standards into the existing accreditation programs using the language and approach specific to each profession but to encourage enough similarities that the intent of the IPE standards is the same across professions.

Support for the Eight Recommendations:

See Appendix 1, for details of the 8 recommendations

RECOMMENDATIONS		NO. OF RESPONSES	SUPPORT
1	NATIONAL R & D AGENDA	54	94%
2	NATIONAL IPE RESPONSE TO NRAS	42	86%
3	IPP GRADUATE ATTRIBUTES	40	95%
4	MODEL CURRICULUM	43	70%
5	REQUIREMENT FOR REGISTRATION/ACCREDITATION	37	81%
6	HEALTH WORKFORCE PRIORITY	34	94%
7	CROSS-SECTORAL MECHANISMS	36	97%
8	INFORMATION EXCHANGE	36	94%

Others, commented on the importance of continuity and sustainability. Russell Linwood, from QLD Department of Emergency Services advised:

Aside from a clear decision and directive to go, get a team together that does nothing else until the job is done. Almost every "incomplete" project I have ever seen (and I am a project manager) has resulted from staff turnover and the resulting loss of continuity.

As noted above, respondents typically supported all recommendations and gave each a high priority. Many indicated that they saw development occurring in a series of stages, with initial enabling actions leading the way for more expansive and system wide development.

5.2 Input from consultations in Western Australia, February 2009

To develop a more interactive engagement with a range of health and higher education providers, a series of meetings were held with key stakeholders in Western Australia. These consultations showed strong and enthusiastic support for the broad thrust of the recommendations but advised that the implementation process should involve a carefully coordinated transition from a series of individual initiatives into a sustainable service model. This, it was argued, required the development of change agents within the system.

The participants indicated that IPE currently lacks legitimacy in the eyes of many in the higher education sector (including students) because it is not a core requirement of clinical practice. Further, they indicated that the promotion of IPE/IPP should not occur at the expense of profession-specific knowledge and identity development, rather it should involve an expansion of professional roles that extend current understandings.

Importantly, and in common with other respondents to the discussion document, the participants urged an inclusive approach that did not seek to impose a new regime from above but which built upon the many activities in WA already working to implement IPP/IPE.

Section 6

The Way Forward

Section 6 of the proposal identifies an agenda for national development. The agenda has been developed and refined through a number of consultation stages, incorporates learnings from the national and international literatures and is responsive to national health and higher education reform priorities.

The next few years provide a unique opportunity to take forward a nationally coordinated approach to IPE within Australia. The development of a health workforce with well-developed interprofessional capabilities responds to a broad range of health reform policy initiatives; to a growing body of evidence as to what is required to deliver health services that are safer, more effective, more patient centred and more sustainable; and to what almost universally stakeholders across the health and higher education sectors have identified as urgently required and long overdue.

Whilst much has already been done, what stakeholders consistently told us is that much more is required, in particular, a development process that is nationally coordinated, inclusive and locally enabling.

Four key areas of development

- *Informing and resourcing curriculum development*
- *Embedding IPP as a core component of health professional practice standards and where appropriate, in registration and accreditation processes*
- *Establishing and implementing a program of research to support and inform development*
- *Establishing an IPE/IPL/IPP knowledge management system*

The primary aim and outcome of the national consultation process has been to identify the need for a national and cross-sectoral approach to building an IPP capable health workforce. In doing this we have identified four key interrelated areas of development and eight associated key actions. To take forward the national IPE development agenda, we propose two enabling strategies.

THE NEED FOR IMMEDIATE ACTION

While acknowledging some concerns about progressing the IPE agenda too rapidly, it is, we believe, essential that the above actions be taken in time to inform the COAG-initiated National Registration and Accreditation Scheme for health professionals. For IPE not to be included at this formative stage in such a major national reform initiative would give weight to the views of those who believe in the inability of the health and higher education sectors to achieve these goals, despite the national and international consensus and growing evidence base as to the benefits and necessity of graduating health professionals with well developed interprofessional practice capabilities.

Eight key actions

1. Identify mechanisms for the development of health professional curricula that embed IPE/IPL/IPP as central components of the curricula
2. Identify approaches to effectively graduating students with well-developed IPL/IPP capabilities. For example, effective learning strategies and the optimal times and settings in which to embed IPE
3. Establish nationally acceptable definitions of IPP/IPE
4. Explore approaches to embedding IPP as a core component of health professional practice standards and where appropriate, in registration and accreditation processes. (These explorations should consider the experience of other national and regional jurisdictions, in particular, Canada, UK and Europe)
5. Review existing Australian IPE programs for what has been learned and for what can be adapted to existing and new IPE initiatives
6. Design and implement a nationally coordinated program of research that is responsive to Australian conditions and requirements
7. Contribute to the development and implementation of a national IPE knowledge management strategy – a strategy to ensure the widest and most effective organisation and dissemination of IPE information, knowledge and resources
8. Prepare a 2010 – 2020 IPE development proposal for consideration by a National IPE/IPP Summit, that would contribute to and run parallel to the international *All Together Better Health V* conference to be held in Sydney in April 2010.

Two enabling strategies

1. The establishment of a national forum comprising senior representatives of key stakeholders in health and higher education.
   The forum would explore the most appropriate mechanisms to progress the IPE development agenda. The forum would also take a lead role in enabling the national summit conference and in presenting to that conference an IPE development agenda for the next decade.
2. A national IPE/IPP summit to be convened in conjunction with *All Together Better Health V* conference {an international standing conference of the Interprofessional Education (InterEd) organisation} to be held in Sydney in April 2010.

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Appendix 1 **Recommendations**

1. The establishment and implementation of a national IPE/IPL research and development agenda
2. The urgent development of a national IPE response to the National Registration and Accreditation Scheme
3. The establishment of nationally accepted IPP health professional graduate attributes and health professional practice capabilities
4. The establishment of a model curriculum for IPE/IPL in health professional education
5. The promotion of IPE/IPL as a requirement of all health professional registration and program accreditation in Australia
6. The promotion of IPE/IPL as a health workforce priority
7. The establishment of national health and higher education cross-sectoral mechanisms and arrangements through which national IPE/IPL leadership and coordination can be developed
8. The establishment of national and regional approaches to IPE/IPL/IPP information exchange, communication, shared learning and development.

Appendix 2 List of respondents

Organisations and individuals who responded to the Discussion Document and who agreed to be identified

Organisations

Aboriginal Health and Medical Research Council of NSW

ACT Health

Armadale Health Service

Australian College of Ambulance Professionals (NSW Branch)

Australian Institute of Radiography

Australian Medical Council Limited

Australian Psychological Society

Bentley Health Service

Curtin University of Technology

Faculty of Health Sciences, Latrobe University

Faculty of Health Sciences, The University of Sydney

Faculty of Health Sciences, University of Queensland

Faculty of Nursing & Midwifery, The University of Sydney

Go Global: Curtin Health - an initiative of Curtin University of Technology

Health Professions Office, Department of Health - WA

Medical Deans Australia and New Zealand

Royal Perth Hospital

Rural Health Workforce Australia

Services for Australian Rural and Remote Allied Health (SARRAH)

Speech Pathology Australia

Sydney Children's Hospital

Workforce Education and Training, WA Health

Individuals

Anne, James Cook University

Bainbridge, Lesley, University of British Columbia

Brewer, Margo, Curtin University of Technology

Brodie, Pat, University of Technology, Sydney & Sydney South West Area Health Service

Carrol, Grace, Health Professions Workforce, WA

Chippindall, Martina, North Metropolitan Health Service Perth

Colyer, Chris, WA Country Health Service Area Office

Daly, Joanne, Child & Adolescent Community Health

Dignam, Denise, Faculty of Nursing, Midwifery and Health, University of Technology, Sydney

Dolley, Pam, Barwon Health La Trobe University School of Public Health

Forman, Professor Dawn, Interactive Leadership and Management Development

Glass, Beverley, James Cook University

Hill, Rowland, Community Pharmacist

Jowett, Lena, Sydney Adventist Hospital

Joyce, Valmae, Lihir Medical Services, Lihir Island Papua New Guinea

Lad, Shushila, Liverpool Hospital

Linwood, Russell, Queensland Department of Emergency Services

Lyon, Eldon, GGT GPET rural GP registrar training program

Malone, Sally, Kimberley Community Drug Service Team

Matthews, Ian, Sir Charles Gardiner Hospital

Morrison, Susan, James Cook University

Parker, Steve, School of Nursing & Midwifery, Flinders University

Pauline, SCGH Perth WA

Ruston, Sally, James Cook University

Smith, AN, University of Newcastle

Smith, Enid, Stawell Regional Health

Wallace, Margaret, University of Wollongong

Waters, Stephanie, WACHS Kimberley

Wemyss, Meg, Sydney Children's Hospital

White, Ian, Diabetes Australia

Wilkinson, Kate, Radiation Therapy Services, Peter MacCallum Cancer Centre

Willis, Eileen, Flinders University

Notes

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For further information on interprofessional education, learning and practice see: www.aippen.net