

Australian Council of Deans of Health Sciences

Submission to Productivity Commission Health Workforce Study

July 2005

1 Introduction

The Australian Council of Deans of Health Sciences (ACDHS) is the peak forum for Australian universities that provide undergraduate education in clinical health sciences (with members providing programs in at least three of: health information management; medical laboratory sciences; nutrition and dietetics; occupational therapy; optometry; orthoptics; pharmacy; physiotherapy; podiatry; prosthetics and orthotics, radiation technology; and speech pathology). The Council is a forum for representation, coordination and information sharing with the aim of strengthening training of allied health practitioners in Australia to meet the needs of communities.

This submission emphasises points of strategic importance in the allied health arena relevant to the Health Workforce Study Terms of Reference.

2. Key issues

- Available evidence suggests that there is a significant undersupply and geographic maldistribution of allied health professionals in Australia.
- Underlying factors appear to be shared with medicine and nursing.
- The strategies to increase accessibility of training and address health workforce maldistribution are well established for medicine and on the basis of available evidence, appear equally applicable to nursing and allied health.
- Education sector reforms (to address geographic maldistribution in particular) should include: greater regionalisation of training delivery, ruralisation of curricula; targeted recruitment of rural and Indigenous students; and repeated undergraduate exposures to rural and Indigenous health.
- Expanded teaching investment in allied health education and training should be linked with undergraduate and postgraduate programs for other health professions, in the interests of efficiency, sustainability and team-based learning. Existing University Departments of Rural Health and Rural Clinical Schools provide an existing successful model that could be expanded to provide health professional program delivery in under-served locations. Engagement of the private sector should also be pursued. This is especially the case where most of the workforce will be in the private sector, e.g. pharmacy.
- The capacity of clinical teaching in health services is likely to emerge as a key rate-limiting factor in national efforts to address health workforce supply and maldistribution.
- The model of public 'teaching hospitals' as the centres for clinical education needs to be replaced by a 'teaching health system' that harnesses both public and private institutions in the primary, secondary and tertiary health sectors across geographical locations.
- Rural and regional investment in education and training of health professionals has benefits beyond production of workforce: it builds community capacity and viability, enhances professional retention and supports quality and safety objectives.
- All health professional programs should be funded by the Commonwealth Government at a level that reflects the true cost of delivering up-to-date, relevant and high quality curricula. The extra costs associated with clinical placement in rural and remote locations should be recognised and funded.
- The Australian Government should assume the major role in funding health system clinical teaching capacity that is regionally brokered among stakeholders, within broader state and national policy parameters.
- A shift to regionalised clinical training is likely to require substantial investment in physical infrastructure, including student accommodation and teaching facilities.
- Allied health practitioners can potentially play an important role in providing greater workforce flexibility by assuming expanded clinical practice roles. A team-based,

flexible 'delegated practice' model is preferred, with a common training pathway across the various health professional groups.

3. Workforce supply

Allied health workforce planning and coordination across education and health sectors is even less developed than medicine and nursing. This is recognised by the Australian Health Workforce Advisory Committee: allied health workforce planning and improvements to national data collections are areas of current work focus.¹

Nevertheless, anecdotal experience and the available data suggest that both workforce undersupply and geographical maldistribution in the allied health professions are similar to those seen in nursing and medicine.²⁻⁴ As with other professional groups, services in rural, remote and Indigenous communities appear to be most affected with a clear gradient of supply across urban, regional, rural and remote in the 2001 Census (from 1.47 allied health practitioners per 1000 persons in major cities down to 0.6 per 1000 in remote areas²).

The underlying factors appear to be similar to those documented for medicine and nursing: an ageing population with increasing health care needs and demands; a higher proportion of women in professions; general dissatisfaction with demands of public-sector work; trends towards part-time work for both men and women; delays in ramping-up undergraduate course numbers to meet anticipated need; lack of rural and regional training options; and early exit from the workforce.

4. Addressing maldistribution

The benefits of recruiting rural students into health professional courses and teaching in rural, remote and Indigenous communities is now well established in the literature. In medicine, students are more likely to choose rural medical practice as a career if:

- they (or their partner) has a rural background;
- they have repeated undergraduate rural clinical exposures; and
- there are opportunities to work rurally during the early post-graduate period.⁵⁻⁹

Academic institutions that are located in a rural population centres, that preferentially select rural students, have rurally-orientated curricula and deliver programs in rural locations are more likely to produce graduates who stay rural.⁹ This mounting evidence helped inform Australian government investment in new rurally-orientated medical schools¹⁰ and other initiatives¹¹

While the experience of medicine can be reasonably generalised to other health professional groups, there is also direct evidence emerging in relation to allied health¹² and nursing in Australia.¹³

However, the level of investment to address problems of undersupply and maldistribution of allied health professionals been relatively modest to date. University Departments of Rural Health (UDRH) were funded in 1996 in each jurisdiction as an initial strategy to increase rural academic education and training programs and applied health research at the regional level.¹¹ Other funding has been provided for mostly one-off projects and minor infrastructure to support training and retention of allied health practitioners through small-scale projects such as:

- the Rural and Remote Pharmacy Infrastructure Grants (RRPIGs),
- establishment of part-time Pharmacist Academics in University Departments of Rural Health (PAUDRH)
- individual projects such as the development of a model of remote sustainable outreach allied health service;¹⁴
- examples of allied-health clinical/teaching capacity co-located with Rural Clinical Schools.¹⁵

While repeated rural experience for students undertaking allied health courses is desirable, a range of factors often makes this difficult in practice. These include:

- capacity of rural practitioners to provide preceptorship and teaching given workload commitments and lack of locum support;
- availability of affordable short-term accommodation in rural areas;

- cost of transport associated with remote clinical placement locations.

Support for new allied health graduates is also crucial. Professional mentoring for occupational therapy graduates to ease the transition to practice has been identified as an important issue, particularly in rural locations.^{12, 16} Innovative approaches to post-graduate mentoring and supervision are required when (as is often the case) the allied health post is in a rural location where only one professional is employed.

There are few Indigenous graduates from clinical health science courses. This relates to a range of factors impacting on Indigenous educational disadvantage including poverty, remoteness and negative experiences in schools. Some 40% of Indigenous students did not meet national year 7 reading benchmark tests in 2001 (compared to 12% of non-Indigenous students). Those from remote areas fared significantly worse (as evidenced by 70% failure rate in the Northern Territory).

5. A 'teaching health system' to replace 'teaching hospitals'

The changing role of tertiary hospitals, the increasing recognition of the role of geographic location of training in relation to under-served populations and the need to harness the capacity of the private sector - all make a transition to a 'teaching health system' in Australia a critical policy priority.

The role of the public tertiary hospitals has been undergoing rapid change. The pattern of shorter and more intensive hospital stays, more highly selected patient groups and a greater emphasis on subspecialty practice, means that there is less opportunity for clinical teaching on cases that are relevant to health care practice in the local hospital or community setting.¹⁷ The context of learning for health topics is recognised as being educationally important in the ruralisation of curricula.¹⁸

In spite of increasingly critical workforce supply problems in hospitals, there is widespread institutional ambivalence regarding clinical teaching and research. Commitment from individual hospitals and regional health administration to policy directives on teaching is often inconsistent if it is perceived to be too hard or costly to implement.

A narrow market ethos in health service management reforms over the last 15 years has undermined partnerships between health professionals, health institutions and universities that are critical to patient-centred care. Health service executive management incentives to contain labour costs, to maximise throughput and reduce elective surgery waiting lists have not been balanced with incentives to invest in training, recruiting, retaining and developing people (and in particular, local health workforce). As a result, Australia relies heavily on short-term employment contracts, agency nursing staff, and international medical and nursing graduates. Staff continuity and a culture of teamwork, ownership and reflective practice have suffered.

Most undergraduate clinical education in health disciplines has centred on urban public teaching hospitals. The 'teaching hospital system' has not been the ideal setting to develop generalist and rural health interests. Medical students are often subtly dissuaded from pursuing rural practice as a career with much teaching delivered by sub-specialists who have little experience outside of the urban tertiary hospital environment and who tend to regard general practice and rural medicine as inferior and of low status.¹⁹ Overt criticism of rural practice expressed to undergraduates by urban consultants is unfortunately common, and appears to impact on vocational choices in medicine.²⁰ In addition, Medical undergraduate training in general practice has improved significantly over the years, but junior doctors then spend most of the next two years in hospitals and do not have the opportunity to pursue General Practice terms.

As a consequence of the above, universities now struggle to find adequate clinical placements for health professional students at the district and individual health service level in both urban and rural settings.. The wholesale de-commissioning of hospital-based accommodation for students in regional areas of Australia is a case in point: it demonstrates the general lack of strategic commitment to regional teaching and development of the next generation of rural and regional health practitioners, let alone support for research and evaluation activities. The role and status of clinical academics within many public hospitals has also been undermined. These factors have contributed to an exodus of senior health professionals from the public system and from clinical teaching and peer support roles.

The situation is generally worse for allied health professions given the lack of a history and culture of hospital professional training outside of medicine and nursing. Allied health students are generally regarded as the last priority in terms of access to clinical experience, teaching facilities and student accommodation.

Meanwhile, the capacity of the private sector for clinical teaching is underutilised. This is particularly important in areas such as physiotherapy where a significant private workforce has been developed. The private sector needs to take some responsibility for training - it is a significant beneficiary of the trained staff who are almost entirely educated in the public system at not insignificant cost

There are other benefits from investment in education. Clinical teaching and academic capacity is critical to quality and safety of health care. Public inquiries into incidents of poor healthcare practice triggered by whistleblowers in Australia (eg: Canberra, Camden, Cambelltown and King Edward Memorial hospitals) overseas (eg: Bristol) have demonstrated that institutional accreditation, external reporting and mere existence of quality systems are not an assurance of institutional quality and safety. External performance indicators are not an appropriate substitute for a local culture of trust and excellence among clinicians and manager in relation to quality and safety of health care.²¹ Clinical teaching is the bedrock upon which a culture of reflective practice and continuous enhancement is built.

6. Recruiting and teaching in rural, remote and Indigenous settings

Quality teaching and educational outcomes in rural, remote and Indigenous settings require well resourced, regionally supported teaching infrastructure that enhances local community and health professional capacity, rather than further extends already over-stretched resources.

Investing in devolved teaching capacity in small towns and community settings, whilst expensive, is a best-buy in terms of health workforce outcomes.

The loss of key teaching regional infrastructure associated with the closure of regional hospital-based nursing training in the 1980s and 1990s has not yet been compensated by investment in regional university campuses for delivery of all or part of undergraduate health courses. A much greater level of regional and local investment is required.

Rural and remote academic teaching infrastructure is a critical means for the health and education systems to partner with local communities, health care providers and schools to aid recruitment and successful course completions by rural and Indigenous students and to develop quality local clinical teaching practices and hospitals.

More rural and regional capital infrastructure will be critical if teaching is to be devolved across a teaching health system. In many rural and remote locations, substantial capital investment for student accommodation and teaching facilities are required. This includes accommodation for use by undergraduates, health professionals undergoing generalist or specialist training as well as consulting and tutorial space and information and communication technology.

Specific investment is needed to build Aboriginal and Torres Strait Islander community controlled health services as key strategic teaching sites for Indigenous health. Programs to inspire, identify and support Indigenous students to undertake science and mathematic subjects at school and to recruit them into clinical health sciences should be a significant funding priority.

7. Investment in clinical teaching capacity

Clinical disciplines cannot be taught without students participating in a structured apprenticeship based on real patients in a context of care that is relevant to future practice. Given the scale of health workforce shortage, access to quality clinical teaching placements is likely to emerge as the major rate-limiting factor in efforts to ramp up professional training programs.

Whilst quarantining teaching functions of health systems is desirable, it has not proved possible to quarantine or tease out 'funded' clinical teaching and supervision activities from the provision of health care within health institutions. Consequently, many health systems apply clinical teaching loadings to designated 'teaching' institutions as funding over-and-above the level of recurrent resources associated with the delivery of health care. However, there is little or no monitoring of institutional performance delivering in teaching

as core business. Clinical academics are leant on to prop up service delivery and there has been a decline in investment in teaching facilities and student accommodation.

Recent Australian analysis of the costs of establishing teaching facilities in a large non-teaching hospital indicate that an additional teaching loading of the order of 20% is a realistic reflection of the costs of delivering integrated clinical teaching. The challenge for the Australian system is how this investment is to be planned, funded and monitored.

More fundamentally, there is a disconnect between parts of the system responsible for planning and investing development of future health workforce and the delivery of health care services. For example, medical specialist training is controlled by professional colleges whilst salaries for trainee places are met up by state governments as part of service delivery in public hospitals. There is limited input from regional stakeholders in the determination of current and future workforce needs. Training arrangements that involve the private sector and/or innovative regional supervision approaches are generally not possible.

The split responsibilities between state and federal governments, and between the education and health sectors and professional colleges complicates workforce planning and blurs accountabilities for outcomes in clinical education and training.

To overcome this, it is proposed that the Australian Government assume more direct responsibility for funding the clinical education of health professionals in Australia. The key level for coordination, planning, investment and evaluation among stakeholders should be regional, within broad jurisdictional and national policy parameters. It is at the regional level that health, professional and education system interests can be appropriately aligned and adequately monitored. Planning and performance monitoring that are undertaken only by individual sectors or at a jurisdictional or national level tends to stifle innovation and be prone to gaming and preoccupation with sectoral self-interest or cost-shifting.

Regionally-brokered funding of clinical teaching and related academic research will enhance responsiveness, coordination and transparency of investment in health workforce development in line with regional population needs and trends.

8. Problems with existing funding and administration arrangements for undergraduate education of health professionals

One factor that limits the ability of universities to develop innovative and responsive health professional training programs is the level of funding for health courses other than medicine. Under the new Higher Education Support Act 2003, health subjects other than medicine and nursing, are funded by the Department of Education Science and Training (DEST) at Cluster 6, *Computing, Built Environment, Health*. This Cluster provides less money from DEST to universities per full time student, than *Languages, Performing Arts and Journalism*. In 2005, Cluster 6 is funded by DEST at \$7064²² per EFTSL (Equivalent Full Time Student Load) compared to \$14,738 per EFTSL for Cluster 9, *Dentistry, Medicine and Veterinary Science*. Nursing as a designated *National Priority*, is funded at \$9,316 per EFTSL. The level of funding for the Clusters is based on an historical model (Relative Funding Model) that was developed over 15 years ago and does not take into consideration the significant developments in biomedical and medical science and clinical health practice that has occurred in the past two decades, and the consequent increased expectations of the knowledge and clinical preparedness of graduates.

Universities also struggle because of the DEST retention model that only funds 75% (compounded annually) of an initial cohort of students, on the presumption of student attrition rates that, in the health professional programs, never eventuate (most health professional programs have student retention rates approaching 85 – 95% over the life of the program); hence most health professional programs are teaching many more students than they are funded for.

The education and training of new health professionals should be responsive to the changing health needs of the population, developments in the professions and evolving workforce requirements. This is important not just to ensuring a relevant and competent workforce, but also to ensuring that graduates do not become quickly disillusioned with the realities of existing health systems, and leave the health workforce. It costs money to

develop new curricula and adapt existing curricula to be more responsive to current workforce needs, but under current DEST funding models universities have little chance of funding innovation in any of the health professional programs other than medicine which is funded at a much higher level.

In addition, the existing DEST funding levels do not provide sufficient income to universities to adequately support the smaller, more specialised health disciplines such as podiatry and prosthetics, that, despite the relatively small numbers of professionals needed in comparison to medicine and nursing, are still critical to the national ability to provide a comprehensive level of health services. These programs often require specialised and expensive equipment, and student intakes are small in comparison to the larger health professions making it difficult to achieve economies of scale. There appears to be an assumption by DEST that these programs can be cross-subsidised by existing larger programs within the university, but this has become increasingly difficult to sustain as the costs of offering all health programs continues to exceed the income from DEST.

Placement in rural areas costs more because smaller and more geographically dispersed placement sites increase the costs per student to provide adequate training and supervision; there are fewer opportunities for economies of scale. However it is in the national interest to encourage training in regional/ rural/remote locations for long-term workforce retention in these areas. Targeted funding has been provided for clinical placement in rural and remote areas for medicine, through funding provided by the Department of Health and Ageing (Rural Undergraduate Support and Co-ordination scheme (RUSC) and Rural Clinical Schools funds). DEST also provides a practicum component as part of the funding for nursing as a "National Priority". However, universities must fund clinical placement activities for other health professional programs from their core DEST funding.

9. Flexible workforce options

The future will require a more adaptable and responsive health workforce than that afforded by conventional 'mono-professional' medical, nursing and allied health professional models.

Whilst conventional health professional models and service delivery structures have served well, reform is urgently needed to meet new challenges. The ageing population, the burden of chronic disease, professional workforce shortages, the changing demographics and aspirations of graduates, the development of information and communication technology and emergence of new health disciplines - all mean that new ways of thinking about the organisation of health workforce labour and health service delivery structures need to be explored.

Rigid demarcation of roles and scope of practice inherent in 'mono-professional' approaches to health labour needs work against efficiency, effectiveness and sustainability of health care.²³

The policy effort in relation to development of nurse practitioner models in most states and territories represents one approach to expanded scope of non-medical clinical practice. The nurse practitioner model training and regulatory pathways into independent specialised nursing practice in a prescribed field, with a registered nurse attaining additional post-graduate nursing qualifications and meeting formal registration criteria. The nurse practitioner provides "expert nursing care by working autonomously but in collaboration with other health professionals as part of a multidisciplinary team" (NSW Nurses and Midwives Board 2003). This is an appropriate option for a number of discrete specialised areas of clinical nursing, albeit mostly in urban centres. Whilst these are important developments, the model is limited to nursing graduates only and has inherent inflexibilities.

A complementary alternative is that of the delegated-practice model of 'mid-level provider' as seen in the USA and increasingly other countries. The distinction is the emphasis on health care being provided by teams with expanded clinical tasks being performed under the formal delegation of local medical practitioners. The US Physician Assistant (PA) profession has been the prototype for development of others that have been implemented or are being planned in Canada, the UK, the Netherlands, Singapore and other countries.

Developed in the mid 1960s, registered PAs now number some 62,000 in the USA. Around half work in 'primary care' (including family practice, obstetric, paediatric and emergency settings). The remainder assume various specialist consulting and procedural roles. In the US, an estimated 86% of qualified PAs are employed as PAs, most with Bachelor degrees. In contrast, only 57% of generally Masters-qualified Nurse Practitioners were practicing as such.²⁴

In the US, the delegated practice model has enabled PAs to establish an extraordinarily flexible and broad scope of practice for a relatively new profession. Agreement on scope of practice is managed in the workplace and regularly reviewed in line with development of individual competence. In this way, legal responsibility and clinical governance in relation to technical care continues to be provided by a medical practitioner. In reviewing the issue of advanced clinical practice roles, the OECD notes the policy tension between further regulation and codification of advanced professional roles for nursing as opposed to "allowing advanced practitioner roles to evolve locally ... less defined by uni-professional groupings".²⁵

Developing generic training pathway and credentialing options for a broad range of Australian health graduates to function as an Australian equivalent of the Physician Assistant ('Clinical Associate') has a number of attractions:

- Physiotherapists, occupational therapists, nutritionists, pharmacists and others could be equipped with the knowledge and skills needed to assume expanded clinical care roles working in teams with doctors. Often this would be in addition to roles related to the primary qualification (eg: the nutritionist providing broader aspects of routine diabetes care);
- It would tap the experience and enthusiasm of health professional groups such as ambulance officers and paramedics, who have until now lacked a training pathway into broader clinical practice;
- International Medical Graduates with permanent residency who are unable to meet criteria for Australian medical registration could access a training pathway into supervised, delegated clinical practice and so make a positive contribution to the health system;
- It would provide trained Aboriginal and Torres Strait Islander Health Workers with another education and training option for senior work in the health industry;
- Flexible, adaptable and cost-efficient education and training pathways into delegated clinical practice would not have to be duplicated across multiple health professions.

Where practice nurses, Nurse Practitioners or Clinical Associates perform medical functions such as diagnosis, prescription writing and ordering of diagnostic tests, these activities should operate under delegated medical authority to prevent fragmentation of the health service and to ensure integration of these practitioners into mainstream safety systems, (particularly in rural and remote practice where numbers of clinicians may be small and support from medical practitioners may be from a distance). Systems of 'Standing Orders' alone will not accommodate the requirements of day-to-day quality health service provision.

Delegated practice arrangements already exist in relation to the role of 'practice nurses' under recent Australian Government Medicare initiatives. Under these arrangements, doctors can apply for incentives to subsidise employment of registered nurses, enrolled nurses or Aboriginal health workers and can access fee-for-service rebates for wound dressings, immunisations and pap smears that are performed by the worker on their behalf. Under Medicare guidelines, individual doctors are responsible for assuring the competence of workers to perform the clinical tasks.

However, the statutory framework to support delegated clinical practice is lacking. Whilst 'guidelines for good medical practice' endorsed by state and territory Medical Boards generally include a statement requiring doctors to ensure competence to perform delegated tasks, this is not reflected in Medical Acts or regulations. Amendment of regulations to support formal delegation of clinical duties by medical practitioner will be an important early consideration for jurisdictions in improving flexibility.

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