



australian nursing federation

Submission to the Productivity Commission on the Health Workforce

1. Introduction

- 1.1 The Australian Nursing Federation (ANF) is the national union for nurses in Australia with branches in each state and territory. The ANF is also the largest professional nursing organisation in Australia. The ANF's core business is the industrial and professional representation of nurses and nursing in Australia.
- 1.2 The ANF's 145,000 members are employed in a wide range of enterprises in urban, rural and remote locations in the public, private and aged care sectors, including hospitals, health services, schools, universities, the armed forces, statutory authorities, local government, offshore territories and industries.
- 1.3 The ANF participates in the development of policy in nursing, nursing regulation, health, community services, veterans' affairs, education, training, occupational health and safety, industrial relations, immigration and law reform.
- 1.4 The ANF has willingly contributed to the reviews of the nursing profession that have been undertaken. For example:
 - Commonwealth of Australia 2002 *National Review of Nursing Education 2002: Our Duty of Care*
 - Commonwealth of Australia Senate Community Affairs Reference Committee June 2002 *The Patient Profession: Time for Action: Report on the Inquiry into Nursing*
 - Health Workforce Advisory Committee (AHWAC) 2002 *The midwifery workforce in Australia 2002-2012*
 - Australian Health Workforce Advisory Committee (AHWAC) 2002 *The critical care nurse workforce in Australia 2001-2011*
 - Commonwealth of Australia 2001 *Scoping study of the Australian mental health nursing workforce 1999*
 - Commonwealth Department of Health and Ageing 2002 *Recruitment and retention of nurses in residential aged care: Final report*
 - Commonwealth of Australia 2001 Working Group on Aged Care Worker Qualifications, *A review of the current role of enrolled nurses in the aged care sector: Future directions*
- 1.5 The ANF is also currently participating in two further AHWAC projects examining the nursing specialist areas of operating room and emergency care.

- 1.6 The nursing profession has also been reviewed or reported on as part of several other reviews, including:
- Australian Health Ministers' Conference April 2004 National Health Workforce Strategic Framework
 - Australian Health Workforce Advisory Committee August 2004 *The Australian Nursing Workforce - An Overview of Workforce Planning 2001-2004*
 - Hogan W P 2004 *Review of pricing arrangements in residential aged care* Commonwealth of Australia
- 1.7 The nursing workforce was also considered in the course of a number of other inquiries:
- Productivity Commission 2004 *Economic implications of an ageing Australia*
 - NHMRC 2004 *Ageing well: ageing productively*
 - Australian Senate 2004 *Inquiry into aged care*
- 1.8 Apart from numerous inquiries into the nursing workforce undertaken in the states and territories, Branches of the ANF have commissioned their own reports, such as:
- Buchanan J and Considine G 1999 *The Hidden Costs of Understaffing: An Analysis of contemporary Nurses' Working Conditions in Victoria* Australian Centre for Industrial Relations Research and Training (ACIRRT) University of Sydney
 - Buchanan J and Considine G May 2002 *Stop Telling Us to Cope! NSW Nurses Explain Why They Are Leaving the Profession* Australian Centre for Industrial Relations Research and Training (ACIRRT) University of Sydney
 - Buchanan J, Bretherton T, Bearfield S and Jackson S 2004 *Stable, but critical: the working conditions of Victorian public sector nurses in 2003* Australian Centre for Industrial Relations Research and Training (ACIRRT) University of Sydney
- 1.9 The ANF has made submissions, given oral evidence, provided expert advice, and participated in numerous consultations over the past five years in relation to the current and future supply of and demand for the nursing workforce. Quite frankly, we are weary of inquiries into the nursing workforce - inquiries that have significant financial and resource implications for many participating organisations and the health sector in responding to them - and which, while frequently resulting in reasonable and achievable recommendations, those recommendations have been completely ignored, responded to inappropriately or only partially implemented. The ANF is stating clearly and unambiguously that there is already sufficient information in relation to the nursing workforce and what needs to be done to ensure that there will be sufficient numbers of appropriately educated nurses to meet the future nursing requirements of the Australian community. What is needed now is a commitment to action.

- 1.10 The slow progress, for whatever reason, of the implementation of the recommendations from the National Review of Nursing Education through the National Nursing and Nursing Education Taskforce has been particularly disappointing. According the N3ET website, many of the recommendations from the 2002 Review are still at a planning stage and the ANF is not optimistic that the results of the planning processes will have a positive impact on the ongoing problems facing nurses in workplaces around the country.
- 1.11 The ANF acknowledges that some short term measures have been implemented however with nearly one half (46.5%¹) of the nursing workforce contemplating retirement in the next 10-15 years, there is too little being done. While there was a welcome increase in full time equivalent nurses reported by the AIHW in their 2005 report, it should be noted that the majority of the increase was the result of additional hours worked by nurses (from 30.7 hours per week in 2001 to 32.5 hours per week in 2003) with only a 3.6% increase in the number of employed nurses.²

2. Nursing and the health care industry

- 2.1 Australia has two levels of licensed nurse, the registered nurse and the enrolled nurse³. Registered nurses undertake a three year undergraduate preparation at degree level for licensure. The increasingly complex and technical nature of health and nursing care has required nurses to have a higher level of knowledge and skill to work as an effective member of the health care team.
- 2.2 Enrolled nurses are associates to and work with registered nurses. Enrolled nurses are educated in the vocational education sector at a Certificate IV or Diploma level. They work closely with registered nurses generally undertaking care that is delegated by registered nurses and under the direct or indirect supervision of a registered nurse.
- 2.3 Assistants in nursing and/or personal care assistants (however titled) assist registered and enrolled nurses in the provision of nursing care. Their educational preparation is generally at a Certificate III level in the vocation education sector and prepares them to work predominantly in the aged care sector undertaking work under supervision that is delegated by registered nurses. Assistants in nursing and/or personal care assistants (however titled) assisting with nursing work are considered part of the nursing family and educational arrangements should provide articulation into a nursing career path.
- 2.4 The registered nurse to enrolled nurse skill mix depends on the context of care and the acuity of people requiring nursing care. For example, in an intensive care unit the ratio of registered nurses to enrolled nurses may be 10RNs:1EN, while in an aged care facility it may be 4ENs:1RN. A reasonable national target would be 3RNs:1EN (ie. 75% RN to 25% EN nursing workforce) with local decisions being made about the appropriate skills mix that is needed in that particular setting.

- 2.5 The International Council of Nurses' definition of nursing demonstrates the broad scope of practice that can be and is provided by nurses:

Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy, patient and health systems management and education are also key nursing roles.⁴

- 2.6 Nurses in Australia are front line health care providers with diverse roles in a wide range of settings: hospitals, community centres, residential facilities, private homes, schools, medical practices, Indigenous Australian communities, prisons, detention centres etc. Their roles include primary, secondary and tertiary health care.

- 2.7 The Queensland Nursing Council was the first of the nurse regulatory authorities to prepare advice on the scope of nursing practice and they use the following definition:

The scope of nursing and midwifery practice is that which nurses and midwives are educated, competent and authorised to perform. The actual scope of an individual nurse's or midwife's practice is influenced by the:

- *context in which they practice;*
- *client's health needs;*
- *level of competence, education and qualifications of the individual nurse or midwife; and*
- *service provider's policies.⁵*

- 2.8 A major determinant of nursing scope of practice is the policies and procedures of employers. Changing the scope of nursing practice for nurses can be straightforward when the change is an enhancement of the current work being undertaken although the impact on workload when changing scope of practice should not be underestimated: busy nurses cannot pick up the work of others such as doctors and allied health providers. Nurses required to make significant changes to the scope of their nursing practice generally require support to make the transition. Employers and nurses can effectively work together to change the scope of practice that is required for the context of health care, including the provision of orientation and preparation for work in new settings. This preparation for practice is particularly important for new graduates making the transition to work from education.

- 2.9 The Queensland Nurses Council recommends that employers and nurses work together to identify the scope of practice required in any particular setting and to plan the professional development that is required so that the nurse is competent to provide the nursing care that is required. Employers and nurses can effectively work together to change the scope of practice that is required for the context of health care, including the provision of orientation and preparation for work in new settings. This preparation for practice is particularly important for new graduates making the transition to work from education.
- 2.10 Nurse practitioners are a relatively new nursing role in Australia with trials commencing in New South Wales in the early 1990's. A number of states have introduced legislation to endorse nurse practitioners and support their scope of nursing practice including prescribing medicines and ordering diagnostic tests. Nurse practitioners are working both in primary health care (eg. emergency departments, womens' health centres and rural and remote health care centres) and tertiary health care settings (eg. oncology and wound care services) in both metropolitan and rural areas.
- 2.10.1 A nurse practitioner is a registered nurse who has been authorised by the state or territory nurse regulatory authority to use the title. The authorisation process ensures that the registered nurse applying for authorisation has undertaken appropriate postgraduate education or equivalent to support their practice and provided evidence of their ability to consistently practise autonomously and at an advanced level. The minimum educational level for nurse practitioner practice is preparation at Masters level or equivalent for the clinical area of practice, supported by relevant clinical experience.
- 2.10.2 The role of the nurse practitioner is characterised by clinical assessment and therapeutic management of health and illness presentations within their scope of practice. This may include the initiation of diagnostic investigations, the prescription of medicines, and referral to other health care providers. Nurse practitioners practice in metropolitan, rural and remote areas of Australia, in both the public and private sectors, and in all clinical areas.⁶
- 2.10.3 The career structure for nurse practitioners is part of the nursing clinical career stream and this role adds another rung in the career ladder which is very important for many expert nurses who have been limited previously in their clinical career options. This is an opportunity to retain nurses who may have previously looked outside of nursing for career development purposes.

2.10.4 There are only small numbers of nurse practitioners in place at this time with the majority employed in the public health system. One of the major obstacles to the utilisation of nurse practitioners in Australia is the opposition of medical practitioners; opposition which has its roots in their desire for control over the activities that nurse practitioners undertake (such as prescribing medicines, initiating diagnostic investigations), which they see as their exclusive domain. The medical opposition ignores the wealth of research demonstrating that nurse practitioners provide a safe and cost effective service which is well accepted by the community. Obstetricians demonstrate similar opposition to the provision of midwifery care.

2.10.5 The ANF was disappointed to see reports in the Australian on 23 July 2005 that some other health care professionals are recommending a doctor-nurse hybrid rather than acknowledging the important role that nurse practitioners can play in the health care system including in rural, remote and other isolated settings. It is time that doctors supported nurse practitioners as valuable members of the health care team rather than competitors for business. Nurse practitioners are educationally prepared and they have the clinical experience to provide high quality and safe health care to the Australian public wherever they live. Nurse practitioners work in collaboration with other health care providers, such as doctors, other nurses and allied health professionals as well as with governments, service providers and consumers. Collaboration and cooperation is essential for optimal health outcomes.

3. Factors affecting the supply of, and demand for, health professionals

3.1 The supply of nurses into the future must take into account the changing models of health service delivery - faster throughput of more acutely ill people with more day only admissions (this requires more intense nursing care; more nursing personnel, not less; and more highly qualified nurses); more nursing care in the community of more acutely ill people, or people recovering from an acute episode; and a greater need for coordination of care across all health care settings.

3.2 The supply of nurses into the future must also take into account the current age of the nursing workforce (46.5% of the nursing workforce in 2002 was over the age of 45)⁷ and factor in the changing work patterns - such as reduced hours and retirement - of nearly half of the current nursing workforce over the next 10-15 years. This has significant implications in relation to the number of people required to be educated as nurses in the future, remembering that it takes three years to educate a registered nurse and much longer for them to gain the specialist qualifications and expertise to adequately replace the ageing nurses who will be leaving the workforce.

- 3.3 Any consideration of the supply of nurses should look at the nursing workforce holistically - registered nurses, enrolled nurses and assistants in nursing (however titled) and focus on the best possible mix to achieve optimal nursing care outcomes, not the mix which produces the cheapest financial outlay, which is a short sighted approach and not cost effective in the long term.
- 3.4 The most recent Australian Government report from the Australian Health Workforce Advisory Committee, (August 2004 *The Australian Nursing Workforce-An Overview of Workforce Planning 2001-2004* www.healthworkforce.health.nsw.gov.au) estimated that for supply to meet demand, between 10,182 and 12,270 new graduate nurses are required to enter the workforce in 2006 and between 10,712 and 13,483 in 2010. They also estimated that new enrolled nurse requirements were between 5,734 and 6,201 in 2010. The numbers quoted reflect completions not commencements.
- 3.5 I quote from the report, which clearly reflects the view held by the ANF and most other nursing organisations in this country: *The consistencies identified across the reports analysed suggest that there is no need to carry out further national supply and demand studies on the overall nursing workforce in the short term. At this point in time, it is more important to develop strategies to ensure that there is an increased supply of new nurses adequately educated and supported for entry to the nursing workforce and then retained within the workforce. And further: In the short term, there is no need to commission any further national nursing workforce planning projects that review the nursing workforce as a whole. The national nursing workforce planning projects reviewed in preparing this paper have contributed sufficient advice on future nurse workforce supply and recommended levels of undergraduate nurse intakes. The scope of the challenge is quite clear, what is now required is implementation.*
- 3.6 It is important to note that issues of supply relate specifically to the lack of education places. Figures from the Australian Vice Chancellors Committee consistently demonstrate that a significant number of eligible people apply for nursing courses each year but are unable to commence their education because of a lack of places in both the university and vocational education sectors.
- 3.7 The issues are clear. The numbers are clear. The reports are the Government's own, so presumably have credibility. The Australian economy is healthy. The cost of responding to the recommendations for the nursing workforce is not prohibitive and the country can afford it - indeed it will be much more costly to the health and productivity of the Australian community in the future to ignore the recommendations. Why are they not being implemented? There is no rational explanation - in fact there is no explanation at all. If the Productivity Commission inquiry results in some action, it will have been worth while. If not, it will have been a waste of time and money. The ANF sincerely trusts it will be the former, not the latter.

3.8 There are numerous studies relating to the issues affecting the retention of nurses in the workforce. One of the main motivations for people to undertake nursing as a career is a genuine desire to make a positive difference to the health and wellbeing of the people they are caring for. If this becomes no longer possible, nurses will leave the profession, and they do. Buchan and Calman report that: (International) research indicates that nurses are attracted to and retained at their work because of opportunities to develop professionally, to gain autonomy and to participate in decision-making, whilst being fairly rewarded. Workplace factors can be critical both in encouraging retention and in causing turnover of nurses.⁸

3.9 Some of the identified factors affecting the supply of, and demand for, nurses are listed below. Many of the issues are the same for other health care professionals.

- Poor remuneration and archaic working conditions;
- Shortage of fulfilling nursing positions that pay adequately;
- An increasingly small pool of young people to draw from for the future nursing workforce;
- Limited support for older workers to make the transition into the industry;
- Inadequate numbers of nursing places in the higher education and the vocational education sector with many eligible students turned away every year;
- The high cost of undergraduate and postgraduate studies;
- Difficulties balancing work, study and personal life which impacts on decisions to undertake continuing education;
- Limited access to quality clinical education that assists with preparing students for nursing work;
- The fact that nursing is hard physical and emotional work and must compete with other occupations that are less demanding;
- The image of nursing being women's work, hard physical work, and unsatisfying work;
- The image of health as an industry in crisis where errors can cost you your career;
- Barriers such as high workloads and poor staffing levels and skills mix which prevent nurses from providing high quality and safe nursing care;
- Limited career opportunities for nurses wanting to remain as clinicians or to move into management, education or research positions;
- The fact that nursing is a 24 hour, 7 day every week industry so the majority of clinical nurses are required to work shift work for many years;
- The limited support structures in place such as clinical educators, clinical supervisors, expert nurses, etc.;
- Perceived difficulties in returning to nursing work after a career break because of reduced clinical support in the workplace; and
- The relatively large number of nurses choosing to work part-time or casual so that they are in control of their workloads and their working hours.

4. The current structure and distribution of the health workforce and its efficiency and effectiveness

4.1 The structure and distribution of the health workforce has not made the most of the nursing profession for the purpose of efficiency and effectiveness. Nursing is often described as having a narrow scope of practice, however even a cursory examination will reveal that nurses' scope of practice is infinitely broader and more flexible than that of any other health care practitioner. The Queensland Nursing Council's decision making framework, developed as part of its work on the scope of nursing practice, demonstrates clearly that any perceived barriers to the expansion of a nurses' scope of practice can be addressed by employers and nurses sitting down together to assess the nursing care needs of the target population and determining:

- whether the expanded scope of practice is lawful;
- whether it is appropriate for the context;
- whether it is consistent with standards acceptable to the profession and to nursing and midwifery organisations; and
- whether it is consistent with the service provider's policies.

4.2 There are few limitations to the scope of nursing practice if the above questions are answered in the affirmative and the nurse is educationally prepared and competent for the nursing care that they are to provide.

4.3 The structure and distribution of the health workforce has changed significantly during the past twenty years as Governments seek to restrain cost blow outs mainly in the pharmaceutical and high technology areas. Unfortunately this cost saving approach to the health care system and its workforce has not resulted in a more efficient or a more effective system. It has not resulted in significant cost savings either as this lean system does not have adequate safety and quality monitoring in place eg over worked nurses have less opportunity to detect errors made by prescribers etc.

4.4 International studies have demonstrated that nurses have a positive impact on health care outcomes for people using the health system. This evidence should not be disregarded as we prepare a workforce for the future.

4.5 A greater emphasis should be given to a team approach in the provision of health care with all members of the team (including medical practitioners) being accorded equal value. There are many excellent examples of clinical teams providing high quality and coordinated health care. Some of these teams have effectively utilised nurse practitioners to complement the team.

4.6 Greater specialisation in the health care system has had some unintended effects including increasingly fragmented care for people. Nurses have always played an important role in the care coordination of people with chronic illness and disability. Increasingly nurses have taken on formal roles as care coordinators in both the acute sector and community settings. Nurses are coordinating care for

people with diabetes, cancer, heart disease, HIV/AIDS and respiratory illnesses and midwives are responsible for care coordination of both high and low risk pregnancies. The NSW cancer care plan highlights the value of these nursing positions and they are an integral part of the way forward in this particular area of health care.⁹

4.7 Workloads are a major issue when considering the effectiveness and efficiency of the current health care system. Workloads need to be addressed as a matter of urgency. The health system is becoming characterised by very high intensity care being provided to more people using the health system, however the workforce has not been adjusted to meet the increased demand. It is becoming increasingly apparent to nurses that many of the intrinsic rewards that led them in the first instance to a nursing career are no longer achievable because of inadequate staffing levels and the skills mix in the workplace. It is cost inefficient to spend scarce dollars on educating nurses to then lose their contribution because of inappropriate and short sighted workplace staffing decisions.

4.8 Unpaid overtime continues to be an unacceptable part of nursing work with Victorian nurses reporting that they work between two and 10 hours of unpaid overtime every week, *over half (56%) of nurses indicated that they felt an imperative to work overtime so that a basic standard of patient care could be maintained.*¹⁰ The following summary of international research into the impact of nurses on health outcomes was reported in a recent publication for the global nursing review initiative:

Nursing shortages and understaffing have been linked to a range of negative outcomes. These include: increased mortality rates; adverse events after surgery; increased incidence of violence against staff; increased accident rates and patient injuries; and increased cross infection rates. A recent review on nurse staffing and quality of care summarised findings as follows: ... the largest of the studies ... found significant associations between lower levels of nurse staffing and higher rates of pneumonia, upper gastrointestinal bleeding, shock/cardiac arrest, urinary tract infections, and failure to rescue. Other studies found associations between lower staffing levels and pneumonia, lung collapse, pressure ulcers, thrombosis after major surgery, pulmonary collapse after surgery, longer hospital stays, and 30-day mortality'.¹¹

4.9 Inadequate staffing levels have the most negative impact on nurses' capacity to provide quality nursing care and their perceived job satisfaction. High workloads and inadequate skill mixes are key factors in the decisions made by nurses to either stay or leave the nursing profession.¹² There is also growing evidence that staffing measures that improve nursing workloads and enhance patient care will attract nurses back into the nursing workforce.¹³ Introducing workload management tools has been found to have a positive impact on the rates of fatigue and burnout. For example, studies have shown that an increase of 1 patient per nurse increases burnout by 23% and job dissatisfaction by 15%. The same study showed that 43% of those nurses experiencing high burnout intended to leave their job within the next twelve months.¹⁴

- 4.10 The ANF and its Branches have been forced to introduce industrial mechanisms in an attempt to control nursing workloads after many years of struggling with employers to achieve a rational balance. A range of systems have been introduced such as: nurse:patient ratios in the State of Victoria to nursing hours per patient per day models in several other Australian States. The ANF would like to issue a challenge to the Productivity Commission to explore in depth the response in Victoria to the introduction of mandated nurse:patient ratios. Not just the quantitative response of over 5,000 nurses returning to the profession, but the qualitative response in patient and nurse satisfaction in having sufficient nurses available to provide quality nursing care. If Governments (as employers of nurses) and employers generally cannot see the advantages to their service of employing sufficient nurses to provide quality nursing care then mandated nurse:patient ratios should be recommended. The cost to the health system of employing sufficient nurses to meet the ratios is more than offset by the cost and waste of resources of unnecessary recruitment strategies, advertising, orientation, and the use of agency nurses when staffing levels are inappropriate.¹⁵
- 4.11 Regulation is often perceived as raising unnecessary barriers to a flexible workforce however nursing regulation provides a benchmark for the profession in terms of education and standards of practice. Regulation is one of the pillars that support the provision of high quality and safe care by nurses. It is also essential to protect the public by ensuring that only those practitioners with the necessary educational preparation and competence are providing care. Recent changes to legislation in most of the Australian states and territories has overcome some of the barriers such as prescribing medicines and ordering of diagnostic tests for expert nurses authorised as nurse practitioners. These changes should be facilitated by funding to support these activities.
- 4.12 The reference to nursing regulation in Box 5 on Page 25 of the Productivity Commission's Issues Paper is not an accurate picture for the majority of registered and enrolled nurses in Australia. There are only small numbers of nurses in some discrete areas of practice, such as mental health, disability, or direct entry midwives, who require different consideration when they apply to register in another state or territory. Nurses and midwives working in these areas may have limitations placed on their practice so they are not placed in a position where they may be working outside their area of competence. Nursing has established streamlined processes that allow for ease of movement of nurses across state and territory borders and between Australia and New Zealand. The ANF acknowledges that nurses working in more than one state or territory of Australia may be required to have two or more licenses to practice, however the Australian Nursing and Midwifery Council has a policy of waiving fees in the other jurisdictions in these circumstances. There are some differences in nursing regulation between jurisdictions and nurses are required to be aware of these differences in the same way that they are required to be aware of the differences in the policies and procedures of different employers.

- 4.13 The nursing workforce makes up nearly 50% of the health workforce. The efficiency and effectiveness of the nursing workforce can be unnecessarily restricted by legislation or more frequently by custom and practice. For example, well qualified and highly experienced nurses are often unable to administer simple analgesics or initiate diagnostic investigations without the authority of a medical practitioner. Invariably, it is the nurse who identifies the need for the medication or the procedure and makes a specific recommendation to the medical practitioner.
- 4.14 Governments and employers are in error in thinking that creating new roles will address the current health workforce shortages. They should instead be considering how current roles can be more effectively utilised, particularly nursing roles. Competency based planning has been raised by some as a way forward in the health care sector. Nursing education and practice has been based on competency standards for many years. The ANF contends that nurses have the competence to provide a significantly greater role in the health workforce now and in the future.
- 4.15 Nurse practitioners, who undergo a rigorous certification process by the nurse regulatory authorities before they are endorsed to practice at that level, could also play a significantly greater role in the health system in many areas - emergency departments, aged care, mental health, women's health, maternity care, rural and remote areas etc - however they face vigorous opposition from medical practitioners, particularly general practitioners, who are anxious to avoid any opposition to their privileged position or any competition to their income.
- 4.16 Nurses are not only highly efficient and effective, they go the extra mile. A study in 1999 in the Victorian health system found that 65% of nurses worked overtime (additional hours before and at the end of a shift and working through meal breaks), however only one in five were paid to do so. They estimated conservatively that nurses' unpaid labour was the equivalent of between 300 and 450 full time nursing positions across the State of Victoria per week.¹⁶
- 4.17 It is no surprise to nurses that for the past eleven years ever since they have been included in the Morgan Poll they have been judged by the community as the most honest and ethical occupational group. Nurses work wherever nursing care is required. Unlike other health practitioners, it is nurses who provide health services in remote rural and remote communities. Nurses provide care where other health practitioners will not.

5 The efficacy of health workforce planning and its linkages to health services planning and the education sector

- 5.1 There is currently no effective national health workforce planning. There is little, if any, linkage between health service planning and the education sector. It is incomprehensible that this is so in a country as well resourced as Australia. As identified earlier, the Australian Health Workforce Advisory Committee has made specific recommendations regarding the number of nurses needed for the future however there has been no response from either the education or the health portfolio.

- 5.2 A National Health Workforce Strategic Framework was released by the Australian Health Minister's Conference in April 2004. The principles and strategies outlined in the Framework could be used by all levels of Government and by other employers as they prepare to meet the current and future challenges of health workforce planning, however it has largely been ignored by the Australian Government and by State and Territory Governments.
- 5.3 There are many reasons for the current nursing shortage in Australia and the Productivity Commission will be well aware that these include: the availability of broader career opportunities for women; increasing rates of movement between careers during a working life; poor working conditions; low rates of pay compared to other careers; and the near absence of effective retention policies (for example, there are 27,846 registered and enrolled nurses who are not working in nursing¹⁷). The most disappointing factor in the current nursing shortage is the failure at the highest level to initiate a coordinated response to the early warning signs. These signs include: the ageing of the nursing workforce with the inevitability that almost half the current nursing workforce will be contemplating retirement within the next 10-15 years; the increasing rates of part time work; and significant attrition rates within nursing as nursing work becomes more demanding, physically and emotionally more difficult, and less satisfying.
- 5.4 The focus of those responsible for health care planning and delivery during the last 10-15 years has been on reducing the cost of health care rather than ensuring there is a sustainable health care system in the future - the penalties are now being paid as we suffer workforce shortages and see safety and quality deteriorate.
- 5.5 Coordinated national workforce planning that includes the education sector and public, private health and aged care employers has been advocated for years but remains an unrealised dream for nurses in Australia. While national workforce planning has commenced in limited areas of specialist nursing practice, the medical model of workforce planning has failed to provide any useful model for the nursing workforce and there has been limited, if any, response to the reports produced.¹⁸
- 5.6 There continues to be an inexplicable and unproductive divide between the health and education sectors, with any recommendations made by the health industry almost halved when translated into nursing places in the higher education sector. The allocation of sufficient places in the education sector, must be accompanied by sufficient investment to ensure that both the education and health sectors are adequately resourced and prepared to take additional students.

- 6 Workforce related policy measures that would help to ensure efficient and effective delivery of quality health services over the next ten years in an environment of demographic changes, technological advances and rising health costs
 - 6.1 One of the most effective ways of meeting the challenge of the ageing of the population and rising health costs is to invest more in keeping people healthy. To do this, the community has to be involved in making decisions about how resources are to be distributed and what the priorities will be. It is difficult for the community to accept the need to ration their own health care when the Australian Government consistently promotes large budget surpluses without adequately explaining the relationship between budget surpluses and economic restraint in health care spending. The community has consistently expressed a view that they would rather see additional spending on health and education rather than cuts to personal income tax however this has not been either acknowledged or acted on by Government.
 - 6.2 The ANF supports a planned move toward a primary health care focus. Such a move requires investment in a national primary health care plan, the reorienting of health workforce education and the development of significantly more community health resources. The move however should not be at the expense of the current acute care sector and the health workforce needs preparation for such a transition. Support structures must be in place as health workers move outside their current boundaries of practice.
 - 6.3 There has been a great deal of talk and speculation about transferring the responsibility for health services to one level of Government, the Australian Government. The ANF does not support such a move. There are sufficient examples of Governments at all levels working together to improve services and enhance care within the current arrangements to demonstrate that it can work where there is a will for it to do so. Identifying the specific elements that make such arrangements work and exploring ways of replicating them would be much more useful than a revolution in health care funding and delivery that may not necessarily, and most likely would not, achieve any significant improvements. This would be enhanced by the establishment of a national health reform council to oversee this process.
 - 6.4 The ANF does not support the mandatory credentialing of nurses working in specialist areas of practice. The model of credentialing that may suit the needs of medical practitioners is not suitable for nursing, except perhaps where nurses or midwives work in private practice. The majority of nurses work as employees and have existing processes in place for monitoring competence that have not been shown to be inadequate. Some specialist nursing organisations have established voluntary credentialing processes and a project is being developed by the National Nursing Organisations to evaluate these processes.

6.5 The use of health informatics is another area where nursing lags behind other health practitioners and productivity savings could be achieved if nurses had greater access to information technology at the bedside in addition to having a greater say in the purchase of IT software and hardware and the construction of the data bases they are meant to use. The ANF is currently conducting a project on behalf of the Australian Government to examine nurses' use of information technology, the barriers to that use, and to make recommendations to enhance nursing practice through the use of IT.

7 The particular health workforce needs of people in regional and remote areas, and Indigenous Australians

7.1 As has been outlined earlier in this submission, nurses are often the only health care provider in remote areas. This is an unsatisfactory situation, for people living in rural and remote areas, which leaves them with unmet health care needs eg for specialist medical care, dental care, physiotherapy, occupational therapy, speech pathology, podiatry, psychology, mental health etc. There should be multidisciplinary health teams attached to each major regional health centre that are able to routinely visit isolated rural and remote areas. It is also an unsatisfactory situation for the nurses who often work long hours 'on call'; who have limited medical and allied health support to enhance the care available to their communities; who struggle to obtain relief staff to backfill their positions so that they can maintain clinical currency; and who have inadequate peer networks or counselling and support services available to them.

7.2 A significant investment in recruiting Indigenous people to nursing courses and structuring courses in such a way that supports their learning would be of considerable benefit in improving the health and wellbeing of Indigenous people. This has been a long term objective of the Congress of Aboriginal and Torres Strait Islander Nurses and despite scholarships being made available by the Australian Government, progress has been slow. Further work is required to explore and remove the barriers to Indigenous people accessing nursing courses.

7.3 Innovative strategies to recruit and retain the health workforce in rural and remote areas have had only a patchy take up and have been inconsistent across the workforce. For example, strategies directed to medical practitioners have not been available to nurses and allied health workers. Such strategies should be universally available and applied, for example:

- subsidies such as isolation and relocation allowances;
- preparation for practice so that the health care practitioner is ready for the work required in the context in which it is to be delivered;
- a focus on a team approach to health care delivery;
- quality accommodation;
- professional support;

- access to continuing education;
- travel assistance to return to home base at regular intervals; and
- appropriate attention to occupational health and safety issues.

7.4 Poor employment conditions for health care practitioners in rural and remote areas are a barrier to promoting a rotation to working in these areas. There are many incentives which could be developed to encourage health care practitioners to spend time in rural and remote areas. For example:

- What would encourage old people heading toward retirement to work for a period of time in a rural or remote area?
- How could the experience of working in a rural or remote area be used as part of a professional development package for nurses working in a primary health care or emergency care setting, such as training programs which include a twelve month rotation to a rural or remote area?
- Is there a way for students to pay off their education debt by working for a period of time in an area of workforce need?

7.5 The Australian Government's nursing scholarship schemes are a very important resource for sustaining the nursing workforce in rural and remote areas and these should be continued and expanded.

7.6 The ANF has long argued for more support for students so that they can experience work in rural and remote areas. The cost of education for students has increased exponentially in the last few years and the added cost imposed of clinical placements in rural and remote areas has been a barrier for students interested in experiencing health care work outside a metropolitan area.

7.7 There also needs to be arrangements in place to assist potential health care practitioners already living in isolated areas to negotiate their way through the education maze. For example, a person living in a small country town may complete a Certificate III in aged care work when working in the local multi-purpose centre. If the town has a vocational education provider the person is then enabled to complete, with articulation arrangements in place, a Certificate IV or Diploma in nursing, exiting with an enrolled nurse qualification. With a license to practice as an enrolled nurse providing employment opportunities and an income, the person can then complete a Bachelor Nursing by distance education with credits for the education they completed in the vocational education sector. They can then go on to do some post graduate courses that meet the needs of the local community where they continue to live. The main issues for such a career path are:

- the cost of education in both the vocational and higher education sectors;
- access to a local vocational education provider;
- admission to a higher education provider with a flexible distance education option;

- support from the employer to balance study, work and family;
- access to clinical education with support from clinical supervisors;
- support from colleagues as the person moves has different educational experiences and moves through different roles in the health and aged care sectors; and
- contact with a professional support network.

8 The provision of out of hours services by general practitioners adjacent to acute care hospitals

8.1 The provision of out of hours services by general practitioners adjacent to acute care hospitals is supported. People often present to emergency departments however because they cannot afford the up front fee charged by a large number of general practitioners. There is no advantage in having general practitioner services adjacent to acute care hospitals if those general practitioners are not prepared to bulk bill people who present for care. It is also necessary for those services to be provided both in and out of hours. People do not only attend acute care hospitals for care that could be provided by general practitioners 'out of hours'. It is often the cost of care that drives people to present to emergency departments, not just the fact that it is difficult to access a general practitioner 'out of hours'.

8.2 The use of nurse practitioners in emergency departments would also assist in improving waiting times and the care that is available as well as more efficiently use the scarce resources of doctors working in emergency departments.

9 Recommendations

9.1 That the Productivity Commission recommends the immediate implementation of the strategies outlined in the Australian Health Ministers national health workforce strategic framework document.

9.2 That the Productivity Commission recommends the development of a national primary health care plan that includes an extensive consultation process with the community as part of its development in order to increase the community's understanding of the cost pressures in the current and future provision of health care and to gain their support and commitment to the pursuit of health promoting activities.

9.3 That the Productivity Commission recommends the establishment of a national Health Reform Commission to identify and eliminate duplication and cost shifting in health service provision; to remove the barriers to and facilitate the development of continuity of care across health sectors such as acute, community and residential care; to identify existing successful cross Government cooperative health provision models and facilitate their replication; and to promote the further development and trial of cross Government cooperative health provision models.

- 9.4 That the Productivity Commission recommends the development and funding of a national education plan for nurses so that the target number of registered and enrolled nurses already identified by the Australian Health Ministers Advisory Council as being required for the future is met.
- 9.5 That the Productivity Commission recommends that a permanent multi-disciplinary planning advisory committee is established that includes clinicians, education and health sector representatives and public, private and aged care service providers and that specific education and workforce targets are established for all health care providers.
- 9.6 That the Productivity Commission recommends the more effective utilisation of the skills of registered and enrolled nurses within the health care setting as a more cost effective alternative than the development of new health care roles and that nurses and their employers are supported to develop appropriate nursing scopes of practice to meet the needs of the community using health care services.
- 9.7 That the Productivity Commission recommends the expansion of nurse and midwife practitioner positions as part of the health care team, supported by fully funding the activities associated with the nurse and midwife practitioner scope of practice such as initiating diagnostic investigations, prescribing medicines and directly referring for specialist medical care.
- 9.8 That the Productivity Commission recommends that workload management tools are developed and implemented as an important retention and quality of care strategy and that employers are required to adhere to the staffing levels and skills mixes recommended by the workload management tools.

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