ROYAL COLLEGE OF NURSING, AUSTRALIA

Submission to Australian Government Productivity Commission Position Paper: Australia's Health Workforce

1. Introduction

Royal College of Nursing, Australia (RCNA) welcomes the opportunity to participate in the public consultation on the Position Paper: Australia's Health Workforce, produced by the Productivity Commission following its receipt of written submissions to the Inquiry into the Health Workforce Study (the Study).

RCNA met with Productivity Commission staff, made a written submission to the first round of consultation for the Study, and participated in the Roundtable discussions in October 2005. A strong interest in the Study has been shown by RCNA members and discussions have been held with other nursing groups both before and following release of the Position Paper.

In a press release issued on 30 September 2005, RCNA stated that it broadly supported the proposals contained in the Position Paper. However, this support was tempered with caution on the suggested directions of some aspects, and this RCNA stated that it intended to address these matters in a further submission.

2. RCNA Response

2.1 General Comment

As a general comment, the approach suggested by the Productivity Commission to reduce committee infrastructure in order to streamline processes for workforce analysis, including education and training, is welcomed. Such efficiencies will improve the decision-making for the health workforce as a whole with flow-on benefits for the consumers of health care. The proposed new bodies to advise on elements of the health workforce appear to be a sensible approach.

As stated in our submission to the Study, RCNA has a critical interest in the current Inquiry into the health workforce because of the central role that nurses play in the delivery of health services. Nurses are the largest single cohort of the health professionals making up approximately half of the current health workforce. Thus RCNA is keen to demonstrate continued interest in the outcomes of the Study by further contribution through specific comments to the draft proposals put forward by the Productivity Commission.

2.2 Specific Comment

As requested, comment will be provided where considered necessary to do so, against each of the draft proposals in the Position Paper.

Draft Proposals from Section 3: Objectives and strategies

Draft Proposal 3.1
In its upcoming assessment of ways to improve the level of integration within the health care system, the Council of Australian Governments (CoAG) should consider endorsing the National Health Workforce Strategic Framework (NHWSF), subject to broadening of the self sufficiency principle, in order to enhance cohesion between the various areas and levels of government involved in health workforce policy.

RCNA supports this proposal. The seven core principles of the Framework provide an excellent base for workforce policy and planning. And, importantly, the Framework promotes national consistency and collaborative deliberation across all sectors of the health workforce. The Framework provides a useful base because of its links with related frameworks and health sector work.

Draft Proposal 3.2
CoAG, through its Senior Officials, should commission regular reviews of progress in implementing the NHWSF. Such reviews should be independent, transparent and their results made publicly available.

RCNA supports this proposal. The health sector needs to have assurance that not only will there be an intention to a nationally consistent approach to workforce planning and an agreed framework within which this is structured, but there also needs to be demonstration of commitment to the process and evaluation of outcomes through regular and independent reviews. Accountability to the consumers of health care is equally important.

Draft Proposals from Section 4: Workforce innovation

Draft Proposal 4.1
The Australian Health Ministers' Conference should establish an advisory health workforce improvement agency to evaluate and facilitate major health workforce innovation possibilities on a national, systematic and timetabled basis. • Membership of the board should consist of an appropriate balance of people with the necessary health, education and finance knowledge and experience.

RCNA supports this proposal as health workforce innovation must be coordinated and implemented in a planned and coherent fashion. A central agency would assist in prevention of rogue, so called innovative roles, being introduced at the whim of individuals, as is presently the case. It would also assist in minimising duplication of effort which is presently the case between jurisdictions as they strive to develop roles reflective of particular sets of circumstances rather than roles which are more generic and portable. The development of the Nurse Practitioner is one such example.

Central to the effectiveness of an agency such as this is its governance. Its governing body could not possibly be representative – rather it needs to be comprised of workforce experts (not exclusively bureaucrats). As the areas of workforce innovation may be diverse, the ability to co-opt or establish subcommittees is essential. It must also have a clear reporting relationship preferably to Health Ministers to enable its proposals to be implemented. In addition it will need clearly articulated links with health professional regulatory bodies.

As nurses are the majority of the health workforce, it is imperative that they are represented appropriately in terms of both numbers and expertise.

Two additional workforce issues which are not articulated in the draft proposals, but which are mentioned in the Position Paper and which RCNA considers are important to make comment on, namely credentialing and recruitment and retention, are included at the conclusion of comment on the draft proposals, under section 3 of this paper.

Draft Proposals from Section 5: Health workforce education and training

Draft Proposal 5.1
The Australian Government should consider transferring primary responsibility for allocating the quantum of funding available for university-based education and training of health workers from the Department of Education, Science and Training to the Department of Health and Ageing. That allocation function would encompass the mix of places across individual health care courses, and the distribution of those places across universities. In undertaking the allocation function, the Department of Health and Ageing would be formally required to:

- *consider the needs of all university-based health workforce areas; and*
- *consult with vice chancellors, the Department of Education, Science and Training, other relevant Australian Government agencies, the States and Territories and key non-government stakeholders.*

RCNA supports a coherent approach to allocation of undergraduate places for health professional education. The report on nursing education which was commissioned at the time of the completion of the transfer of nursing education to universities – *Nursing Education in Australian Universities Report of the national review of nurse education in the higher education sector 1994 and beyond* – recognised the problem of allocation of numbers of nursing places based on available workforce planning data and made recommendations to this effect. These recommendations were largely ignored.

RCNA cannot comment on whether transferring primary responsibility for allocation of funding for undergraduate education to the Department of Health and Ageing is feasible (or indeed politic). However, linking of this allocation to workforce data with places dedicated to health professional education is highly desirable to ensure that the supply of graduating health professionals is not dependent on the whim of individual universities. Furthermore, undergraduate places will need to be tied to funding and not be subject to reallocation once the funding reaches a university. If an individual university cannot fill places earmarked for undergraduate health professional education, they should then be reallocated to another institution. This would then guarantee the level of supply of nurses and other health professionals into the workforce.

Draft Proposal 5.2
The Australian Health Ministers' Conference should establish an advisory health workforce education and training council to provide independent and transparent assessments of:

- *opportunities to improve health workforce education and training approaches (including for vocational and clinical training); and*
- *their implications for courses and curricula, accreditation requirements and the like.*

RCNA supports this proposal. The establishment of such a council would assist in national consistency and thus enable easier transportability of prior learnings and skills across jurisdictions. In addition it would facilitate access and funding equity, to clinical training, across health professional disciplines.

Draft Proposal 5.3
To help ensure that clinical training for the future health workforce is sustainable over the longer term, the Australian Health Ministers' Conference should focus policy effort on enhancing the transparency and contestability of institutional and funding frameworks, including through:

- *improving information in relation to the demand for clinical training, where it is being provided, how much it costs to provide, and how it is being funded;*
- *examining the role of greater use of explicit payments to those providing infrastructure support or training services, within the context of a system that will continue to rely on considerable pro bono provision of those services;*
- *better linking training subsidies to the wider public benefits of having a well trained health workforce; and*
- *addressing any regulatory impediments to competition in the delivery of clinical training services.*

RCNA supports this proposal. Clinical training is fundamental to a competent health workforce. As the numbers of clinical placements diminish in the traditional venues such as public acute hospitals and community health centres, innovative solutions need to be found to ensure an adequate number of clinical placements. Furthermore, establishing a realistic cost of clinical placements and subsequent provision of funding to place students may decrease the reluctance of many providers to provide student placements. Whilst determining the cost of clinical experience may have some unintended negative flow on effects such as jeopardising pro bono contributions, the present situation cannot be sustained.

Draft Proposals from Section 6: Accreditation

As will be explained in the response, Draft Proposal 6.1 and 7.1 are treated together below.

Draft Proposal 6.1
The Australian Health Ministers' Conference should establish a single national accreditation agency for university-based and postgraduate health workforce education and training.

- *It would develop uniform national standards upon which professional registration would be based.*
- *Its implementation should be in a considered and staged manner.*

Draft proposal 7.1
Registration boards should focus their activities on registration in accordance with the uniform national standards developed by the national accreditation agency and on enforcing professional standards and related matters.

A possible extension to VET should be assessed at a later time in the light of experience with the national agency.

Accreditation of courses leading to registration is a complex undertaking, not the least on account of the numbers of both universities and vocational education institutions and the professions concerned.

In Australia, admission to the register in the case of all health professionals is contingent on an individual successfully completing the educational requirements of a program accredited with the particular registering authority. For example, to gain entry to the nursing register, an individual must have completed a degree program or a vocational program in the case of the second level nurse, accredited by the jurisdictional nurses registration board or council. There are no examinations leading to registration as there were in the past and indeed still exist in some parts of the world. Therefore, the nexus between accreditation of programs (vocational, undergraduate and graduate) which lead to registration as a health professional by registration boards or councils is critical as a registration board must be assured that in order to fulfil its mandate of protection of the public, applicants for registration are so qualified. Currently, these programs are accredited by both educational providers such as universities and registration boards.

In light of the foregoing, Draft Proposal 6.1 cannot be considered in isolation from Draft Proposal 7.1.

RCNA supports national consistency in the structural aspects of the health workforce but would not support a universal approach which diminishes the unique structural attributes of individual health professions. There are differences between all the health professions and most have their own idiosyncrasies. For example, a large number of health professionals are self employed. On the contrary, the great majority of nurses are employees. Some professional groups such as dentists have very specific tasks which they can undertake and there are also grey areas in their practice where it overlaps with medicine. Similarly this grey area exists between nursing and medicine and with other health professions.

In order to establish a coherent structure for national accreditation of health professional educational programs and registration of health professionals the following structure could be implemented.

1) A single national registering authority with uniform umbrella legislation and heads of power for the core regulatory activities such as registration requirements, disciplinary processes and requirements for ongoing competence, with separate sections for each profession in the legislation to provide regulatory integrity.

2) A national accreditation body which accredits all programs – vocational, undergraduate or postgraduate – which lead to registration as a health professional and develops accreditation guidelines in consultation with each profession and representatives of the national registering authority.

From a legislative perspective, the jurisdictions would cede power to the Commonwealth which would then implement national umbrella legislation for registration of the health professions currently registered. Contained in this legislation would be a head of power enabling it to acknowledge the national accreditation body, and accept for entry to the respective registers, graduates from accredited programs. The national registration board

would concentrate on registration, disciplinary processes and requirements for re-licensing or ongoing competence of its registered practitioners. It may need to establish a presence in the jurisdictions for the investigation of all matters related to its disciplinary function. It should have provision for members of the public to participate in its processes.

This approach will require significant legislative development and its success will depend on political will. From a nursing perspective, outcomes such as uniform registration processes, uniform fees for registration, enhanced arrangements for cross border practice and streamlining of categories of nurse registered, will be welcomed. The current arrangement for mutual recognition legislation - complementary legislation at State/Territory/Commonwealth levels - is dependent on each jurisdiction maintaining its legislation and thus cooperating in the interests of national consistency. When this breaks down for reasons of political contrariness or bureaucratic incompetence, it is individuals who suffer the consequences. Therefore, if there is the will for change in this area, it must be accomplished through solid structures which are difficult to dismount.

An alternative approach would be to strengthen mutual recognition legislation. Through this vehicle, requirements for nationally consistent health professional regulation could be agreed to and enacted. This would negate the need for ceding of powers to the Commonwealth and passage of national registration legislation. However, as processes for mutual recognition are dependent on each of the nine jurisdictions passing complementary legislation and preventing the legislation from lapsing, it again is a large undertaking and one which could readily falter.

Whatever process is adopted, it is important that the structures at jurisdictional level which provide flexibility for nursing are replicated at national level to facilitate rather than impede the development of nursing and nursing practice.

Draft proposal 6.2
The new national accreditation agency should develop a national approach to the assessment of overseas trained health professionals. This should cover assessment processes, recognition of overseas training courses, and the criteria for practise in different work settings.

RCNA supports this proposal but the implementation is largely dependent on the arrangements in place for proposals 6.1 and 7.1.

Draft Proposals from Section 7: Registration

Draft proposal 7.1 has been dealt with under the above Section 6.

Draft proposal 7.2
States and Territories should collectively take steps to improve the operation of mutual recognition in relation to the health workforce. In particular, they should implement fee waivers for mobile practitioners and streamline processes for short term provision of services across jurisdictional borders.

RCNA supports this proposal in principle but notes that should the proposal discussed above on national registration be implemented, the need for mutual recognition legislation as it relates to the health professions would be redundant.

It should be pointed out that mutual recognition legislation in its present form does not provide for fee waivers for mobile practitioners or for short term cross border assignments, despite these provisions being in the overall spirit of mutual recognition. The locus of power for these provisions is the individual jurisdictional health practitioner legislation and associated powers under that legislation. Individual registration boards may be able to make regulations or other determinations to implement this proposal.

Draft proposal 7.3
Under the auspices of the Australian Health Ministers' Conference, jurisdictions should enact changes to registration acts in order to provide a formal regulatory framework for task delegation, under which the delegating practitioner retains responsibility for clinical outcomes and the health and safety of the patient.

RCNA has some difficulty with this proposal.

First, it is unclear whether the regulatory framework for task delegation will operate between existing health practitioner Acts or between one regulated group and an unregulated group. RCNA would not be opposed for example for this framework to operate to allow registered nurses to delegate certain tasks to unlicensed workers as is the case in Queensland. However, it would be opposed to a delegation, for example, from a medical practitioner or physiotherapist to a nurse as each health professional is accountable in law for its practice.

Second, a framework for task delegation must be purely a framework and not contain specific tasks which could be delegated as is the case in Canada. Such legislation soon becomes obsolete as technology and treatment modalities change clinical practice. Amending legislation can be a lengthy process and is not recommended as the head of power for clinical practice.

Draft Proposals from Section 8: Funding mechanisms for health care services

Draft Proposal 8.1
The Australian Government should establish an independent standing review body to advise the Minister for Health and Ageing on the coverage of the Medicare Benefits Schedule (MBS) and some related matters. It should subsume the functions of the Medical Services Advisory Committee, the Medicare Benefits Consultative Committee and related committees. Specifically, the review body should evaluate the benefits and costs, including the budgetary implications for government, of proposals for changes to:

- *the range of services (type and by provider) covered under the MBS;*
- *referral arrangements for diagnostic and specialist services already subsidised under the MBS; and*
- *prescribing rights under the Pharmaceutical Benefits Scheme.*

It should report publicly on its recommendations to the Minister and the reasoning behind them.

RCNA can not make comment as to the merits of an independent standing review body to advise the Minister for Health and Ageing on the coverage of the Medicare Benefits Schedule (MBS) and some related matters as suggested in this proposal.

However, RCNA would like to make comment on the range of services (type and provider) covered under the MBS.

In 2000 RCNA and the Royal Australasian College of General Practitioners (RACGP) proposed that the Australian Government enhance the role of the general practice nurse and increase the numbers of nurses working in the general practice setting. The two Colleges had a clear vision that better utilisation of nurses within general practice could provide a more comprehensive service of health care to Australian communities. This proposal was subsequently adopted by the Government through the Federal Budget Initiatives of 2001/2002 for general practice (known as the General Practice Nurse Initiative/GPNI). However, while a growing number of General Practitioners embraced the GPNI it became clear that there were distinct barriers to a full acceptance of including nurses in the general practice team due to the fact that in order to attract MBS payment, each patient had to be seen by the General Practitioner in addition to the nurse.

This situation has begun to be addressed by the inclusion of MBS items for nurses to undertake immunisation, wound care and Papanicolou smear testing. RCNA fully supports moves to increase the range of care activities undertaken by general practice nurses which can directly attract MBS item payments. This will then more fully achieve the original vision of RCNA that nurses can assist general practice to increase access to timely health care to a broader section of our communities. Further, RCNA contends that these additional nurse MBS items attract separate billing for service arrangements, as will be expanded on under draft proposal 8.2 below.

In relation to the proposal to *evaluate the benefits and costs, including the budgetary implications for government, of proposals for changes to……prescribing rights under the Pharmaceutical Benefits Scheme,* RCNA urges the Productivity Commission to specify that this process involve the inclusion of Nurse Practitioners. This special practice area of nursing has been established in most States and Territories and has been found through research to provide safe and effective health care services in a range of health care settings. This category of health professional increases choice and access for consumers of health care in service delivery, and has been legislated to prescribe and/or supply medication from approved formulary.

While the Productivity Commission accurately reports in the Position Paper that the numbers of authorised Nurse Practitioners in Australia is currently low, this has been due in part to the amendments to underpinning legislation in each jurisdiction and in part to the nursing profession choosing to work collaboratively with other health professionals in the establishment of these roles. Both aspects have needed to be undertaken over a considerable period of time in order to achieve desired outcomes.

In order to maximize the potential of the Nurse Practitioner role in its service to the Australian community it is paramount that prescribing rights be granted under the Pharmaceutical Benefits Scheme.

Draft Proposal 8.2
For a service covered by the MBS, there should also be a rebate payable where provision of the service is delegated by the practitioner to another suitably qualified health professional. In such cases:

- *the service would be billed in the name of the delegating practitioner; and*
- *rebates for delegated services would be set at a lower rate, but still sufficiently high to provide an incentive for delegation in appropriate circumstances.*

This change should be introduced progressively and its impacts reviewed after three years.

RCNA does not support this proposal.

As stated above under draft proposal 8.1 RCNA fully supports the expansion of the range of services (type and provider) covered by the MBS. Under recently introduced arrangements general practice nurses can attract payment under the following MBS items: immunisation, wound care and Papanicolou smear testing.

A move to greatly increase the numbers of rebatable MBS items for general practice nurses is essential but this must be under the arrangement of separate billing for services and not through a delegated system. The Productivity Commission must see that it is time to move on from restrictive arrangements of the general practitioner being the gate keeper for services covered by MBS.

The change to the services covered by MBS then should be that the general practice nurse be able to bill separately for services, that these services cover an agreed broad range of services provided by general practice nurses, and that these nurses be employed in a General Practice.

Draft Proposals from Section 9: Workforce planning – projecting future workforce needs

Draft Proposal 9.1

Current institutional structures for numerical workforce planning should be rationalised, in particular through the abolition of the Australian Medical Workforce Advisory Committee and the Australian Health Workforce Advisory Committee. A single secretariat should undertake this function and report to the Australian Health Ministers' Advisory Council.

RCNA supports this proposal. A single entity would enable an integrated approach to health workforce planning and design to more fully meet the needs of the Australian community. The current disaggregation of health workforce projection and planning is not in the best interests of consumers as it can lead to overlapping and competition of services which are differentiated only by mode of delivery of the health professional, or at the other extreme, to complete gaps in service delivery.

It will be important for the single workforce entity to maintain consultative links with the distinct health professional groupings as is currently the arrangement with working parties deliberating particular specialty fields within the workforce. The difference will be that the recommendations from these activities will be considered within the context of the total health workforce.

Draft Proposal 9.2

Numerical workforce projections undertaken by the secretariat should be directed at advising governments of the implications for education and training of meeting differing levels of health services demand. To that end, those projections should:

- *be based on a range of relevant demand and supply scenarios;*
- *concentrate on undergraduate entry for the major health workforce groups, namely medicine, nursing, dentistry and the larger allied professions, while recognising that projections for smaller groups may be required from time to time; and*

be updated regularly, consistent with education and training planning cycles.

RCNA fully supports this proposal.

Draft Proposals from Section 10: Rural and remote issues

Draft Proposal 10.1
The Australian Health Ministers' Conference should ensure that all broad institutional health workforce frameworks make explicit provision to consider the particular workforce requirements of rural and remote areas.

RCNA fully supports this proposal. As can be seen from the table provided on page 164 of the Position Paper, nurses from the largest single component of the health workforce in every geographical region shown, and particularly in the rural and remote settings. Generally when the Position Paper is referring to the fact that there are communities with problems in accessing health professionals, one must assume that this reference is to medical practitioners as there are very few places which do not have access to a nurse. While some jurisdictions have taken moves to reduce or eradicate single nurse post health centres, there are still areas in which these exist and are problematic for a number of reasons, not the least being professional isolation and personal safety and well-being.

Draft Proposal 10.2
The brief for the health workforce improvement agency (see draft proposal 4.1) should include a requirement for that agency to:

- *assess the implications for health outcomes in rural and remote areas of generally applicable changes to job design; and*
- *as appropriate, consider major job redesign opportunities specific to rural and remote areas.*

RCNA does not necessarily agree that there needs to be major job redesign speficially targeted at rural and remote areas.

The inequity in incentives provided to attract health professionals to rural and remote areas is blatantly obvious to those groups of health professionals who work in those areas, and must be addressed by the health workforce improvement agency.

Currently RCNA administers several millions of dollars for the Australian Government in the provision of scholarship funding to enable access for rural and remote people to undergraduate, postgraduate, re-entry and upskilling programs. These programs are making it possible for people to enter and re-enter nursing who otherwise would not be able to bear the financial load involved, and to undertake activities ranging from conferences to masters degree courses which enable nurses to retain competence in their specialty field and thus improve the quality of their care to their communities. The overarching aim is to increase the numbers of nurses living and working in rural and remote Australia and limited research and anecdotal evidence suggests this is being achieved.

RCNA recommends that health workforce frameworks looking at specific requirements for rural and remote areas include maintenance of funding assistance for beginning and

postgraduate education, and continuing professional development for nurses. Further that this funding be regularly reviewed to ensure that the amount allocated is meeting the needs of people in these areas in overcoming their access barriers to maintaining competence.

Draft Proposal 10.3
The Australian Health Ministers' Conference should initiate a cross program evaluation exercise designed to ascertain which approaches, or mix of approaches, are likely to be most cost-effective in improving the sustainability, quality and accessibility of health workforce services in rural and remote Australia, including:

- *the provision of financial incentives through the MBS rebate structure versus practice grants; and*
- *'incentive-driven' approaches involving financial support for education and training or service delivery versus 'coercive' mechanisms such as requirements for particular health workers to practise in rural and remote areas.*

There should also be an assessment of the effectiveness, over the longer term, of regionally-based education and training, relative to other policy initiatives.

The only additional comment RCNA wishes to make to those expressed in 10.1 and 10.2 is that while provision of education and training at regional centres may be desirable there should always be the facility for health professionals in rural and remote areas to access programs in major centres if those programs are more pertinent to their needs.

Draft Proposals from Section 11: Addressing special needs

Draft Proposal 11.1
The Australian Health Ministers' Conference should ensure that all broad institutional health workforce frameworks make explicit provision to consider the particular workforce requirements of groups with special needs, including: Indigenous Australians; people with mental health illnesses; people with disabilities; and those requiring aged care.

RCNA supports this proposal.

3. Additional Items

3.1 Credentialling

The Australian Council for Safety and Quality in Health Care (the Council), was charged with *leading national efforts to promote systemic improvements in the safety and quality of health care in Australia with a particular focus on minimizing the likelihood and effects of error*. One of the commissioned works of the Council was to explore the

processes and standards for credentialling of clinicians. Unfortunately the Council considered this from the narrow focus of medical clinicians and adopted the stance that credentialling processes should be the same for **all** clinicians – medical and nursing. This was despite earnest endeavours by RCNA to present and gain acceptance for the approach to credentialling taken by the nursing profession. The essential difference in approaches is that credentialling for medical practitioners is through an organisational focused framework whereas the nursing profession has taken the path of self-regulation through the development of national standards and credentialling driven by the professional nursing colleges and specialty nursing groupings.

Despite credentialling being a key issue for the Council for the majority of its term (five years), the implementation of a national approach has not yet occurred. The Review of future governance arrangements for safety and quality considered that credentialling is a priority issue and has recommended that an implementation plan for credentialling standards be developed across all health settings by June 2006. RCNA thus sees the establishment of a new national body for safety and quality as an opportunity to revisit the progression of credentialling and the linking in of the nursing profession into the national credentialling framework. RCNA will seek acknowledgement for flexible approaches to the process of credentialling for different groups of health care professionals.

The Commission will recall that in its submission RCNA recommended that the focus of the health system move away from the competitive provider driven culture to a consumer focused, consumer driven culture. Further, that there be a focus on skill sets in health professionals predicated on responding to needs of the consumer. As an integral part of delivering safe, quality care that is driven by health consumer needs, RCNA sees the need for processes of self-regulation that provide a framework for maintenance and enhancement of competence to practice.

The development of credentialling processes for all practitioners is considered an essential aspect of ensuring competence of health professionals and resultant patient safety. These processes are occurring internationally for nurses and RCNA has participated in international forums aimed at progressing credentialling across the globe.

While there has been little progress on credentialling for advanced practice nurses in general, some specialty nursing groups have established credentialling processes for their members. These groups are: the Australian College of Critical Care Nurses, the Gastroenterological Nurses College of Australia, the Australian and New Zealand College of Mental Health Nurses, and the Diabetes Nurse Educators. RCNA maintains a program for credentialling and re-credentialling nurses who provide Papanicolou Smear testing, primarily in general practice settings.

RCNA continues to provide leadership for nurses on the need for credentialling as a public demonstration of advanced practice competence, and requests the Commission to support the progression of credentialling for nurses in Australia.

3.2 Recruitment and Retention

In 1982, the American Academy of Nursing's Task Force on Nursing Practice in Hospitals conducted a study of 41 hospitals. The aim of this study was to identify and describe variables that created an environment that attracted and retained well-qualified nurses who promoted quality patient care through providing excellence in nursing services. These institutions were called "magnet" hospitals and served as "magnets" to attract and retain professional nurses who experienced a high degree of professional and personal satisfaction through their practice. The Magnet Recognition Program (MRP), an accreditation program conducted by the American Nurses Credentialing Center (ANCC), has grown from this beginning. It is based on a set of standards – *Standards of Care and Standards of Professional Performance* - and the health service is assessed against those standards.

The MRP evaluates nursing services within health facilities with a focus on attracting and retaining qualified staff and improving health outcomes. For some time RCNA has been exploring the concept as conducted in the USA, and more recently in UK, Europe and Canada. RCNA has identified that many of the principles within the Magnet concept would be particularly appropriate and beneficial for improving nursing services and client outcomes in Australia.

Two facilities outside North America have been accredited so far – those being the Birch Hill NHS trust (formerly Rochdale) in the Manchester UK area, and the Princess Alexandra Hospital, Brisbane, Australia. The New Zealand Government has made a commitment to examine the MRP in detail to assess its applicability in NZ. In early 2002 the Ministry of Health established the NZ Magnet Advisory Network now Magnet NZ. RCNA has made contact with Magnet NZ with the aim of working together to develop this concept in this region.

A large body of evidence has been gleaned from research on the MRP and this demonstrates linkages between numbers or ratios of qualified nurses to patients and enhanced outcomes of care. References for this research and further readings on the Magnet Recognition Program is provided in the References at Section 5 below.

Essentially research has documented the following as being evident in Magnet Hospitals:

- Lower mortality rates
- Lower morbidity rates
- Lower complication rates
- Higher patient satisfaction
- Higher staff job satisfaction
- Lower overall costs
- Greater nurse autonomy
- Better managerial support of nursing
- Better doctor-nurse relationships
- Higher quality of care ratings

While it is clear from the research that no one solution will solve the recruitment and retention crisis in nursing, and thus increase the standard of in-hospital care, adoption of Magnet principles is one of the identified strategies to do so. The current MRP is tailored to the North American health system and culture but, as has been demonstrated in the UK, it can be adapted to a very different health system and culture.

The experience from North America is that the MRP while it is directly applicable to nursing is in fact a program which has an impact on all areas of a hospital or health service. That being the case, it is imperative that the membership of any group involved in either the assessment of Magnet applicability or its implementation is multidisciplinary.

One of the questions frequently asked about the formal Magnet accreditation is how the program differs from other forms of accreditation. The most relevant difference is that the standards are pitched at the excellence level or ceiling rather than being minimum or floor standards. It is important that Magnet accreditation is linked to other accreditation programs to prevent excessive paper work and duplication of effort.

RCNA has in the past proposed to the Australian Council on Safety and Quality in Health care that an Australian Government funded group be set up to explore Magnet principles in Australia which have the potential to significantly reverse the current trends in the retention of nurses in the health system and enhance the delivery of patient care. The implementation of Magnet principles will not provide a 'quick fix' for the current problems in retaining nurses, however, as it aims to introduce long term culture change in the way nursing is organised and nursing care is delivered. The distinct benefits for the Australian community would be the retention in the health system of well-qualified nurses and enhanced outcomes of care.

4. Conclusion

RCNA welcomes the opportunity to be able to provide comment on the draft proposals contained in the Productivity Commission's Position Paper: *Australia's' Health Workforce,* and to submit additional comment on matters mentioned in the Paper.

As stated in the RCNA submission to the Commission, and reiterated for emphasis, *equity for health consumers and equity for the health workforce are two important goals and must be prominent in any reform initiatives recommended*. It is imperative that this opportunity for reform be taken seriously, and that real reform for the health workforce be effected leading to positive outcomes for the betterment of the health system, the health consumers, and the health workforce.

The foregoing response paper clearly shows that RCNA is supportive of the directions proposed by the Commission for reform in the health workforce sector. However, there are concerns on some aspects of the detail of draft proposals and these have been highlighted with rationale for RCNA's view.

RCNA looks forward to the final report from the Commission and reasserts its offer to assist in future work on health workforce deliberations.

5. References

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