ROYAL COLLEGE OF NURSING, AUSTRALIA

Submission to Productivity Commission Inquiry into the Health Workforce

July 2005

The agenda for healthcare in developed countries in the 21st century will be dominated by a vision of quality which seeks to address the deep seated problems of the past. The ability to deliver safe, effective, high quality care within organisations with the right cultures, the best systems and the most highly skilled and motivated workforces will be the key to meeting this challenge…. The need for health services to give priority to developing health professionals equipped to practise in a new way and thrive in new organisational environments requires a rapid response to reshape curricula and training programmes.

….tomorrow's citizens will see themselves as true potential consumers of a service which they, as taxpayers fund. Tomorrow's patients will expect to be accorded respect, to be empowered with information to enable them to make informed choices, and to become an equal partner in decisions about their case. In the field of chronic diseases this shift in emphasis goes even further with patients being enabled to become "experts" and to have greater autonomy managing their care.

…The health professional of the future will need to have core skills and competencies in the diagnosis, treatment and care of illness, but much more. The ability to form genuine partnerships with patients, the ability to work effectively in multidisciplinary teams, the ability to recognise the causes of unsafe practice and act on them, the ability to assess quality of care and identify ways of improving it, and the ability to communicate, inform and educate are only some of the skill…..

. . . Health care in the 21st century will require a new kind of health professional: someone who is equipped to …. reach a new level of partnership with patients; someone who can lead, manage and work effectively in a team and organisational environment; someone who can practise safe high quality care but also constantly see and create the opportunities for improvement.

Sir Liam J Donaldson – Chief Medical Officer for England (Donaldson 2001)

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1. Introduction

Royal College of Nursing, Australia (RCNA) welcomes the opportunity to provide a submission to the Productivity Commission Inquiry into the Health Workforce

2. Recommendations

The following recommendations are a collection of the recommendations made throughout this submission

Recommendation 1:

That incentives be explored and introduced in order to:

a) move the focus of the health system away from the competitive provider driven culture to a consumer focussed, consumer driven culture, and
b) have a focus on skill sets in health professionals predicated on responding to needs of the consumer.

Recommendation 2:

That strategies are developed and implemented by employers and educational institutions in order to improve the relationships within and across multidisciplinary teams in order to improve the quality and safety of care provided to consumers.

Recommendation 3

That, in relation to new roles:

a) the Nurse Practitioner role, now validated by extensive Australian and international research, be recognised and further developed as an integral part of the health professional workforce, and
b) their introduction should take place following assessment of the current workforce roles, and especially exploration of the broad scope of nursing practice, in the interests of consumers and the utilisation of educational resources.

Recommendation 4

That, to address current jurisdictional barriers, there be:

a) more integration across jurisdictions to allow for planning and roles within the health care system,
b) a strong nursing focus at national level to co-ordinate the nursing workforce, and
c) mechanisms put in place to ensure work around national consistency (such as that being done by the National Nursing and Nursing Education Taskforce) is implemented across all jurisdictions in a sustainable manner.

Recommendation 5

That Australia seriously addresses the issue of sufficient provision of health professionals to sustain workforce needs into the future, in terms of: undergraduate supply, those employed, and potential re-entering supply.

3. RCNA – Background

RCNA is the peak national professional organisation for nurses in Australia. Established in 1949, RCNA was until the early 1990s a provider of formal education for nurses to gain higher qualifications and take leadership roles within nursing. Following the completion of the transfer of nursing education to the higher education sector in 1993, RCNA refocused its functions to encompass continuing professional development and policy analysis and development.

In 1997, RCNA became the Australian representative to the International Council of Nurses (ICN), a federation of 127 national nurses' associations representing over 12 million nurses worldwide. Operated by nurses for nurses since 1899, ICN is the international voice of nursing and works to ensure quality care for all and sound health policies globally. RCNA is also affiliated with several other international organisations and numerous national

organisations/associations, including a memorandum of collaboration with the Australian Nursing Federation.

With members in all States and Territories, RCNA represents nursing across all areas of practice throughout Australia. RCNA is a not-for-profit organisation, providing a voice for nursing by speaking out on health issues and policies that affect nurses and the community. Through representation on government committees and health advisory bodies, RCNA is recognised as a key centre of influence in the health policy arena in Australia. When health policy decisions are made, RCNA presents a professional nursing perspective, independent of political allegiance.

4. Environmental scan

Nurses work in a dynamic environment, and one that is particularly sensitive to social, political and economic change. The work environment today would be unrecognisable to nurses of a generation or two ago and today's healthcare workplace will almost certainly be unrecognisable to nurses of the future. The Productivity Commission should consider this dynamism in framing its conclusions and RCNA offers some observations below for guidance. These observations shape many of the concerns of RCNA; indeed, RCNA believes that the multiple social, professional, political and economic changes impacting on health and the health care setting have led to a variety of nursing education and workplace issues, namely

- The decreasing appeal of nursing as a profession
- The poor retention rates of nurses in the workforce, and
- The way the available nursing workforce is utilised.

These factors in turn have an impact on the health workforce as a whole as nurses are often the mainstay of health services, particularly in smaller facilities.

The changes of recent decades are therefore multiple and interconnected. While they must be understood separately, it is essential that solutions are devised and implemented with holistic vision. RCNA believes that single solutions will not be effective. A variety of measures both in education and in the workplace are required. These measures must address the complexity and compounding nature of the causes of the current health workforce crisis.

Some of the specific changes in the health environment which will have an impact on the demand for health professionals and the way in which the health workforce is deployed are as follows.

- Consumer involvement in health care has gained momentum, and consumers are now raising their voices over cost, competency of health providers, treatment options and quality of care delivery. RCNA sees increased consumer involvement as a positive and necessary change although it is one which places more pressure on a system that is already over-stretched.

- The ageing of the population is well documented and articulated elsewhere but it should be mentioned as it will increase the demand for health professionals and drive changes to how health care is provided in community settings.

- Technological change has been a feature of the health system for many years and indeed has driven significant change which in turn has an impact on the health workforce. The pace of change has increased and nurses and other health professionals are now involved in technologies such as tele-health and point of care testing and investigation. Other technological changes arising from stem cell research and enhanced drug therapies also have an impact on workforce.

- Bioterrorism and disaster preparedness must also be taken into account as governments have a responsibility to care for their populations in times of crisis. The need for planning and education of health professionals in this context will grow.

- The demand for competent practitioners is growing as consumers no longer accept health care of varying standards and health professionals whose expertise does not match that of their peers. In the USA, the Citizen Advocacy Centre, in response to what they see as an unacceptable level of preventable errors in health care and problems in overall quality of care, have developed a road map to continuing competency assurance (Citizen Advocacy Service 2004).

Finally, the health care environment in Australia is replicated to a greater or lesser degree in the rest of the world. Australia needs to become self sufficient in its supply and ongoing education and development of its workforce as relying on outside resources is unsustainable.

5. General Comments

There is little doubt that planning for the safe, effective, and efficient delivery of health care services to meet the health needs of communities is a significant challenge. Policy makers, health planners, health bureaucrats, educators, health service researchers, health professional organisations, economists, health union organisations and health services continually struggle with the best way to plan for a workforce that is equipped to meet community health needs (O'Brien-Pallas, Duffield et al. 2005).

There is little controversy around the World Health Organisation's (WHO) view that the health work force is the most important of all inputs into the health system (Australian Health Ministers' Conference 2004). There is also little argument that the core business of the Australian Health workforce "is providing effective, safe, quality care that improves the health and well being of

the Australian community" (Australian Health Ministers' Conference 2004a). What is controversial is the proposition that members of different health professional groups work together "in a team or as seamlessly as possible" (Australian Health Ministers' Conference 2004a).

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 make up approximately half of the current health workforce.

RCNA proposes that:

- the lack of true consumer participation in the policy development, planning and evaluation in the health system;
- the ways that the health workforce is educated in exclusive professional educational silos;
- the cultures of the professional groups gathered in professional silos; and
- the way the health system is currently structured and funded,

are all real disincentives to high quality, safe health care being provided to health consumers and hence warrant close scrutiny, analysis and change.

John Menadue is insightful yet cutting in his critique of the health workforce in Australia in 2004. He says:

> *The structure of the workforce is more appropriate to the needs of the 19th century than the 21st century. It is archaic and incoherent. As put to me by a senior clinician in NSW, "We have boxes everywhere, junior doctors, clinicians, nurses, allieds, (sic) managers, colleges and universities, but there is not a thesis or a plan that draws it all together. Training and work are in separate compartments. Teamwork is not promoted. Work demarcations abound. Health is rife with restrictive work practices and denial of career prospects, particularly for nurses, whether it is in the community or hospitals. Many senior nurses are more skilled and experienced than most junior doctors and many registrars. Because of the opposition by obstetricians, less than 10 per cent of normal births in Australia are managed by midwives. In the Netherlands it is over 70 per*

cent and in the UK over half. Many more leave nursing for management or academia because of a lack of career prospects and financial reward. The medical colleges protect their own interests in the name of 'quality' (Menadue 2004).

Clearly there is a need for radical reform!

Generally, RCNA supports the seven principles developed to underpin Australian health workforce policy (Australian Health Ministers' Conference 2004a). Each has a particular relevance to many of the points outlined below. While we will be making several recommendations in the course of this submission, the Strategic Directions outlined in the National Health Workforce Strategic Framework broaden the action outlined in the National Health Workforce Action Plan (Australian Health Ministers' Conference 2004b) to effect real reform in the health system.

The overarching principle from the Australian Health Ministers' Conference Strategic Framework (2004a) and a strong starting point is Principle 7:

PRINCIPLE 7:
Australian health workforce policy development and planning will be most effective when undertaken collaboratively involving all stakeholders. It is recognised that this will require:

- cohesion among stakeholders including governments, consumers, carers, public and private service providers, professional organisations, and the education, training, regulatory, industrial and research sectors;
- stakeholder commitment to the vision, principles and strategies outlined in this framework;
- a nationally consistent approach;
- best use of resources to respond to the strategies proposed in this framework; and
- a monitoring, evaluation and reporting process (Australian Health Ministers' Conference 2004a).

RCNA and the nursing profession have participated in a number of major Government Inquiries that relate to workforce in the past decade and notes that the Reports of many of these are listed in the Reference list in the Commission's comprehensive Issues Paper. We will not reproduce this already available and

valuable work, but will reiterate some points that are of particular relevance to the Commission's Inquiry.

RCNA urges the Commission to also review the work done in the course of the National Review of Nursing Education (Department of Education Science and Training and Department of Health and Ageing 2002) and the Safe Staffing Consultation Report (Australian Council for Safety and Quality in Health Care 2005) as the issues canvassed in those Reports and the submissions they obtained are fundamental to any discourse on the health workforce.

6. A Health Workforce Centred on & Driven by Consumer Needs

PRINCIPLE 6:
Health workforce policy and planning should be population and consumer focused, linked to broader health care and health systems planning and informed by the best available evidence (Australian Health Ministers' Conference 2004a).

Few will dispute that the health and aged care systems have been traditionally provider focussed enterprises rather than consumer focussed. Hospitals and health services are organised for provider expediency NOT consumer convenience. Consumer stories abound of their tortured negotiation through a system of silos that represent the current structures in health services organised in specialties and professional groupings. Review of the annual reports from the state and territory health complaint watchdog agencies are one accessible source of such information.

Traditionally provider groups have had the ultimate power in the relationship with individual consumers and the community generally. In 1992 Bartholome described the relationship of health professionals to health consumers as 'parentalism'. He argued that parentalism:

> *…incorporates both the paternalism traditionally practiced by physicians and the equally problematic "maternalism" practised by nurses. Without*

question health care professionals well into the second half of the 20th century regarded and responded to their patients as if they were parents providing care to childlike patients. This parentalism was no simple arbitrary imposition of professional power over the lives of patients. It was a complex process in which patients – who were scared and sick – often desperately sought out providers who would take care of them and make things all better again. It was a process in which provider and patient engaged in an elaborate, mutually reinforcing, inherited and unexamined charade. The self-interests of the provider were carefully hidden away behind the myth that health care providers always and only seek to advance the interests of their patients. Pervasive uncertainty and the fallibility of the provider were hidden behind the masks of authority and competence. Patients were asked and expected to trust in the goodness of providers. It was assumed that part of the calling of the health care provider was to take on the burden of responsibility so as to preserve the patient's hope and protect him or her from the crushing, awful knowledge of the inevitability of suffering, disability, loss of function, and untimely death. It was assumed that the only road to healing required that patients place themselves in the hands of benevolent providers who both knew and would do what was best. Good patients, like good children, passively obeyed and complied with the orders of parental caretakers (Bartholome 1992).

Bartholome argues that the "elaborate charade of parentalism is now breaking apart" for a number of reasons and that "the era of the provider knows best has come to an end". (Bartholome 1992) One must acknowledge that parentalism does imply a relationship with a health consumer however it bears no relationship to a partnership given the overt power imbalance. While it may be based on beneficence or doing no harm, parentalism removes the person from the 'patient'. He argues that the "use of the term patient compliance may soon become a sign of profound misunderstanding about and disrespect for the essential role of the patient in decision making" (Bartholome 1992).

The decline of the provider knows best era is also becoming evident in the rise of the research and literature around preventable adverse events and error in health care. There is the increasing recognition that health professionals and health services do not always know best; that not all treatment and care for consumers has been always based upon the best scientific evidence; and that people are exposed to significant risks when intersecting with the health system. On the other side of the coin is the situation where the treatment and care may be evidence based but the consumer is essentially bullied into having the treatment by clinician (doctor, nurse or allied health professional) exerting their influence and taking advantage of the imbalance of power created by fear, lack of knowledge, alien environment or other factors. They may have chosen, with full information and feeling empowered to make their own choice, not to have the treatment recommended and choose an alternative path of care or palliation.

The way that health services have been organised - generally with the needs of the health providers as the primary concern is another manifestation of this parentalism in the health system. No consumer would suggest that a hospital was intuitively designed to first meet their needs and secondly for providers.

There has been another shift in the way that consumers intersect with the health system in the past two decades as the provision of health care to individuals has gradually ceased to be seen as solely the domain of the independent medical practitioner, capably assisted by nurses and therapists following their orders. A person today using health services invariably is exposed to a multifarious network of professional personnel (not just medical), with a broad range of knowledge skills and experience, performing complex caring, diagnostic, therapeutic and monitoring roles that would be impossible to be managed by an individual practitioner, however clever.

Collaborative partnerships between the health professionals and other members of the health workforce need to be built around the recognition that the provision of health services should be looked at as a continuum of care for the

consumer rather than the emphasis being placed upon the vertical professional silos and support groups, and the discrete services that they offer. This notion of continuum of care, based as it is upon the health consumer's conceptual horizontal journey through the health system has been largely rhetorical in the past but if it is to become a reality, does require a significant shift in thinking. Governments are espousing it. Funders are articulating it. Health consumer groups are demanding it. Services are beginning to respond to it. However, we have a long way to go.

RCNA is of the view that there is a need to re-look at the health workforce from this different perspective. A consumer driven health system asks the question 'what are the needs of the consumer?' And secondly, 'What are the requisite set of knowledge, skills and experience that are needed to meet these needs?' A provider driven workforce has a propensity to focus on 'this is my profession's patch and this can only be done by an x professional'.

In focussing upon the health needs of the community rather than the traditional 'turf' claimed by each professional group there may be an opportunity to realign the way that the health system operates – around its true *raison d'etre*.

RECOMMENDATION 1:

That incentives be explored and introduced in order to:

a) move the focus of the health system away from the competitive provider driven culture to a consumer focussed, consumer driven culture, and
b) have a focus on skill sets in health professionals predicated on responding to needs of the consumer.

7. Quality and Safety

As noted above questions about the quality and safety of health care and the risks to health consumers have come into sharp relief since the research done over the past fifteen years. For example: the Professional Indemnity Review (Tito 1992; Tito 1994; Tito 1995; the Quality in Australian Health Care Study (Wilson, Runciman et al. 1995; Wilson, Gibberd et al. 1999; Wilson, Harrison et al. 1999; Wilson and Van Der Weyden 2005); and equivalent studies in the USA (Brennan, Leape et al. 1991; Leape, Brennan et al. 1991); New Zealand (Davis, Lay-Yee et al. 2002; Davis, Lay-Yee et al. 2003); the United Kingdom (Vincent, Neale et al. 2001); and Canada (Baker, Norton et al. 2004). This requires bold and broad re-evaluation of health policy to ensure that all safeguards are in place to minimise the risks and learn from previous errors and 'near misses', not tinkering around the edge of existing health policy. The way that the health workforce is planned for, organised and regulated, is an integral part of this process.

The harm and costs of adverse events to health consumers and the community more broadly have exceptionally high social and economic costs to society.

Poor relationships within a clinical team; lack of respect; and failure to communicate effectively between members within a clinical team are widely acknowledged to be important root causes of unsafe health care for consumers. Having members of different 'tribes' in these clinical teams is fraught with the same potential for power plays, discrimination and alienation that are a feature of human behaviour across the globe and back through the annals of time.

The following is an excerpt from the NSW Health Care Complaints Commission Report on the investigation into Campbelltown and Camden Hospitals in 2003:

Relationships and communication within and across clinical teams

Of the 47 clinical incidents examined by the Commission, team communication was identified as a possible issue in 14 cases. A feature of a number of these cases was the lack of collegiality or effective communication within the group of clinicians responsible for the care of patients within a clinical unit.

This is symptomatic of poor team work……Teamwork is defined as a cooperative effort by members of a team to achieve a common goal. It is increasingly evident that improved teamwork can have a profound impact on patient care in the acute care setting. It is especially important in an acute care setting as there is often no opportunity for lengthy discussion of differences – a multidisciplinary approach to patient care must be driven by a common understanding of collective objectives to be effective……..

The impression of MHS developed by the Commission is that, as in many health services, the professional groups have not shown that they can share completely the collective objectives of providing safe, quality care to patients and develop a culture of cooperation, collegiality and effective communication strategies to achieve that goal. Until they do, patients will remain at risk, relying on the earnest best endeavours of individual clinicians brokering one-off relationships with other individual clinicians.

It is imperative that the health system develops strategies to improve the relationships and communication between the individuals and professional groups that make up clinical teams. They need to focus on safe quality care for the patient rather than on defending the boundaries of each profession's roles (Health Care Complaints Commission 2003).

Good relationships are founded on mutual understanding and respect for each other's contribution to achieving team goals. However, like any relationship these need strong foundations and constant vigilance and effort to maintain them.

RECOMMENDATION 2:

That strategies are developed and implemented by employers and educational institutions in order to improve the relationships within and across multidisciplinary teams in order to improve the quality and safety of care provided to consumers.

8. Competence and Skill Mix

PRINCIPLE 4:
Cohesive action is required among the health, education, vocational training and regulatory sectors to promote an Australian health workforce that is knowledgeable, skilled, competent, engaged in life long learning and distributed to optimise equitable health outcomes.

Principle 5:
To make optimal use of workforce skills and ensure best health outcomes, it is recognised that a complementary realignment of existing workforce roles or the creation of new roles may be necessary. Any workplace redesign will address health needs, the provision of sustainable quality care and the required competencies to meet service needs (Australian Health Ministers' Conference 2004a).

Rather than an emphasis being placed upon professional boundaries, the emphasis shifting to competence and skill mix in the health workforce would be a refreshing change.

Many opportunities for common preparation and ongoing professional core educational modules exist, yet few appear to be being taken up by the university and technical education sectors in a collaborative and cogent way.

Current attitudes are also preventing the roll out of practical and beneficial models of care such as the following:

Imagine a rural town where a multi GP practice has shrunk to only one GP who after toughing it out for a few years is seriously thinking about leaving the town also. The community has advertised extensively and has contributed significant incentives to the salary package, such as a rent free home, payment of school fees for children in the city, regular flights back to place of origin etc.

Life changes dramatically when funding arrangements enable the practice to collaborate with the local health service to incorporate nurse practitioners. A mental health nurse practitioner, two primary care nurse practitioners and a midwife practitioner mean that the GP only has to be on direct call one in five days after hours and is only called on the other days if assistance is required with a clinical problem outside the expertise of the nurse practitioner on call and the other primary care nurse practitioner(s).

The community now has specialist care in mental health and midwifery and the GP is supported in these two

very important areas of clinical practice. The pace of consultations has also reduced from frenetic to reasonable with the assistance of the two primary care nurse practitioners sharing the burden.

The GP is even considering a holiday, her first for many years. Locums are now lining up to work for a few weeks in this practice.

The social and economic benefits of more integrated care teams to promote good health and reduce the impact of ill managed disease and injury are profound. The research that has now been conducted in most states and territories in Australia on the role of nurse practitioners highlights this (NSW Department of Health 1995; Department of Human Services (Vic) 1999; ACT Health and the Nurses Board of the ACT 2002; Department of Health Western Australia 2003) and rebuts the presumption that only medical practitioners have the knowledge, skills and experience to practice autonomously and provide safe, accessible, high quality care to people across primary care and a wide range of specialised clinical areas.

Other health professionals – nurses, midwives and allied health professionals prepared to level of competence and working with other health professionals with complementary skills also provide great potential for innovative care models. Mental health and drug and alcohol services are two areas where evidence of this is more apparent than in other areas of the health system.

The subsequent struggle to introduce nurse practitioners into communities and health services has been accompanied by the most extraordinary propaganda campaign on behalf of the Australian Medical Association and demonstrates the competitive and cultural divide that currently exists between the health professions dressed up in the emotive language of safe high quality care being compromised.

As noted above, RCNA is of the view that there are opportunities for collaboration across traditional professional and other workforce groups in their

educational preparation that may assist in breaking down some of the bias, barriers and misconceptions that go to creating elitism and silos.

In line with the discussion above, RCNA also supports strongly the possibility of the:

> ……*complementary realignment of existing workforce roles or the creation of new roles may be necessary. Any workplace redesign will address health needs, the provision of sustainable quality care and the required competencies to meet service needs* (Australian Health Ministers' Conference 2004a).

However, RCNA **does not** support the introduction of new roles or redesign of roles that are primarily intended to make budgetary savings at the risk of compromising the safety and quality of care for health consumers, nor when the action is being taken to get around traditional industrial safeguards and benefits for any group. Principle 7 clearly espouses the need for collaboration with all stakeholders in health workforce policy development and planning. It should not be a competition to outwit one group or other. (Australian Health Ministers' Conference 2004a)

Recommendation 3

That, in relation to new roles:

a) the Nurse Practitioner role, now validated by extensive Australian and international research, be recognised and further developed as an integral part of the health professional workforce, and
b) their introduction should take place following assessment of the current workforce roles, and especially exploration of the broad scope of nursing practice, in the interests of consumers and the utilisation of educational resources.

9. Jurisdictional Barriers to a Rational Health Workforce

Because nurses have a desire to, and are educationally prepared to be able to provide high quality nursing care, RCNA is of the view that health and aged care systems:

- are first and foremost centred upon the health needs of the Australian people;
- involve those people actively in decision making in health policy and resource allocation;
- are properly funded, universal and well coordinated;
- truly value people and the nurses and other members of the health workforce who care for them; and
- support a skilled and sustainable health workforce (Iliffe 2004).

RCNA perceives that these goals are currently not being met across the Australian health system. While there is regular rhetoric about Australians having access to one of the best health care systems in the world, Australians are increasingly becoming aware that their health care system is unreliable at times, and at other times, dysfunctional. Public hospitals have major problems because of ever-increasing demand, lack of funding, and shortages of appropriately skilled health professionals. The essential continuum of care that should link primary, community, aged care and hospital services is made all but impossible because of the jurisdictional inefficiencies associated with the poor relationships between the Australian Government and the State and Territory Governments.

Little has changed since 1999 when Duckett said:

> *Government responsibility for health and community services in Australia is shared between the Commonwealth and the states. Unfortunately, this sharing is not done in a consistent and coherent manner, and it is difficult to develop comprehensive national policies in this area. The state responsibility for hospital services, the Commonwealth responsibility for medical services, the joint responsibility for home and community care projects, and the divided responsibility for disability services, render*

coherent policy-making at the state level almost impossible (Duckett 1999).

Health workforce policy particularly, is high risk when different health professional groups are slotted into jurisdictional enclaves. For example: general practitioners and private medical specialists are very much within the Australian Government domain through the Medicare funding mechanisms; while the nursing workforce is very much within the state and territory funding and regulatory responsibilities.

Some of the direct impacts for health consumers and the health workforce that are attributable to this lack of rational policy include:

- General practitioners are undertaking little after hours work.
- Hospital emergency departments are becoming defacto primary care centres placing enormous pressure on those services.
- Lack of coordination of care for people with chronic and multiple health requirements across mental health, primary, acute, rehabilitative, disability and aged care services.
- Inadequate access to dental care is significantly impairing the overall health of people unable to afford private dental services.
- Personal finances and capacity to pay are increasingly becoming a major determinant of health care and health outcomes.
- Shorter stays result in a greater turnover of people with more complex care needs. The effect on hospital staff is increased workloads, no downtime, greater stress with admissions and discharges, let alone more complex care requiring greater alertness and vigilance. Figures from the AIHW clearly demonstrate the increased workload for nurses with higher levels of patient separations and days per full time equivalent nurse (Australian Institute of Health and Welfare 2002).
- Nurses are frequently being required to provide care with inadequate material resources and in situations where, it could be argued, they are in danger of breaching their own professional standards and duty of care. For example, people waiting or being treated on trolleys in corridors because

there are no available beds. This is not the kind of environment where nurses are happy to provide care, yet they often have no other alternative. This leads to low staff morale and more nurses leaving the system.

- The discharge of people requiring more complex care has put a strain on community resources which they are unable to meet. This is resulting in poorer health outcomes for people and placing a greater burden on families to provide the care (for example, early postnatal discharge, failure to establish breast feeding). The issue is not the desirability or otherwise of early discharge, but the inadequacy of community resources for appropriate follow up. Nurses are often placed in a situation where ethically they do not want to discharge people because they know they will not be able to access the community care they need, however pressure is being placed on them to discharge as the bed is required for a more acute admission.
- Staffing levels are reduced, ostensibly to save costs, which increases workloads and gives rise to increased rates of adverse outcomes, occupational injury (stress, needle stick injury, back injury), sick leave and staff turnover. Increasing numbers of nurses are leaving the profession or choosing to work part time or casual in an effort to control their workloads. This puts an even greater strain on those nurses that remain as full time workers as they are constantly orienting new staff unfamiliar with the environment or picking up workloads for new staff who are unable to perform high level functions.
- The predicted and serious future nursing workforce shortage, because we are not educating sufficient nurses to replace those who will be retiring from the sector over the next 10-15 years, will impact directly on the health and wellbeing of the Australian community yet nursing is not 'owned' or respected at the Australian Government level (Consumers' Health Forum of Australia 2004; Dwyer 2004a; Australian Nursing Federation 2005; Bryant 2005).
- The duplication in regulatory authorities with each of the states and territories replicating the health professional registration process for each of their registered health professionals. In some states and territories the

numbers in each professional group are so low that, as well as the financial costs of duplication, there are also significant issues of conflict of interest.

Added to that mix is the Australian Government responsibility for aged care; and the profound health inequities for Aboriginal and Torres Strait Islander people, and there is a potent brew for the political melting pot. Even the current Health Minister has been driven to describe the Australian Health System as a "dogs breakfast" and one that has too often been put in the "too hard basket" (Dwyer 2004b).

The failure to broker any real reforms in the health system under the most recent Australian Health Care Agreements was a major disappointment and will inevitably have a major impact on nursing and hence the community who require nursing care, unless reform can be generated from another source.

The percentage of nurses over the age of 45 continues to increase (17.5% in 1986; 30.3% in 1996; and 37.3% in 1999; 41.7% in 2001), while there has been no improvement in the percentage of nurses under the age of 35 (33.3% in 1995; and 24.7% in 2005). The allocation of additional undergraduate places for nurses in recent federal budgets, will have little impact when over a third of nurses will be contemplating retirement within the next 10-15 years. In raw numbers, that equates to nearly 70,000 nurses! What will the impact be upon the community (Australian Institute of Health and Welfare 2002)?

RCNA is strongly of the view that there are considerable disincentives to achieving the goals of consumers and the health workforce with the current dysfunctional relationships that exist between the different levels of government in Australia. Lack of trust, overt cost shifting and little cooperation and coordination in cogent policy making, funding arrangements, service planning and service delivery are features of the existing health system in Australia.

The complexity of the current system and lack of rationality in the roles and responsibilities of the three layers of government in Australia in relation to the health workforce warrants urgent attention, debate, innovation, commitment,

effective reform and investment to be able to meet the challenges posed in the recent Report *Economic Implications of an Ageing Australia* (Productivity Commission 2005a).

In 1992 the National Review of Nursing Education made the following observations that hold true, not just for nursing, but across the health system:

> *Despite the progress and the important role nurses have had in caring for the Australian people—whether in the cities or in rural and remote settings, where they often form the front-line of health care—there are a number of barriers to nursing development. Many of these flow from the fragmentation brought about by different policy and funding responsibilities. These barriers need to be removed and replaced with a more coordinated national approach.....*
>
> *.....Given the number of players with different responsibilities for diverse but intertwined elements of nursing, Australia will need to develop collaborative partnerships at all levels to make progress in many of the problem areas faced by nursing today, and to plan and respond to future challenges. At present there is little opportunity for this to occur in a way that interfaces all the different interests. We believe it is in the national interest to promote arrangements that bring together the Commonwealth, State and Territory health and education interests, nursing bodies, and the range of service providers, including government and non-government, that represent the different contexts in which nurses work* (Department of Education, Science and Training or the Department of Health and Ageing 2002).

Until we do achieve some level of commitment to consistency and cooperation across the health system in relation to broader health policy as well as health workforce policy, the current crisis management approach to single issues, will continue to suck up valuable resources that could be much better invested in improving the health of Australians.

Recommendation 4

That, to address current jurisdictional barriers, there be:

a) more integration across jurisdictions to allow for planning and roles within the health care system,
b) a strong nursing focus at national level to co-ordinate the nursing workforce, and
c) mechanisms put in place to ensure work around national consistency (such as that being done by the National Nursing and Nursing Education Taskforce) is implemented across all jurisdictions in a sustainable manner.

10. National Self Sufficiency in the Health Workforce

PRINCIPLE 1:
Australia should focus on achieving, at a minimum, national self sufficiency in health workforce supply, whilst acknowledging it is part of a global market (Australian Health Ministers' Conference 2004a).

RCNA applauds the inclusion of this principle in the National Health Workforce Strategic Framework. While nurses and other health professionals have always been very mobile professions because their knowledge, skills and experience are highly valued across the globe, there are significant ethical conflicts in the aggressive recruitment campaigns that a number of Australian jurisdictions have run to attract health professionals from other countries.

This can have catastrophic impacts upon the health workforce, particularly of developing countries where the health challenges are often extreme and the numbers of health professionals are already stretched to deal with them.

While the shortages of health professional in the Australian workforce are having profound effects, it is difficult to support the aggressive techniques used by recruitment agencies, particularly in these countries where the remuneration and conditions available in Australia can be seen as a windfall.

The International Council of Nurses has issued a sage position paper in relation to nursing career moves and migration. (International Council of Nurses 2002) In this document they outline an Ethical Framework for Nurse Recruitment based upon 13 key principles:

> *ICN denounces unethical recruitment practices that exploit nurses or mislead them into accepting job responsibilities and working conditions that are incompatible with their qualifications, skills and experience.*
>
> *ICN and its member national nurses' associations have called for a regulated recruitment process based on ethical principles that guide informed decision-making and reinforce sound employment policies on the part of governments, employers and nurses, thus supporting fair and cost-effective recruitment and retention practices.*
>
> *These key principles include:*
>
> 1. *Effective human resources planning and development*
> 2. *Credible nursing regulation*
> 3. *Access to full employment*
> 4. *Freedom of movement*
> 5. *Freedom from discrimination*
> 6. *Good faith contracting*
> 7. *Equal pay for work of equal value*
> 8. *Access to grievance procedures*
> 9. *Safe work environment*
> 10. *Effective orientation/ mentoring/ supervision*
> 11. *Employment trial periods*
> 12. *Freedom of association*
> 13. *Regulation of recruitment* (International Council of Nurses 2002).

Implicit in these principles is the fact that there are other risks in importing large groups of health professionals to fill work force vacancies such as the differences in culture and educational preparation across international borders. Critically, there is often the inability of the Australian employer to support the

individuals adequately: exposing health consumers to risk; and leaving the health professional culturally alienated and being unable to meet consumer needs, ultimately leading to the possibility of regulatory censure being taken as the standards of the profession in Australia are not met.

Recommendation 5

That Australia seriously addresses the issue of sufficient provision of health professionals to sustain workforce needs into the future, in terms of: undergraduate supply, those employed, and potential re-entering supply.

11. Conclusion

PRINCIPLE 2:
Distribution of the health workforce should optimise equitable access to health care for all Australians, and recognise the specific requirements of people and communities with greatest need.

PRINCIPLE 3:
All health care environments regardless of role, function, size or location should be places in which people want to work and develop; where the workforce is valued and supported and operates in an environment of mutual collaboration (Australian Health Ministers' Conference 2004a).

Equity for health consumers and equity for the health workforce are two important goals and must be prominent in any reform initiatives recommended.

In this submission RCNA has made much of the traditional hierarchy and culture of the health system and the barriers and disincentives that will challenge workforce reform. However, with the ageing of the health workforce, particularly those undertaking nursing work, there is an imperative to take urgent action.

While the potential change that is needed may be significant, RCNA agrees with the proposition in the Issues paper that:

> *… introducing change on a broad front can be especially useful in reducing resistance to change. Specifically, by offsetting losses for particular groups from one policy change with gains from others, broadly-based reform 'internalises' transitional costs and makes it more likely that most groups will benefit in overall terms* (Productivity Commission 2005b).

In the course of the Inquiry RCNA submits that all aspects of the health workforce need to be considered, even those considered to be 'sacred cows'. Indeed it is these that will be the most difficult to tackle and while RCNA acknowledges that the Australian health system is complex, pluralist and diverse in both service delivery and consumer expectations, it is essential that the status quo does not prevail.

RCNA would be pleased to assist the Commission in any way it can in the course of its work in this area over the coming months.

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