Submission

The Health Workforce
Productivity Commission Issues Paper

CHAMBER OF COMMERCE AND INDUSTRY

WESTERN AUSTRALIA

Introduction

About CCI

The Chamber of Commerce and Industry of Western Australia (CCI) is one of Australia's largest multi industry business organisations. CCI represents small to large businesses across a diverse range of industry sectors.

CCI Mission

CCI exists to serve its Members by:-

- Providing quality cost-effective support and services to help members build their business; and

- Lobbying government to promote an economic and legislative environment that encourages the development of responsible private enterprise.

Member Profile

CCI represents almost 5,000 private organisations large and small, in most industries across WA. CCI membership is open to businesses of any size across all industries. At present, over 11% of Members are in the health and community services industry sector.

Health Care Industry

The provision of quality cost-effective health care is a major priority of private health care providers around Australia. Adequate staffing of all occupational groupings is an essential component of health care delivery with just under a third of all nurses and allied health staff, both nationally and in Western Australia, employed by the private sector. The majority of these staff work in acute/psychiatric hospitals or aged care.

CCI welcomes the "The Health Workforce", Productivity Commission's Issues Paper ("the Issues Paper") examining issues impacting on the health workforce including the supply of, and demand for, health workforce professionals, we support the overall direction of the Issues Paper, agree with many of the current problems described and accept a number of the proposals put forward for change. We describe in this response our preliminary observations ahead of the Draft Report and look forward to making a more extensive submission on the draft later this year.

We note at the outset that shortages are not confined to the nursing, medical and allied health workforce but are also beginning to affect our members in the recruitment and retention of other employees such as third level carers.

We have grouped our responses to the issues identified within the paper under five broad headings described below.

Absence of co-ordination from the State and Commonwealth Governments to collect and share data for strategic workforce planning.

It is not disputed that the effective delivery of health services requires appropriate and coordinated input from governments, planners, educators and trainers and public and private service providers and funders. The shortcomings raised in the Issues Paper from lack of coordination are supported.

They include the tendency for planning to occur in a vacuum, ineffective coordination between governments at the planning phase, ineffective coordination and conflicting incentives between aspects of education and health services delivery and ineffective coordination between education providers in institutional and clinical settings and with those responsible for funding post-graduate clinical training.

RECOMMENDATIONS

CCI recommends a visible high-level strategic workforce planning council be established with a broad mandate to assess trends for resource allocation and demographics facilitating a system for ongoing planning of future resources across the industry. It should review funding allocation models and must include all stakeholders including government, health service providers and educators operating in or in connection with the health industry.

The council should include within its mandate, exploration of the relationship between rates of pay and conditions of employment paid to employees (including medical practitioners and specialists whether directly employed or not) and the recruitment and retention of employees in all occupational groups and especially in the professions.

Lack of connectedness between all of the contributors to the provision of health services including State and Commonwealth Governments, public and private sectors and education and training providers.

The lack of connectedness has lead to dysfunction, duplication and poor delivery of service. The Issues Paper describes many of the problems under a banner of “Tensions in current arrangements”.

Leadership from the Commonwealth is needed for the development of a culture of cooperation and collaboration in which all participants are recognised as partners. Examples of the problems caused by the lack of “connectedness” are described below.

Conditions of Employment

The nature of awards and enterprise bargaining in a competitive environment enables people in short supply such as doctors and nurses to work increasingly limited hours on relatively large incomes. There is no cohesion between the sectors in terms of discussion about rates, affordability to the community and the impact of higher rates on productivity levels including hours worked and availability of labour.

Utilisation of skills – Nurse Practitioners

While nurse practitioners are generally regarded as a short term solution to the larger problem of a shortage of doctors and nurses, in managing the current problems many operators in the aged care sector would employ a nurse practitioner in areas where general practitioners are in short supply. However, a nurse practitioner will not have access to medical benefits schedule item numbers and as a result the cost to the aged care facility of purchasing drugs would be significant. So while the State Government has provided the enabling legislation by amending the *Nurses Act 1992 (WA)* to provide for the employment of nurse practitioners the Commonwealth Government will not grant access to item numbers and as a result the aged care industry in Western Australia loses a significant opportunity to fill the gap caused by lack of service by general practitioners.

Training of specialist medical practitioners

The Issues Paper describes an increasing proportion of acute hospital care being provided in the private system and discusses the benefits provided by the latter. It goes on to suggest that the greater provision of acute care within the private hospital system is reducing the time that specialist practitioners can devote to clinical training within the public hospital system. This leads to suggestions of an inevitable redistribution of the training load in the future.

While the private sector in Western Australia is already engaging in the training of specialist practitioners and is prepared to participate in discussions towards an ongoing role for the private sector in such training, a better interface between all sectors is needed to resolve a range of issues such as funding that will limit real cooperative initiatives.

Lack of uniformity of Regulations

We support the comments made in the Issues Paper about the inflexible regulatory arrangements. In particular, the inflexibilities brought by rigid demarcations within and between workforce groups are often reflected in and reinforced by prescriptive government and professional regulatory arrangements. The result is a reduction in the scope of service providers to fully utilise their workforce and leads to a loss of flexibility and responsiveness of the workforce to technological advances and changing models of care. In some cases a more flexible approach to regulation of actual work demarcation will deliver better outcomes for service delivery.

Effective coordination by all state authorities for a single streamlined approach to professional regulation will also reduce restrictions in employment and enhance the scope of service providers.

In relation specifically to nurse registration, the benefits gained from consolidation of professional requirements across States and Territories or national registration requirements would outweigh any potential benefits from jurisdiction divergence such as opportunities for policy learning or a movement towards a "lowest common denominator". In other words, a national uniform approach has far more benefits than possible opportunities to be gained from maintaining separate requirements in each State and Territory.

Poor usage of public hospital bed capacity

The lack of a culture of collaboration and willingness to cooperate to resolve issues for residents of nursing homes leads to costly and avoidable visits to acute public hospitals. Collaboration between sectors could result in better training of staff in all sectors of health delivery and management issues to reduce costly hospital stays, achieve better health outcomes for elderly residents and higher levels of job satisfaction for employees.
The lack of confidence held by public hospital staff in nursing home staff is often misplaced and leads to missed opportunities to capitalise on existing skills; problems caused by poor communication and lack of relationship building between the sectors.

Provision of clinical training experience

Ineffective coordination between education providers in institutional and clinical settings and with those responsible for funding clinical training has not only contributed to mismatches between the numbers requiring clinical training and the places and resources available to conduct the training but also to poor experiences for many students.
Where resources are insufficient there is often a lack of preceptoring and support for students leading to unsatisfactory experiences and sometimes an exiting from the profession.

RECOMMENDATION

CCI recommends and advocates for leadership to be taken by the Commonwealth to sponsor and promote a new culture of collaboration between stakeholders. Private sector providers in WA who are members of CCI are committed to the overall principles and strategies articulated within the National Health Workforce Strategic Framework and keen to actively participate in collaborative partnerships that could be developed to advance progress in specific areas.

Education and Training issues

Generalist versus specialist training

While there is a need for some specialist education and training (the areas of shortage are noted) there is an equally great need for generic education and training upon which specific skills can be built. With the emerging shortages in so many areas of the workforce generalists will be increasingly relied upon.

At the same time, decreasing the number of specialists will drive up the cost of specialist services and create a greater disparity between the cost of the GP and the cost of a specialist. In relation to specialities in nursing, consideration needs to be given to the high cost of post-graduate courses which has become a strong disincentive to potential students.

In relation to nursing education in particular, the existing comprehensive nurse training programmes are a good example of successful nurse education and should be continued because it has successful application to all industry sectors albeit the attrition rate in the first year of entry into the workforce is too great.

By contrast, very specialised training such as direct entry midwifery, whereby a nurse is educated for midwifery only and not in general nursing skills, has more limited application to very large metropolitan hospitals. Such courses, if approved, should be confined in a way that ensures graduates are few in number. The appropriate number needs to be determined with industry input as part of the strategic workforce planning framework already mooted.

In addition, a specific strategy needs to be developed to cater for the needs of regional and rural Western Australia where vast distances and remote locations create even more complex problems for health care delivery. If midwives are not trained in both general and specific midwifery skills, a serious diminution in both numbers of midwives employed and service delivery will result.

We believe it is necessary to rethink training for the allied health professions towards including general therapy components for all of the therapy professions and therapy assistants.

Clinical Placements

There continues to be tension between education and health service providers for clinical training places because of insufficient resources to conduct training.
Health service providers continue to seek mentor and preceptor support and clearly targeted clinical placement programs for all students from education providers.

Nurse Graduates “work-ready”

The matter of whether nurse graduates should be “work-ready” when they graduate is no longer as relevant as it was when the universities commenced nurse education. This is because the larger employers, who are also those sought after for initial employment by graduate nurses, have in place well established graduate programs. However, there is a concern about the readiness and ability of many overseas graduates from non-English speaking countries because of poor English language skills and therefore an inability to effectively communicate with patients.

In addition, the reliance on large employers to provide training disadvantages smaller employers who are not able to attract graduates.

However, in the changing health environment in which resources are reducing increasing pressure is likely to be felt by graduates for their service when they enter the workforce

and as a result consideration should be given to new methods such as combining education with paid work as detailed below.

New education models

With the advancing age of the nursing workforce there is an urgent need for consideration to be given to innovative methods of educating doctors and nurses and removing artificial barriers imposed by Medical Colleges. One means of addressing both the impending critical shortage and providing an income to students is to incorporate paid work into nurse education programs. For example, during the final 6 months of the program the student could be treated as a full time employee of the workforce in the same way as teachers currently do in certain states such as Western Australia.

The benefits of this model are more clinically competent students at the end of the program. Legislative barriers should not restrict initiatives in this area.

Length of Education and Training programs

We support programs for all professions at an appropriate length to be determined by the necessary body of knowledge needed to be attained to enable proper and effective practice in the relevant profession. This includes both practical and theoretical components and should not be time-honoured.

With the above principles in mind it is possible to significantly modify the structure of many programs, reducing the length without compromising content. This should not only reduce the cost of training but also enhance total opportunities for students.

In addition, a combination of encouraging participation in the paid workforce during the formal education period as discussed above may assist with both student preparedness, student income needs and workforce issues.

Collaboration for engagement of private sector

As discussed earlier a collaborative approach is necessary to ensure that the private sector continues to be engaged in providing training for medical specialists to ensure supply of medical practitioners and specialists appropriately trained and familiar with the use of emerging technology now available in the private sector.

Industry Focus needed

University education needs to develop a genuine focus on industry needs and have a greater preparedness to flexible and adaptable structures and delivery of courses to industry and client requirements including examining the feasibility of total course delivery on site.

RECOMMENDATION

CCI recommends a process and structure be established for formalised dialogue between all stakeholders to progress initiatives recommended in each of the areas listed above.

Scope of Roles

Whole of workforce approach

The shortage issues raised in the Issues Paper relate to all occupational groups and present problems and challenges for each group. The resolution should not be managed by looking only at single groups although that is also needed. It is important to examine the workforce from a "whole of workforce" approach to ascertain whether current roles for one group are appropriate within the entire group.

For example, nurse practitioners may have a role in anaesthesia as promoted in the Issues Paper and they may also have a role in rehabilitation but such roles cannot be considered in isolation from the medical workforce. Further, if such roles were to be developed for nurse practitioners their training needs to be inclusive of limits to their role.

Other roles may also be appropriate for nurses or allied health staff. Allied medical personnel could undertake some of the less complex roles of the doctor but within certain procedures and with specific training.

In addition, with appropriate levels of training and support, enrolled nurses may be able to undertake greater levels of responsibility in, for example, dementia care and rehabilitation care.

Given the fact that in excess of 60% of public hospital patients are elderly, some valuing and educating for "age friendly" behaviours among public hospital staff may result in better outcomes for patients and more rewards and increased job satisfaction for staff.

Nurse Leadership needed to tackle traditional nurse roles

Nurse leadership and a collaborative approach between all stakeholders is needed to address a number of problems in the nursing workforce to encourage nurses to take advantage of new roles and opportunities and reduce rigidities in the workforce.
Examples of the problems are the fear by nurses of "letting go" of traditional roles while seeking greater levels of specialisation and greater involvement in higher technology, reduced valuing of hands-on "essential nursing care" by highly skilled nurses, diminishing levels of loyalty to the employer and to the patient and reduced continuity of care to patients.

Use of technology without compromising essential nursing care

A range of different technology can be utilised in nursing homes, private homes and GP surgeries over relatively low risk interventions to assist reduce travel time by GPs and other time consuming activities in the nursing home or in the community dealing with a resident's case involving possible multiple morbidities and interactions with families. Simple but complex technology used strategically can alleviate visits to hospital and result in significantly fewer interventions and greater levels of satisfaction for both clients and also staff.

Role of Nurse Practitioner

As already discussed, nurse practitioners may be used as Consultants, for example, in aged care provided the Commonwealth is prepared to support trial arrangements (to demonstrate that costs can be contained) for access to Medicare provider numbers thus facilitating improved service for elderly residents of nursing homes and a reduction in hospital visits.
Distortions in funding mechanisms across governments and between public and private sectors can lead to undue focus on cost containment rather than on matching appropriate workforce skills to health needs and associated redesign of jobs and careers paths. An example quoted refers to limitations on Medicare provider numbers.

Generalist versus specialist roles

Reducing staff numbers means there is an inevitability for generalist over specialist skills. Further, regionalisation will be less effective if there is an emphasis on specialisation due to specialised staff tending to be concentrated in metropolitan areas.

The comments we made earlier in this paper in reference to education and training issues are pertinent. It is vital that generalist skills be further developed not only as a means of containing costs but also to maintain service levels.

Utilisation of skills

The Issues Paper mentions a number of areas where care could be undertaken by someone other than the person who was traditionally educated or trained to undertake the duty. For example, it discusses the idea of paramedics, allied health staff and nurse practitioners undertaking some of the “less complex” work of the medical practitioner.

As a general principle we support the upskilling of nurses and allied health professionals to relieve medical practitioners to enable them to concentrate on higher level health care delivery.

We support in principle some reallocation of tasks and examining traditional methods for more flexible methods of operating where appropriate.

Consideration should also be given to utilising practice nurses to relieve general practitioners. Medicare incentive numbers for provision of routine interventions by practice nurses would assist.

A number of other issues such as medical defence would need to be addressed.

Part-time employment significant

The limited supply of doctors, nurses and allied health professions will be exacerbated even further in the future by the trend for part time employment as part of a preferred life style choice. Industry employers are already negotiating attractive remuneration packages and incentives to encourage employees in all groups to remain in their professions. Wages become an ineffective tool in resolving entrenched shortages.

RECOMMENDATION

CCI recommends that a whole of workforce approach be taken to reviewing all areas of clinical focus described above.

Consumer expectations

Consumer expectations about universal health care appear to be based on the false premise that the Medicare levy funds health care. While it is agreed that efforts ought to be made to condition expectations of consumers to manage costs, availability and supply of resources for health will be managed more effectively if depoliticised.

With support from the major political parties to redefine and reprioritise health care delivery and expenditure it will be possible to manage the limits in a more cooperative and cost effective way.

RECOMMENDATION

In the process the Commonwealth Government should educate the community about which services it can provide and which it cannot ensuring delivery of fundamental services for those genuinely unable to pay.

At the same time it must address issues relating to medical insurance and the gap between fees charged and insurance cover. The Commonwealth could make a requirement on doctors as part of Medicare to explain to a patient prior to the commencement of any treatment a full treatment plan including any anaesthesia, physiotherapy etc and all fees associated with every item of service. Full gap insurance should also be made available.