Submission

Australian Government Productivity Commission
Health Workforce Study

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The College of Nursing (incorporation the NSW College of Nursing) is pleased to provide this submission to the Australian Health Workforce Study.

We acknowledge that our comment is based largely upon our experience of the nursing workforce, however, in the broader social, political and economic climate, many of the challenges facing the nursing workforce[1] are shared not only by other members of the health workforce, but also by other Australian workers[2] (the ageing of the population; a demand for flexibility and a greater balance between lifestyle and work and; the trend towards multiple careers rather than one 'job for life').

We applaud the fact that this study aims to look at system-wide issues but contend that the system itself will reflect the broader socio-political context. We acknowledge the large body of quantitative research evidence on the health workforce but make the following comment from a perspective that calls for similar attention to the personal, contextual and cultural tensions involved in 'looking at new ways to meet old objectives' (Issues Paper p.42).

LACK OF COMMUNICATION AND ACTION

The Issues Paper (p.10) identifies the lack of action in implementing recommendations from the extensive range of previous workforce studies. We believe the effect of this inaction on the general attitude of the health workforce has not been fully considered. Similar to other sectors of the health workforce, the nursing workforce (both in Australia and overseas) has been extensively investigated, evaluated and researched over the past 10 years. As a result, nurses have become increasingly skeptical of workforce investigations. Study 'fatigue' combined with the lack of action on recommendations and current poor working conditions has the potential to

[1] NSW Health Department Nursing Branch. NSW Nursing Workforce Research Project 2000. Available URL www.health.nsw.gov.au/nursing/publications.html

[2] Andrews K, Curtis M. Changing Australia. Social, cultural and economic trends shaping the nation. The Federation Press. Sydney 1998.

erode enthusiasm for change. Change management strategies are required to complement future workforce redesign initiatives.

We strongly agree (Issues Paper p.28) that the proliferation of intra-discipline studies has contributed to maintaining demarcations between various sectors of the health workforce and, has contributed to a lack of progress in workforce adaptation to changing health needs. It is timely that these intra-disciplinary studies are brought together under the one banner of the health workforce and that attention is given to the standardisation of data collections across disciplines to improve longer-term planning (Issues Paper p.28 & 38).

Improved communication with the health workforce is essential to changing established patterns of health care and driving change. For example, clinicians (by virtue of their direct care role and/or isolation if in rural or remote areas) are underrepresented in decisions about the health workforce as a whole. These decisions appear to have become the exclusive privilege of government, researchers and academics. All sectors of the health workforce need to be kept informed of developments and shown how these efforts have been translated into real action. Workforce reform must involve the workers. Effective change can only be achieved from the 'ground' up.

PREPAREDNESS TO CHANGE

There is no doubt that the current health workforce requires redesign to meet changing health needs and priorities. Part of this redesign will be about challenging the current definition of roles and approaches to education while maintaining appropriate levels of training for the level of care[3]. There have been significant innovations around implementing and evaluating alternate models of education and care, however, reform will also require a significant shift in the attitude and culture of a wide range of interest groups.

The recent protracted debate in New South Wales over the introduction of Nurse Practitioners provides yet another example of action to maintain the status quo (Issues Paper p.32). The extent to which nurses and professions other than medicine gain independent prescribing and practice rights is crucial to relieving workforce shortages. Unfortunately, role substitution appears only to be tolerated when the field is one that is not desirable to others (e.g. in rural areas or aged care). Paradoxically, General Practitioners have sought the introduction of Medicare rebates for care provided by Practice Nurses. While this undoubtedly increases the capacity and range of services a general practice can offer, it does little to address imbalances of power and control between disciplines.

[3] Duckett S J. Health workforce redesign for the 21st Century. *Australian Health Review* 2005;29(2):201-210.

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Similarly, nursing faces its own cultural challenge as traditional models of care are expanded to include a greater number of Enrolled Nurses and assistive health care personnel in the skill mix.

For all healthcare workers, clearly identifying the scope of practice for each new role is implicit in changing the boundaries around these roles. Moving health care workers to a collegial position in which they can identify the appropriate mix of skills (regardless of profession) to produce the desired outcome (the safe, efficient and effective provision of a service) will require significant time and more specifically, an impetus of significant magnitude to force change in long-held traditions and rituals surrounding health care.

RE-THINKING EDUCATION

In his article *Health Workforce Redesign for the 21st Century*, Stephen Duckett[4] proposes that 'incremental change in the educational preparation of health care workers is probably no longer an appropriate response to the major challenges facing the health system and its workforce'. Expanding opportunities for inter-professional education has been raised as a solution to the education and training of a 'new-look' health workforce and for building effective multidisciplinary teams. In reality, the practical and organisational aspects of cross-faculty education can be daunting[5]. Increasing use of on-line instruction may assist in this regard, however, the success of this educational format and the outcomes of inter-disciplinary education are yet to be evaluated across professions or cultures. There is urgent need to determine whether alternate models of education will produce the outcomes desired in a future health workforce.

We also believe there is a significant amount of work still to be done in regard to looking at possibilities for articulation and co-ordination between existing tertiary and other programs, and in addressing the disparity between demand and the number of available training places (Issues Paper p.41 & 42).

The major reorganisation of faculties to accommodate inter-professional learning also requires motivation and support from staff. The attitudinal and cultural traditions of health professionals, faculty and students are identified as important obstacles in inter-disciplinary education[6,7].

[4] *ibid* p.201
[5] Sheets Cook S. Evaluating the merits of interdisciplinary education. *Nursing Times* 2002;98:30-32.
[6] Reuben DB, Levy-Storms L, Yee MN et al. Disciplinary Split: A threat to geriatrics interdisciplinary team training. *J Am Geriatr Soc* 2004;52:1000-06.
[7] Harris DL, Henry RC, Bland CJ et al. Lessons learned from implementing multidisciplinary health professionals education models in community settings. *Journal of Interprofessional Care* 2003;17:7-20.

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LIFELONG LEARNING AND CONTINUING PROFESSIONAL DEVELOPMENT

As identified in the Issues Paper, the field of health care is changing more rapidly than ever. It is acknowledged above that new models of education and training will be required for the future, but who is taking care of the continuing education of the current worker? The lack of an evaluation culture is significant in health services (Issues Paper p.32) but development of this culture requires a greater depth of input from institutional, funding and regulatory bodies to increase the potential of the health workforce to achieve this goal.

For example, continuing professional development is often left to the discretion of the individual. While it is clearly not feasible to implement across-the-board credentialing systems, regulatory and institutional bodies can encourage a commitment to lifelong learning among their workforce by leading by example and providing more flexible work practices. Information technology increases prospects for education and training and is a cost-effective alternative for staff in rural and remote locations (Issues Paper p.43), however, protected in-service time (usually by providing staff replacement) then becomes vital to allow the health workforce to take advantage of these opportunities.

The need to invest in human capital and reward excellence is obvious which is why it underpins at least three of the seven principles at the core of the 2004 National Health Workforce Strategic Framework.

We trust this submission will assist the Health Workforce Study and encourage the Commission to incorporate parallel organisational and professional change management strategies into future recommendations designed to reduce or overcome the impacts of current workforce issues.

Please do not hesitate to contact us on 02 9745 7512, if you require any further information or clarification.

Yours sincerely,

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