ANF (Vic Branch)

Submission to Productivity Commission
Health Workforce Study

July 2005

Preamble

The Australian Nursing federation (Vic Branch) makes this submission to the Productivity Commission's Health Workforce study. The following comments and argument are from a Victorian perspective, which, in certain instances, may be at variance from other States and Territories.

While we commend the Commissioners on the thoroughness and quality of the Issues Paper, and agree with:

- the current problems identified (Growing shortages in some workforce areas; geographic mal-distribution of the available workforce; skill mixes that do not always match current needs; concerns about the capacity of the current workforce regime to respond effectively to changing needs; unrealized opportunities to improve productivity and service quality; and job dissatisfaction)

- the key tensions arising from
  - the need to meet equity and access objectives in a fiscally responsible manner
  - fragmentation of roles and responsibilities across and within governments, education and training institutions, professional and regulatory bodies, and public and private providers of health care
  - tradeoffs between longer term requirements and short term imperatives

However, the analysis of these problems and arising tensions has been based on untested assumptions, with an over-emphasis on the problems perceived to be a result of our aging workforce and skill shortage, and an over reliance on perceived impediments, such as professional and industrial demarcations and inflexible regulatory arrangements. This ignores the fact that, from a nursing point of view there is no skill shortage, with some 30,000 registered nurses in NSW alone not working as registered nurses because of lack of job satisfaction, poor pay and conditions and a rigid inflexible management structure. While in Victoria, since 2000 a vigorous state government initiative to address many of these working conditions has recruited 5,600 nurses back to nursing.

Not surprisingly, the policy solutions fail to address the key issues concerning health workforce related issues: ie those arising from insufficient investment in education and training, increased – yet unacknowledged – productivity of nurses, due to increased patient acuity and the corresponding shorter length of patient stay. Perhaps, most importantly, we are concerned policy solutions have been proposed without due regard being given to the development of a sustainable, equitable consumer focused, quality outcomes based model of health care. Such solutions have a strong emphasis on worker substitution, and the development of new lesser skilled occupations.

Certainly, the Productivity Commission Research Report: Economic Implications of an Ageing Australia states that while we face a pronounced ageing of our population over the next forty years, "Timely action would avoid a need for costly or inequitable 'big bang' interventions later. Population ageing can only be conceived as a crisis if we let it become one."[1]

[1] Australian Government: Productivity Commission Research Report, Economic Implications of an Ageing Australia, March, 2005

It is the model of care which will determine the health workforce needed to support it. To speak of the health workforce in the absence of the model of care, is to miss valuable opportunities and runs the risk of introducing 'changes' which in countries abroad have not been successful.

The Australian Nursing Federation (Victorian Branch) has the responsibility of protecting and seeking to advance the industrial and professional interests of its 42,000 members. Nurses comprise the single largest health profession, accounting for about 60% of all health industry employment.[2]

The Issues Paper claims that recent work by the Australian Medical Workforce Committee (AMWAC) and the Australian Health Workforce Advisory Committee (AHWAC) pointed to "a shortfall of nurses of around 2.2 percent by 2006, requiring an additional 4000 graduates (an increase of 40 over projected graduate completions)"[3], and states AHWAC's "overview of recent reports undertaken by others suggested inadequate numbers of nursing graduates to meet demand more generally"[4]

Yet, that being the case, it is worrying the federal government is under funding nursing, with 2,716 potential students being turned away from nursing this year[5]. Clearly, the increased training places in universities did little to address both the supply and demand side of the problem.

Thus it appears the number of students gaining entry to university to undertake nursing courses may be being manipulated, so that a severe shortage will be inevitable by about 2009 – 2010.

The Issues Paper (and other publications) mentions professional demarcations as negative and outdated, however, an actual analysis of the many nursing and other health professional roles reveals:

- A degree of overlap, so that continuity of patient care is possible
- A commitment to a multi-disciplinary approach, and,
- A highly functional division of labour

It is worrying that there is a growing trend whereby such assertions are not analysed, and, as a consequence, take on a life of their own, with nurses and others who seek to advance their craft and profession - and ensure safe patient care – being labeled as inflexible. Yet, to even the most casual of observer, the nurse is the most flexible of workers – competent, compassionate, multi-skilled, attending to highly complex technology and to the most basic of human needs and wants at the same time.

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[2] Duckett, S. Health workforce design for the 21st century, article in Australian Health Review, May 2005, Vol 29. No 2.
[3] The Productivity Commissions Issues Paper, The Health Workforce, May 2005, p.13
[4] The Productivity Commissions Issues Paper, The Health Workforce, May 2005, p.14
[5] The Lamp, No Fix Without Student Nurses, July 2005, p. 12

The role of the nurse has changed, and continues to change as the health care system changes, and there is scope for nurses to provide services that were once the sole domain of the doctor – nurse practitioners are one example of this, and, with the initiative (in Victoria, at least) in its infancy, one can only anticipate the many challenging opportunities that may emerge. The fact that the role of the nurse practitioner thus far has proved successful is testament to the fact that "professional demarcations" are not necessarily constant. It is interesting to note that while many medical organisations have vigorously opposed the introduction of nurse practitioners, they are now supporting a role for a new worker, titled "medical assisting" who (according to draft competency standards) will be performing the role now performed by practice nurses, but with the proposed level of education, it will be limited to a task oriented approach – a role not consistent with our contemporary health system

Further, we are frequently told that health care is changing so rapidly, we are in danger of not being able to keep pace. A sense of perspective is required if we are to identify adequate and appropriate strategies to meet the challenges ahead. Technological change is occurring in the home, office, school and university. Whether it is changing more in the health care sector is questionable. Regardless, the work of a nurse remains that of using skills and knowledge to care for patients/residents/consumers/clients and their families.

The current model of nursing in Victoria is one where there are two levels of registered nurse, with matching expectations, responsibilities and scopes of practice. There exists opportunities for the registered nurse division 2 to undertake additional education, with recognition of prior learning to be eligible to seek registration as a registered nurse division 1.

Workforce Planning

The National Health Workforce Strategic Framework is certainly a welcome initiative, as, until last year planning of this calibre was lacking. Its principles are sound, and presumably the underlying rationale for health workforce planning in the Australian context is to provide models for health service delivery, in response to consumer need, at optimal standards, and to plan for the education and training of future workers.

The current arrangements of health workforce planning go some way to identifying and planning for our health workforce of the future, however, a number of worrying trends are becoming apparent:

- The tendency to regard the future as critical as a result of the fact that there will be far fewer school leavers available for employment in the health field

- The tendency to presume there will be insufficient numbers of people to fill professional roles, therefore a need to "fill gaps" with generic or lesser educated workers

- The failure to recognize that there will not be the exit of older workers, at relatively early ages, as has been the case to date

- There has been scant regard or research given to actual models of health care which may be suitable and sustainable in the future. Much of the debate is hospital centric, with an illness focus. Consumer focused primary health and health promotion models of care also need to be factored into the equation.

- Much of the debate appears to be employer led, with a cost containment agenda

Until recently, nursing workforce planning in Australia took place at the state and territory or regional level. AHWAC was established in the late 1990s to provide advice on addressing the immediate challenges and the more long-term issues that are likely to shape the Australian health workforce in the future. However, as it is a relatively recent iniative, there exist a number of problems and shortcomings, including:

- A lack of meaningful data

- A lack of mechanisms to enable an integrated approach to health workforce planning

- The need to acknowledge that health workforce planning is not only about planning for service delivery, but planning for a consumer centered model of health care which is dynamic and vibrant, and able to compete with other industries in order to attract the 'best' young people of today to become the health practitioners of tomorrow.

The National Health Workforce Strategic Framework states it has been developed " within the overall context of a population health framework that embraces health protection and promotion, disease prevention, primary care, community care, remote care and acute care. The population health framework recognizes that the health and well being of the Australian people is the result of a complex interplay of biological, psychological, social, environmental and economic factors which operate at the individual, family, community, national and global level"[6].

However, in reality, it is doubtful that sectors such as aged care, Aboriginal and Torres Strait Islander health, and the health of other marginalised groups, such as the disabled and mentally unwell receive equal consideration. All too often the debate about planning for the future health workforce centers on what is possibly more correctly termed the "illness workforce", and is limited to ways in which costs may be reduced – with the substitution of nurses and other professionals by less educated, less costly workers.

Not only is such a debate frustrating because of its narrow focus, but also because it is illogical. On the one hand, we are told about the impending problems associated with our aging population, for example, "Over the next 10-20 years Australia will need to deal with an ageing population, a 'tightening' labour pool and an increasing global and mobile workforce."[7]. Yet, there is evidence to support the contention that many see (at least part) of the solution in training which is not concerned with qualifications, but with "skills clusters" – a mix and match of competency standards so that employers can meet short term imperatives and 'plug holes' with minimal investment in the longer term viability of the health services. The current review of the Health Training Package by the Community Services and Health Industry Skills Council is an example of this, whereby new roles, with minimal education and training are being developed as substitute nurses. The 'medical assisting' mentioned earlier is one example of this.

[6] Australian Health Ministers' Conference, National Health Workforce Strategic Framework, Sydney, 2004
[7] Australian Health Ministers' Conference, National Health Workforce Strategic Framework, Sydney, 2004, p 7

We need to recognize that a lesser skilled and less educated labour force as a strategy to replace nurses will only accelerate the exodus of registered nurses from the health system.

Scant attention has been paid to the increasing intensification – and corresponding productivity – of nursing work. This has occurred as a result of a health system that moves patients through the hospital system, with ever decreasing lengths of stay, where the inpatient time is for the most intense phase of a person's illness or disorder.

Workforce participation

The suggestion that the long lead times required to educate and train new practitioners has a negative impact on the provision of nurses is a particularly short sighted view, and overlooks the fundamental issue that to provide an acceptable level of health care with quality outcomes requires time and resources.

The fact that the nursing profession is flexible – able to respond to changing technologies and health care needs, within an increasingly tight budgetary framework is a situation to be applauded and used as a template rather than considered a negative pressure. These flexibilities have been demonstrated time and time again providing greater efficiencies than ever before. Reduced length of stay for patients across all areas is an example par excellance of such productivity achievements.

The Issues Paper suggests that structural changes (including reduction in average hours worked by practitioners) have had a pervasive impact on supply. Yet an article in the Australian newspaper (14/7/5) on a recent report soon to be released by the Australian Institute of Health and Welfare appears to dispute this. It identifies "a 5 per cent increase in the total number of registered and enrolled nurses between 2001and 2003…" . The article continues,… "The report also shows at turnaround in the declining number of hours worked by nurses, an increase in the number of working midwives and the lowest number of part time workers in six years"[8].

Key influences on workplace participation and job satisfaction (whatever they may be, or however they may be defined) cannot be seen as fixed or concrete. Such influences will always be changing, depending on the individual workplace, management style, working conditions and improvements that are implemented.

American research has identified "…lower nurse retention in hospital practice was related to burdensome workloads and high levels of job-related burnout and job dissatisfaction"[9]. This was also identified in Victoria, with moves made to improve the situation with the introduction of nurse patient ratios in the public sector in 2000. This has resulted in 5600 nurses re entering the workforce since 2000, with the vast majority choosing public sector employment. This clearly identifies that reasonable wages, linked to nurse patient ratios (as a measure of workload), as well as improved conditions (including provision of some paid maternity leave, and access to study leave) provide incentives to nurses re entering and remaining in the workforce. While these initiatives have managed to stabilise the situation, certainly more needs to be done to continue to improve the situation.

[8] Article in The Australian, 14 July 2005
[9] Aiken et al, JAMA, October 23/30, 2002-Vol 28 8, No 16

The most common economic strategy to the health professional shortage appears to be the dilution of the role of the health professional, with the introduction of lower level health workers. Such moves are short sighted, and run counter to current evidence. In fact, the only benefit that can be possibly perceived is the reduction of the cost of employing health professionals, with no benefit to the provision of health care, healthcare outcomes and job satisfaction for nurses.

Research in Victoria identifies that "ratios have contributed to a major improvement in patient care and working life. Their full benefits, however, have been diluted by wider systemic problems particularly continuing pressures to increase nurses' workloads and the related problem of the Australia-wide nursing shortage. These pressures are being experienced by nurses as increased work intensification and continuing high incidence of overtime, much of it unpaid"[10]

The research also identifies the concern "that nurses are also receiving mixed signals from employers about the value the industry places on their skill. While nurses acknowledge the commitment by employers to provide assistance for further study, nurses clearly identify that employers are seeking to reduce the nursing workforce by replacing nursing staff with Patient Care Assistants (PCAs) and non-nursing personnel. Nurses overwhelmingly expressed a view that increased use of non-nursing staff to undertake duties traditionally undertaken by nurse professionals will undermine the overall quality of patient care delivered by the health system and increase their workloads" [11].

Thus it is reasonable to make the connection that any benefit achieved since 2000 to improve nurses workplace participation and job satisfaction will be lessened and potentially worsened with a move to implement a third level nurse.

Workforce participation

There are a number of measures that can be improved upon, redeveloped and created to help reduce the attrition rate of nurses and to facilitate their re-entry into the workforce. Broadly, they can be summed up as The Work/Life Balance. However, rather than acknowledging the problem and adopting strategies in a way which provides a degree of balance in their working and non working lives, the Australian response has been to continually change the system to enable the employer to have increasing control over the employee's hours of work.

Health sector management is frequently inflexible and autocratic, offering little incentive for workers to think and act "outside the square". All too often, iniative is viewed as a negative.

The provision of funding for re entry/refresher courses for nurses has been particularly successful in Victoria. Changing technologies and constant improvement in best practice may, at times, lead nurses to feel that the challenge of re entering the workforce is too great, particularly where to do so often creates a financial burden on families. (as stated earlier, the provision of government funding has allowed for the return of some 5,600 nurses to the workforce). The pool of nurses available to re enter the workforce is a continuing resource as the predominately female workforce stops work to have families.

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[10] Buchananan,J et al, Stable, but critical – The working conditions of Victorian public sector nurses in 2003, p.6, Australian Centre for Industrial relations and Training, University of Sydney, Mach 2004
[11] ibid, p.6

The provision of quality child care at a reasonable cost that is also more flexible in its hours of operation would be of great benefit to enable nurses to remain in/return to the workforce.

Other changes which deserve consideration include:

- Involving nurses in job redesign
- Ensuring manageable workloads
- Offering school term employment
- Self rostering
- Offering educational and professional development opportunities and the time to persue them

Migration Issues

There are ethical considerations to be made prior to actively pursuing recruitment of overseas health workers. These relate specifically to the recruitment of nurses, however the same applies to all health workers.

Any recruitment of nurses from overseas should be as a last resort. The ANF Federal Policy identifies that, "Prior to the recruitment of nurses overseas, the following avenues for nurse employment are to be explored in the following order of priority:

- The employment of nurses who are made redundant as a result of services closing:
- The employment of nurses already practising
- Non practising nurses encouraged to return to the workforce using a range of incentives:
- Nurses recruited from interstate: and finally
- Nurses recruited from overseas."

Any recruitment from overseas must include sufficient and ongoing support systems for the individual and stringent assessment of qualifications, competency, and proficiency in the English language (written as well as verbal) prior to employment.

All measures to reduce the need to recruit from overseas should be taken, including insuring there are sufficient higher education places available for those individuals interested in pursuing a nursing profession. Government funding/supplementation should also be made available to ensure that these courses are affordable.

Where recruitment from overseas occurs, it should not be a matter of course that these recruits come from those countries that are themselves struggling to provide health services. Rather, Australian sponsorship of nurses could be utilised as a method of providing professional development for these individuals on a temporary basis.

There will always be a number of Australian nurses who choose to combine travel and work. We should promote this to certain countries, so that their nurses may enjoy similar arrangements here in Australia. Exchanges could occur on an equal basis, as is the case in the education field.

Recruitment of overseas professionals to address short term gaps in rural and remote areas should not be pursued. Remote and rural areas often lack the support services needed by overseas educated health professionals. Remote areas, in particular, are often very challenging for Australian health professionals with a sound understanding of the particular needs and cultural norms of Aboriginal and Torres Strait Islanders and other groups who reside in our more remote commuinities. There is certainly scope to provide rotations through rural and remote areas for Australian health professionals and the use of incentives needs to be revisited.

Education and Training

It is the Victorian experience that over the past five years (since changes to State Government policies in 2000) the nursing workforce has changed significantly. This has been due to:

1. A significant injection of funds into post registration education for RN Div1 and RN Div2. These funds have been targeted to areas of specialty nursing needs such as Intensive Care, Neonatal Care, Pallative Care, Mental Health etc and;

2. A concerted State Government campaign to recruit nurses back into the nursing profession through the provision of refresher and re-registration programs. This campaign included advertising through daily press and television

3. An increase in available VET sector places for RN Div2 pre-registration education. Initially an additional 900 places in 2001 decreasing to some ongoing 1000 places per annum since.

4. The funding of workload measures in the public sector EBA i.e.: nurse patient ratios which have actively encouraged nurses to return to and remain nursing.

To date an additional 5600 registered nurses have been recruited into the public sector. The ANF (Vic Branch) for many years had provided information to governments that the "nursing crisis" in Victoria was not that we didn't have enough nurses – but that nurses did not want to work in nursing due stressful and exhausting working conditions – absurdly high workloads, poor shift arrangements and a lack of recognition of increasing intensification of nursing work. These initiatives over the past five years have led to an annual Full Time Equivalent increase in nurses in the public sector in excess of 1000 nurses per annum. On average during the 1990's the FTE increase was 300 per annum or less. The average hours worked by nurses has risen during this last five years as well.

ANF (Vic Branch) submits that with continuation of these successful initiatives, Victoria has a finely balanced supply/demand situation currently. Initiatives currently in place to increase the education and qualifications of RN Div2's are also assisting in meeting the needs of health service provision. These include qualifications in medication administration and postgraduate education in specialty areas of acute nursing for which government grants are available. The one area of unmet demand in nursing education remains in the University sector. Unless the Commonwealth Government expands University places for nursing undergraduates, the future supply of registered division one nurses for our major teaching hospitals and specialty fields of nursing across the state will be damaged irreparably.

In October 2003, Melbourne hosted an international conference on nursing regulation. Two of the keynote speakers were the CEO and Chief Nurse of the United Kingdom nurse regulatory authority. They stated that in the UK in the early 1990's (and remembering that Australia's demographic shift to an aging population is about ten years behind that of Europe including the UK), their government made the mistake of believing that, due to technology and medical advances, it would not need as many nurses. Factored into that was a move in the National Health System to introduce large numbers of care attendants. They stated the UK reduced nursing places in the tertiary sector right through the 1990's. As a consequence, the UK is now wearing the consequences of that belief at great cost to the community, to its government, and to the international scene because the UK is the greatest importer of nurses from third world countries.

In Victoria, and Australia, generally we have not cut the number of nursing places so much, as not increased them to meet needs. We need now to increase undergraduate places at a greater rate than the past two years. One of the difficulties with nurses' education is the clinical component of the education – this means that our hospitals and health services cannot just suddenly double their placements for student nurses. In other words a sudden big catch up is not a feasible option.

Another myth at policy level in relation to the nursing workforce is that nurses can be substituted with cheaper, lesser skilled workers. This approach has failed in America. We refer you to some American research[12] that demonstrates that lesser educated nurses increase the morbidity and mortality rates of patients. It demonstrate that the cost to the community in terms of mortality and recovery of ill people is exacerbated when there exists differing education levels amongst nurses and a consequent inadequate nursing skills mix, let alone non-nurses doing nursing work.

"Keeping Patients Safe", a recent report to Congress concludes that is it well educated registered nurses in adequate numbers who keep our patients safe[13]

In Victoria since 1984 there has been an agreement that nurses do not perform non-nursing work – this has freed up nurses to perform only nursing work and ensures that ancillary work such as food services, cleaning, portering etc is performed by non-nurses. The introduction of unregulated care workers into acute health would mean they would be providing nursing care to patients who now have a very short stay intensive care period in hospital. The use of unregulated care workers in the acute section now would necessarily mean the registered nurse being removed from the bedside - in our modern health system this would inevitably lead to a lowering of standards of nursing services with profound and adverse implications to patient outcomes.

In Victoria we have a large component of DIV 2 RNs (Enrolled Nurses) who are educated in a 12 month VET course leading to eligibility for registration. These nurses deliver nursing care including so called Personal Care, (actually this work in nursing is termed assistance with activities of daily living) and also more complex care such as wound care, skin care and medication administration. Div 2 RNs also assists DIV 1 RNs with patients who have unstable health and complex care needs.

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[12] Aitkens L, et al: Educational Levels of Hospital Workers and Surgical Patient Mortality, JAMA, Sept 2003

[13] Institute of Medicine of the National Academies: Keeping Patients Safe, Quality Chasm Series, USA, Jan 2004

In Victoria the ANF (Vic Branch) and other nursing organisations fought successfully throughout the 1990's to keep and maintain our second level nurse against what was then Government policy to stop training the 2nd level nurse. We currently have over 18,000 DIV 2 RNs – the highest number of any state. NSW has 16,000 ENs and Queensland just over 6,000 ENs on their respective registers. Our position on this has now been manifestly justified, as this 2nd level nurse is performing an essential and increasingly skilled role in the delivery of health services. To continue to provide a balanced skill mix of nurses and maintain efficient and safe health services ANF (Vic Branch) is of the strong view that undergraduate places for Div 1 and Div 2 nurses are required to maintain a workforce of two thirds Div 1 and one third Div 2. This overall workforce balance will enable appropriate skills to ensure nursing is able to maintain the efficiencies in health services obtained over the post decade (i.e.: short length of stay and increasing provision of care in the community)

Our current balance of skill mix is 23 per cent Div 2 RN and 77 per cent Div 1 RN (as at 2004). In Victoria our community has, due to a timely change of State Government policy in 2000, a "window or opportunity" of another five years to continue to invest in nursing education and maintain and grow the nursing profession to enable it to deliver an efficient and quality health service to the Victorian community.

Recommendation 1

(i) increased nursing undergraduate places be made available (as recommended by the National Review of Nursing Education Report 2002[14]) in Victoria and

(ii) nursing places in the VET sector be maintained, at least, at 1400 places per annum, with an aim of overall nursing workforce skill mix of one third RN Div 2 and two thirds RN Div 1.

(iii) existing government funding be maintained for post graduate study assistance for both divisions of nurse.

Regulation of the Health Workforce

The regulation of the nursing workforce in Victoria has two stated aims:

1. To ensure a consistent education of the nursing workforce to ensure that the practice of nursing is carried out by competent people (i.e. registered nurses) in order to protect the public (from poor practice).

2. To ensure that those people on the nursing register maintain competence in nursing practices and ethical behaviour (also to protect the public from harmful and poor practice).

These have been the objectives of regulating nursing practice since its inception in this state in the 1920's. To allow the practice of any health practitioner to be deregulated we do not believe is the intention of National Competition Policy but inevitably when the glare of NCP principles is shone on a regulated profession elements of restricted practice are raised as issues.

[14] National Review of Nursing Education Report: Our Duty of Care, Commonwealth of Australia, 2002

In the case of the practice of nursing, we have been accused of being "precious" about our work. This is a most unreasonable and unsubstantiated allegation. Over 99% of registered nurses are employees. They have no "business" to protect.

As registered nurses we are required to perform work in a strict ethical and behavioural framework. At times nurses are confronted by employers directing them to perform work which is outside this regulated framework and directly at odds with practice standards set out by the regulatory authority and the profession. The nursing profession is the largest health profession facing these issues as employees. Nurses are also likely to be in a position of least power within the work organization.

We ask the commission to consider this when looking at issues arising from regulation. Ongoing regulation of nursing education standards for entry to practice and standards of practice and professional behaviour is essential in order to protect the public and maintain standards of health care delivery. It is of increasing concern to every one in nursing that deregulation in some areas of health – for example residential aged care – has led to declining standards of nursing care in this sector. In effect it is the community that suffers from this deregulatory approach. To introduce unregulated "nurses" into the acute sector – as a cheaper worker in an attempt to cut the costs of health care – raises more problems and issues than it addresses.

Overseas experiments in this approach give us examples to analyse. In America, the use of technicians throughout health has been demonstrated not to have contained the cost of health. Currently and for the past decade it has been almost double the GDP% of Australia's health costs.

In the UK, the introduction of unregulated health care workers has caused problems around quality and safety – so much so that those workers are now being "regulated" under legislation and having boundaries of practice imposed on them. This unregulated role was engineered in the early 1990's when the second level regulated nurse was stopped and removed from the workforce. Registration procedures and professional standards of practice do protect the public. In Australia they do not hinder workforce mobility, and the restrictions on re-entry to the workforce after an absence are minimal standards needed to protect patient care.

The ANF has always opposed the introduction of credentialing to nursing. Where it has been used overseas, there has been no demonstrated benefit to the public, it has imposed an escalating cost to the individual registered nurse and has led to artificial "barriers" to nursing practice specialties. ANF (Vic Branch) remains opposed to "credentialing" in this form.

We have seen no analysis of credentialing linked to re-registration having a positive outcome for clients of nursing services either – and do not support moves by nurse regulatory authorities toward this end.

The regulation of care attendants in Residential Aged Care is becoming a necessity. The level of vulnerability of the client group (many with no significant other to look out for their safety and interests), combined with their increasing complexity of illness and disease and lowered cognitive ability means that the skills required to deliver appropriate care to these residents is increasing

ANF (Vic Branch) supports current Victorian nurse regulatory requirements but with additional powers under the Act to make it an offence for employers to direct nurses to act outside of regulated standards. We strongly support the regulation by legislation of direct care workers in residential aged care service.

Recommendation 2

That nurse statutory authorities be given the power to prosecute employers of nurses for directing nurses to act outside of standards of nursing practice

Recommendation 3

That direct care workers in residential aged care services be regulated by legislation to ensure adequate standards of education, and adherence to an acceptable code of conduct.

PRODUCTIVITY

ANF (Vic Branch) is not aware of any formal measures of productivity being applied to nursing. We recommend that standard measures are developed as a matter of urgency in order to assist in the projection of workforce needs. Without informative data on productivities made over at least the past two decades in health, we cannot accurately begin to predict workforce needs.

There have been suggestions made of changing workforce skills mix with no analysis of the impact of these lesser skilled workers on the productivity of the health workforce. In our experience (for example, Residential Aged Care) as lesser skilled workers are introduced into health there is an increase in stress on registered nurses (due to attempts to maintain safety and standards for clients) a rapid move out of that nursing specialty by registered nurses due to their ethical standards and burnout, and an inability to recruit young graduates into the specialty.

For this to occur in the acute health sector would inevitably lead to a loss of the productivity gains of the past decade. Only highly skilled nurses with a thorough preparation in nursing are able to maintain the intensive high turnover of patients in our hospital sector today. Similarly, the increasingly complex care delivered in the community can only be co-ordinated and delivered by resourceful, knowledgeable health professionals able to operate on an autonomous level.

Any measure of productivity would have to take into account high turnover of patients/clients, ability to refer safety to substitute services etc.

We also believe that in health services corporate structures and their cost productivities need to be measured and analysed separately from, for instance, the delivery of nursing services.

As nursing is very much a human service and is often the face of the health service provider and given the usually very personal nature of health services we would suggest that the use of robotics to have a very limited use in provision of nursing.

Delineation of work practices have in nursing largely been a product of lack of access to education, knowledge and skills. The difference between a Div 1 RN and Div 2 RN is after all one of knowledge and competence. It is therefore greater access to education as well as skills development that produces constraints and barriers in the nursing workforce. The Victorian Health experience, through the 1990's demonstrated very clearly to our community that excessive zeal on the part of governments to squeeze the last possible drop of "productivity" out of our health workers produced very serious stresses in our system and a failure to satisfy our community's health needs

Conclusion

In summary we offer the following points:

- The challenges associated with the planning for the provision of a health workforce to meet short, medium and long terms imperatives need to be considered from a whole of society perspective, not merely from a service delivery perspective

- Untested assumptions have no place in the identification and analysis of the issues and problems

- Worker substitution for cost containment and cost reduction reasons will have serious negative effects on the system, both in terms of standards and cost of care (productivity), and in terms of attracting and retaining health professionals

- Costs associated with education and training are investments in our future, assuming the correct decisions are made, which will provide healthy returns on such investment.

- Our ageing demographic ought not be seen as a crisis, but rather as a challenge that requires measured and well conceived responses

- The provision of health care will continue to change – it is the responsibility of policy makers to ensure such change is in response to community need, and not driven only by a cost reduction/cost containment agenda

- Primary health care – the least expensive level of healthcare requires close consideration, as this is often not given due weighting in the allocation of funds.