The Health Workforce Study: Productivity Commission

This response has been drafted by the School of Nursing in the Faculty of Medicine Dentistry and Health Science, University of Melbourne,

Introduction

The need for an examination of the structure of the health workforce is indeed long overdue and we welcome this initiative of the States and the Commonwealth to commission the Productivity Commission's study into the health workforce.

This submission will concentrate on four areas:

1. The preparation of health professional for clinical practice; the regulation and oversight of health professionals entry to practice and continuing competence

2. The education and clinical preparation of the specialist nursing workforce.

3. The preparation and supervision of non-professional workforce

4. Interprofessional education, clinical practice and governance

In all four areas the issues of recruitment, retention, oversight of practice and clinical governance will be addressed.

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Preparation of Health Professionals for Practice

We concur with the Issues Paper that jurisdictional issues are a major problem in the preparation of a health workforce. Nursing is a paradigm case of the confusion of state and commonwealth responsibilities, and education and health domains. The university education of nurses depends upon state health facilities cooperation for the provision of clinical places. The important graduate year consolidation is also dependent on state supported arrangements. Postgraduate specialist education again falls between state health and commonwealth education jurisdiction in that its close alignment with workforce needs warrants state-based clinical support and affiliation.

Undergraduate curricula are typically compressed with little flexibility and little choice of clinical places. As a consequence there is a lack of exposure of undergrad nurses to specialised areas such as mental health, operating room and paediatric settings due to rigidity of mandated clinical component in curriculum from regulatory authorities and low availability of clinical places –

Moreover there is a complete lack of opportunity for undergraduate nurses to develop supervision skills. This issue is of particular importance of workforce reengineering calls for an increase in assistants and generic workers.

Note too lack of exposure in Australian nursing educational programs to interprofessional learning experiences, an issues highlighted in health care workforce and system reforms in Canada and the UK (refs).

Ambiguities over the level of skill, variations in scope of practice between individual nurses at the same level (ie some Div 2 nurses may be competent and authorised to administer medication while most are not) is an unacceptable level of clinical risk unless occurring within an appropriate clinical governance framework.

Oversight of continuing competence in a dynamic workplace …
Issues of risk, accountability and national consistency …

The education and clinical preparation of the specialist nursing workforce

Existing options for the educational preparation of specialist nurses vary from in-service and vocational training that is state funded through to undergraduate, postgraduate certificate, diploma and Masters level programmes funded through the Commonwealth. Private agencies also provide education programmes that prepare nurse in a variety of specialist settings.

Clinical preparation of specialist nurses for practice requires close collaboration between those in the practice setting and those conducting education programmes in order that the education programme provides the nurse the foundational specialist knowledge. In the specialist setting, this specialist knowledge is then used to underpin practice as psychomotor skills are taught and practiced by expert nurses. Specialist knowledge and skills are combined in the practice setting with the aim of providing a competent practitioner prepared for the workplace. Specialist workplaces such as emergency, critical care and operating theatre

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departments are high intensity and high acuity with rapid turnover of patients and staff.

National nursing shortages currently exist in midwifery, critical care, mental health, perioperative, emergency and aged care and these areas were identified in 2001 by the Australian Health Ministers Advisory Council (AHMAC) as priority areas for examination by the Australian Health Workforce Committee (AHWAC).

The projects have been completed apart from the emergency and perioperative projects that are currently underway and due to report at the end of 2005. In most cases, specialist nurses were recruited to these committees and therefore were able to participate in policy development. Recommendations from the earlier reports included funding nurses for postgraduate education through scholarships and grants. Recent Commonwealth and State/Territory government initiatives to recruit and retain nurses such as scholarships targeting these areas are to be supported in order to attract nurses to key areas of shortage.

Strategies for retention of specialist nurses in rural and metropolitan areas need to be explored and supported including exchange programmes for specialist nurses where rural nurses come to metropolitan areas for skills updates and metropolitan nurses go to country areas and gain insight into the rural experience for nurses and patients from country areas that need to travel to major centres for treatment. The School of Nursing conducted a successful programme for perioperative nurses through the Rural Health Support and Education Training (RHSET) programme. Programmes such as this require funding for accommodation, travel and clinical support for the nurses as they gain or update knowledge and skills.

Strategies for the retention of older workers in the workplace must be seriously considered. The combinations of the physical demands of the workplace, shiftwork, and shortages of nurses mean that nurses may choose to either leave the profession or reduce their work hours. Areas such as the operating room require standing for long hours, lifting and moving heavy equipment and exposure to body fluids. Better ways of working with people over 50, ergonomics, flexibility in rostering, shorter shifts and other ways that will retain nurses already in the workforce need to be investigated. Employee loyalty programmes and rewards for long service should be considered.

Oversight of clinical practice through the provision of funding for clinical teachers and time release for nurses is a critical issue for patient safety in specialist areas for many reasons including: mobile staff in these areas, different educational preparation of staff (including junior doctors and nurses), changing technology, acuity of the patients, complexity of care, the need for rapid accurate assessment and the rapidity in which decisions need to be made regarding treatment.

As well as these factors, areas such as critical care, emergency and perioperative nursing require nurses that are able to be multiskilled and work in sub specialist areas within departments. These nurses are required to be flexible and adaptable in the workplace and their educational preparation provides for a flexible worker that is able to move within their speciality area. For example, the after hours perioperative nurse may be required to provide assistance to the neurosurgeon,

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orthopaedic, and reconstructive surgeons all working on the one patient. It is essential that funding be provided for designated educational support in these areas to meet the educational needs of nurses from the novice to expert levels for practice.

The Preparation and Supervision of a Non-Professional Workforce: A Generic Healthcare Worker

From time to time, vocational training models are proposed such as those in the UK that train non nurses to work in specialist areas. The respiratory technician in the USA is another example of a non nurse working in a critical area. This worker manages the equipment including the ventilators. Australian nurses are educationally prepared and manage this as part of their day to day patient care. Working with the physicians and using protocols nurses in Australian ICUs incorporate this into patient care delivery. The focus of the technician is the equipment and just one aspect of patient care whereas the nurse in collaboration with the physician can encompass total care for the patient using complex decision making and protocols.

Unregulated workers in the operating theatre are trained to work for specialist surgeons or to support anaesthetists. The adaptability of non nurses is limited as is their education as they are trained to work in one particular skill set and are not educationally prepared to work in other areas within the speciality. Their skills are often not transferable within the department or out of hours. This is or particular importance in rural areas where staffing is limited and a flexible worker is required.

The educational preparation of the nurse by a postgraduate certificate and postgraduate diploma gives the nurse portable skills and knowledge and provides nurses working in specialist areas with the knowledge foundation that enables the nurse to be the ultimate flexible worker 24 hours a day.

Non nurses working in specialist areas also require supervision by registered nurses because of the nature of the patients and complexity of nursing care. The non nurse does not recognise the significance of slight changes in patient observations and so must be supervised when delivering care. Expert nurses may delegate to junior nurses and to unregulated workers but in doing this, the public needs to be assured that adequate supervision is available to ensure safe practice and best patient outcomes.

Recently tree has been discussion around the training of a generic healthcare worker as a possible answer to resolve the nursing shortage. The model of the generic health worker that has been proposed provides a worker that is educationally prepared at a superficial level in many areas including basic nursing skills, occupational therapy and physiotherapy. This worker would function at an assistant level to the registered nurse, would require supervision and again limited transferability of skills and limited flexibility in staffing over 24 hours would limit the use of this worker. In order to implement this role, extensive workplace training by nurses would be required.

The generic health worker is a role that appears to be diffuse and poorly defined. This would be another unregulated worker unless the worker is eligible for registration at the Enrolled Nurse (or Registered Nurse Division 2 in Victoria and WA) level or through physiotherapy or occupational therapy. The costs in time and money that the consumer would outlay on the education programme, the skill limitations on completion, the lack of transferability of skills and industrial issues such as the low remuneration versus start-up costs would likely limit applicants for this type of course.

We argue that the registered nurse is the ultimate generic health worker. On registration, the nurse is able to work in any area from the community to the intensive care unit. The nurse has foundational knowledge and skills that can be adapted and built on to work any area of practice.

Although our current health workforce faces many challenges, the worsening shortages of key health professionals is probably the most serious. In terms of the recruitment and retention difficulties and the disparity in workforce distribution, many of the constraints to addressing the imbalance have existed for years.

Over the past decade both national and state reports have been released from various organizations that identified multiple gaps in the healthcare system. It is unfortunate that we now find ourselves a decade later, in an increasingly complex environment, with many of the issues identified then, still on the agenda now. We would argue that the more formal introduction of a generic health worker to 'complement' as some might suggest, our contemporary health needs is not the answer.

There is no doubt that the health workforce requires urgent and comprehensive attention; that is without question. What is concerning is the impetus towards a model that appears to hold up a generic worker as the ultimate solution. It is clear that the workforce requires a greater degree of flexibility if we are to keep pace with the shifting needs of individuals, groups and larger communities. It is however also blatantly clear that the key professions, who are crucial to providing an efficient, effective and quality health system, must be strengthened for the future.

If governments are seriously considering a generic model for our healthcare system then surely the recent United Kingdom (UK) pilot experiences would raise a number of concerns. In particular the large proportion of unregulated levels of workers within the UK model is of concern to any system proposing quality and effectiveness of care. If Australia is seeking to provide quality and be responsive in healthcare then surely there is no place for unregulated workers. It is vitally important as a nation that we do not purely follow the example of other countries but carefully consider the best options for the context in which our work is done.

Although regulation of health professionals has some limitations, surely it is an essential safeguard for the community. It would be entirely unfortunate if Australia was to adopt yet another model for our healthcare system without considering innovation in practice, a commitment of realistic funds to our

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community focused model and the development of strategies to harness and extend the strengths of our current system.

Further, this notion of the generic healthcare workers seems to be based on the premise that they will be a cheaper employee that a registered nurse, for example – cheaper to train, cheaper to employ. However, issues such as patient safety, healthcare outcomes for patients, employee career paths and job satisfaction, and workplace morale are rarely, if ever, considered in the equation.

It appears that health economics and policy makers devise such plans under economic constraints and pay little attention to the human outcomes. Also, whilst it may be cheaper to train and employer a generic healthcare worker than an RN, if and where mistakes happen and lives are put at risk or lost as a result of poor care, the economic and human cost becomes much higher.

Another aspect to consider is the work that an RN actually does. Nursing is a holistic profession, and is not easily broken up into composite parts and distributed to lesser trained people. Health services must look to models that enhance work environments; making them desirable to stay, not leave. This includes a focus on healthy workplaces that are inclusive of workers, have a genuine shared vision supported by management, and have individuals motivated to lead in a proactive team.

Interprofessional Education and Practice

A way forward for the health professions is the use of interprofessional education of health care providers including doctors, nurses, physiotherapists, psychologists, and occupational therapists as it promotes collaborative problem solving and decision making with the aim of better patient outcomes based on collaborative care. Interprofessional education at all levels of practice beginning at undergraduate level would be a start in encouraging future health professionals to work together with the aim of transferring these ways of working into the health workplace.

In recent years there has been enormous interest in the United Kingdom and Canada in the development of new and innovative models of interprofessional education and the fostering of new models of interprofessional practice. There have been three main drivers of this change:

1. the development of clinical governance frameworks under which service and workforce restructures occur. The need to maintain a safe high quality health care system overrides economic or efficiency drivers and by anchoring reforms to a clinical governance framework patient safety remains the paramount concern.

2. Patient safety and quality data points to problems in communication as critical to patient care. The motivation for improved interprofessional communication and collaboration is to ultimately improve the quality of

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patient services and reduce the risks brought about by more traditional siloed forms of professional practice

3. A flexible workforce is predicated upon the ability of health team members to develop the skills and roles appropriate to the service needs in that particular client population. This flexibility requires a high level of professional collaboration and skilled mentorship and supervision of a range of assistant-level staff.

There is no doubt that economic constraints continue to place a strain on the health budgets of both State and Federal Governments. However, any redevelopment of the health workforce need to take place within a clinical governance model that makes patients safety its primary concern, enhancing interprofessional communication and practice and sets a framework for the delegation of tasks and the supervision of less qualified workers.

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