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# HACSU COMMENT ON THE 'AUSTRALIA'S HEALTH WORKFORCE: PRODUCTIVITY COMMISSION POSITION PAPER'.

**Tuesday 8 November, 2005**

## Introduction

Health and Community Services Union is the Victorian Branch of the Health Services Union with 6000 members working in mental health, forensic mental health, drug and alcohol and disability services. In relation to mental health the membership of the union includes psychiatric nurses, general nurses, state enrolled nurses (hospital, university and VET trained), clinical psychologists, psychologists, social workers, occupational therapists, clerical and administrative staff and support staff.

The Mental Health System in Australia is currently under pressure. As the principal Union covering Mental Health Workers in Victoria HACSU is well placed to describe the workforce issues.

The problem associated with current increased demand for mental health services are compounded by serious workforce issues. The supply of new graduates is low, nursing in particular. It is estimated that nationally only 4 per cent of new graduates are entering the mental health system. Of those who do enter many quickly leave.

According to the Victorian Department of Human Services in the recently released (November 2004) 'Nurses in Victoria: A supply and demand Analysis 2003/04-2011/12, calculations reveal mental health has a nursing deficit of approximately 480 nurses. Based on current demand of 2,228 the current full time equivalent shortfall represents a deficit of 21.5 per cent and will exponentially get worse as demand increases and services grow.

The average age of a Victorian psychiatric nurse is 48. The bulk of these nurses are graduates of the former direct entry psychiatric nursing courses (i.e. specialised three year courses with 18-24 months dedicated specialist psychiatric nurse training. These specialist trained psychiatric nurses are leaving the workforce. The consequence is that the availability of a specialised workforce is diminishing.

Whilst the union welcomes this effort by COAG and the Productivity Commission to study the healthcare workforce needs of Australia over the coming years, it is important that this report not become the means by which the high standards and excellent skill base of the

psychiatric nursing profession, or indeed any healthcare profession, are watered down by State and Federal Governments in an attempt to reign in increasing healthcare costs due to factors, such as an ageing population identified in the Productivity Commission Position Paper.

Given the strict timelines associated with responses to the Position Paper, HACSU has outlined responses to specific Draft Proposals below followed by a response to Chapter 11.3 which deals with Mental Health.

## Response to Draft Proposals

### *Draft Proposal 3.1*

*In its upcoming assessment of ways to improve the level of integration within the health care system, COAG should consider endorsing the National health Workforce Strategic Framework (NHWSF), subject to broadening of the self-sufficiency principle, in order to enhance cohesion between the various area and levels of government involved in health workforce policy.*

### *Draft Proposal 3.2*

*COAG, through its Senior Officials, should commission regular reviews of progress in implementing the NHWSF. Such reviews should be independent, transparent and their results made publicly available.*

HACSU would, in a broad sense, agree with the general direction of the seven principles set out in the National Health Workforce Strategic Framework. However, if COAG were to commission regular reviews of the NHWSF, it should be done in a context of actual health workforce needs and not as part of the industrial relations agenda being pursued by the Federal Government to lessen the capacity of employees to be represented by unions, or as an attempt to lessen terms and conditions of employment.

This is particularly important. The Position Paper makes numerous references to the need for improved efficiencies in the workplace; and the 'scope and need to increase the productivity and effectiveness of the available health workforce' (p.XVI).

There has been some discussion of late, including in both the Issues and Position Papers released by the Productivity Commission around the notion of training a so-called 'generically trained healthcare worker' trained in component parts of healthcare professionals' jobs. HACSU is adamantly opposed to such a level of healthcare worker in Australia. There is recognition from COAG in its report that Australia enjoys one of the best healthcare systems in the world.

A major reason for that is our highly skilled and trained healthcare workforce. Seeking to introduce a lesser trained worker to undertake the component parts of current healthcare professionals' jobs (such as giving injections as mentioned in the Position Paper), would not only lessen healthcare standards over time, it would also threaten patient safety and more importantly lessen morale of those psychiatric nurses who have spent years training and practicing to become the experts in the field that they are.

It is already acknowledged in Chapter 11.3 that morale is low amongst the mental health workforce. It is HACSU's view that it would be lessened further if lesser trained workers took over tasks which take years of training to acquire.

There is no doubt that the mental health system is under pressure at the moment. However lesser trained workers would exacerbate existing problems and increase that pressure rather than be part of a solution.

There have been numerous problems (educational and workforce-based) confronting the psychiatric nursing workforce over recent years. Many of them stem from the decision of the Victorian State Government to remove direct entry for psychiatric nursing, and instead have a single undergraduate nursing course.

HACSU was instrumental in the establishment of a Ministerial Taskforce commissioned by the Victorian Health Minister which spent many months examining the current state of education of psychiatric nurses in Victoria. A direct outcome from HACSU's work with the Taskforce has been the Victorian Government's decision to fund a pilot program to initiate a specialist nursing degree with a major in mental health in both a rural and metropolitan setting.

It is clear that there are a number of measures being implemented at a State level which would need to be taken into consideration by both the Productivity Commission and any government agency established to consider workforce issues in order to ensure that duplication not occur, but also to ensure that innovative approaches to the provision of healthcare and the structure of the health workforce in other jurisdictions not be overlooked.

***Draft Proposal 4.1***

*The Australian Health Ministers Conference should establish an advisory health workforce improvement agency to evaluate and facilitate major health workforce innovation possibilities on a national, systematic and timetabled basis.*
*Membership of the board should consist of an appropriate balance of people with the necessary health, education and finance knowledge and experience.*

If such an advisory health workforce agency were to be established, HACSU would seek direct representation for psychiatric nurses within such an agency. Also, as mentioned above, it is important that such an agency not simply become a means of introducing generically trained workers into the healthcare system or indeed be a means of imposing conservative industrial relations changes onto the psychiatric nursing workforce.

Whilst there is reference in the Draft Proposal for there be a balanced representation on such an agency, it is all too often the case that nursing, and in particular psychiatric nursing, is not adequately represented. Given that psychiatric nurses make up 63% of the mental health workforce, according to page 200 of the Position Paper, they should feature significantly on any workforce agency.

***Draft Proposal 5.1***

*The Australian Government should consider transferring primary responsibility for allocating the quantum of funding available for university-based education and training of health workers from the Department of Education, Science and Training to the Department of Health and Ageing. That allocation would encompass the mix of places across universities. In undertaking the allocation function, the Department of Health and Ageing would be formally required to:*

*Consider the needs of all university-based health workforce areas; and*
*Consult with vice-chancellors, the Department of Educations, Science and Training, other relevant Australian Government agencies, the States and Territories and key non-government stakeholders*

Nursing has only been in the university system for a little over 20 years. It therefore, in many instances, does not occupy a senior place within the university hierarchy. In considering the needs of all university-based health workforce areas, it is important that real consultation occur. In the interests of proper and real consultation HACSU would request that the Department of Health and Ageing consult with Schools of Nursing directly, rather than just with Vice-Chancellors.

Also, specific mention should be made of unions in the consultation process rather than just mention 'non-government stakeholders.'

Further, if a transfer were to occur there would still need to be consideration given of policies generated by the Department of Education, Science and Training, such as the Research Quality Framework which is having a significant impact on nursing at a tertiary level. In other words, whoever has funding allocation responsibility needs to be informed by, and in turn inform, the other Department.

***Draft Proposal 5.2***

*The Australian Health Minister's Conference should establish an advisory health workforce educational and training council to provide independent and transparent assessments of:*

- *Opportunities to improve health workforce educational and training approaches (including for vocational and clinical training; and*
- *Their implications for courses and curricula, accreditation requirements and the like.*

Numerous Industry Training Boards, as well as professional registration boards, already play a major role in this area. Whilst HACSU supports improvements in the education and training of the health workforce, it is important not to duplicate what already exists, nor ignore the significant experience and expertise in the Boards and agencies that currently perform this role.

Further, a number of the Draft Proposals suggest the establishment of new agencies or structures, all of which cost money and some of which replicate existing structures. An assessment is therefore needed to ensure that resources going towards establishing new structures could not be better spent going directly into the healthcare system in a targeted manner. For example, resources may be better spent actually training and employing new psychiatric nurses rather than going into an agency that considers improvements in an area where other government bodies already do that job.

Also, there is a difference between making existing structures more accountable and efficient on the one hand, and creating entirely new structures (at much higher costs) on the other.

***Draft Proposal 5.3***

*To help ensure that clinical training for the future health workforce is sustainable over the longer term, the Australian Health Ministers' Conference should focus policy effort on enhancing the transparency and contestability of institutional and funding frameworks*, *including through*:

- *Improving information in relation to the demand for clinical training, where it is being provided, how much it costs to provide and how it is being funded;*
- *Examining the role of greater use of explicit payments to those providing infrastructure support of training services, within the context of a system that will continue to rely on considerable pro-bono provision of those services;*
- *Better linking training subsidies to the wider public benefits of having a well trained health workforce; and*
- *Addressing any regulatory impediments to competition in the delivery of clinical training services.*

HACSU agrees that greater effort is required in balancing university-based education with clinical experience. However as with many other health workforce areas, it is often a lack of funding coupled with a lack of clinical places which compounds the problem.

In relation to the fourth dot point it is important to address impediments to the efficient delivery of clinical services, but simple competition may not be the answer. There is, as acknowledged by the Productivity Commission throughout this study, a complex, cumbersome and often duplicated approach to health care provision in Australia.

It would be more beneficial to examine the structure of funding arrangements at a state/federal/agency/clinical level before simply taking an approach that talks about competition as being a possible answer.

***Draft Proposal 6.1***

*The Australian Health Ministers' Conference should establish a single national accreditation agency for university-based and postgraduate health workforce education and training.*

- *It would develop uniform national standards upon which professional registration would be based.*
- *Its implementation should be in a considered and staged manner.*

*A possible extension to VET should be assessed at a let time in the light of experience with the national agency.*

Whilst it is important to eliminate duplication it is also important to recognise that individual registration boards have a wealth of professional, clinical and education experience. In streamlining the process it is crucial that such skill and experience is not lost. It is

essential that an accreditation agency has the capability of ensuring accountability in relation to health workforce education, training and registration.

In Victoria the Nurses Board has immense local knowledge and experience and direct representation from the clinical, practicing field. The Nurses Board has the function of accreditation of nursing courses ensuring that standards and competencies are met for the purposes of registration and community safety. A distant national body could not have local representation to the same extent and would therefore lose its links with the local clinical field.

As mentioned above, it is also important to include the work already done by the various Industry Training Boards in this field.

***Draft Proposal 6.2***

*The new national accreditation agency should develop a national approach to the assessment of overseas trained health professionals. This should cover assessment processes, recognition of overseas training courses, and the criteria for practice in different work settings.*

Australia enjoys a very high standard of care due in large part to our excellent education and training system. This must be maintained. In any discussion around overseas trained professionals we also need to consider that many thousands of students in Australia miss out on higher education due to the limited availability of funding. Additional funding should be directed at creating new health care places within tertiary education to deal with current and future shortages.

Within an international social policy framework it is also important that Australia not only maintain its high healthcare standards, but also that it not deplete the health workforce resources of countries which can ill-afford to have their healthcare professionals leave. Developing and poorer nations have an urgent need to maintain and increase health workforce levels. Australia needs to continue facilitating improvements in healthcare in such countries.

***Draft Proposal 7.1***

*Registration Boards should focus their activities on registration in accordance with uniform national standards developed by the national accreditation agency and on enforcing standards and related matters.*

As described in the Productivity Commission Position Paper. HACSU'S position in relation the above is that the functions of the state based boards need to be maintained in relation to registration in accordance with developed standards, maintaining registers and on enforcing professional standards including professional development requirements and administering disciplinary procedures. The function of collecting workforce data should continue to enable ongoing review and evaluation of health workforce trends.

***Draft Proposal 7.2***

*State and Territories should collectively take steps to improve the operation of mutual recognition in relation to the health workforce. In particular, they should implement fee waivers for mobile practitioners and streamline processes for short term provision of services across jurisdictional borders*

HACSU agrees that members who are registered in one state should be able to practice in another without incurring significant costs associated with duplicate registration. A central focus of any registration board must be that professional standards be maintained. However, it also important that local knowledge and expertise in Boards be maintained.

***Draft Proposal 7.3***

*Under the auspices of the Australian Health Ministers' Conference, jurisdictions should enact changes to registration acts in order to provide a formal regulatory framework for task delegation, under which the delegating practitioner retains responsibility for clinical outcomes and the health and safety of the patient.*

HACSU has always supported ensuring healthcare workers have a career path, which independent registration offers suitably skilled nurses. The Union has been associated with the Nurse Practitioner Project currently underway in Victoria and is supportive of psychiatric nurses being able to register as independent practitioners subject to them acquiring the necessary skill base.

It is also important that the Productivity Commission be aware that there has been considerable opposition to the notion of the Nurse Practitioner from the medical profession who would be more comfortable with a credentialing system where the authorising medical practitioner is still in control of the delegating process.

The Union's point of view is that nurses with sufficient skills, experience and training ought to be registered in their own right with the possibility of credentialing perhaps as an interim measure while independent registration is being sought.

***Draft Proposal 9.1***

*Current institutional structures for numerical workforce planning should be rationalised, in particular through the abolition of the Australian Medical Workforce Advisory Committee. A single secretariat should undertake this function and report to the Australian Health Ministers Advisory Council.*

***Draft Proposal 9.2***

*Numerical workforce projections undertaken by the secretariat should be directed at advising governments of the implications for education and training of meeting differing levels of health services demand. To that end, those projections should:*

*Be based on a range of relevant demand and supply scenarios;*
*Concentrate on undergraduate entry for the major health workforce groups, namely medicine, nursing, dentistry and the larger allied professions, while recognising that projections for smaller groups may be required from time to time; and*
*Be updated regularly, consistent with education and training planning cycles.*

***Draft Proposal 10.1***

*The Australian Health Ministers' Conference should ensure that all broad institutional health workforce frameworks make explicit provision to consider the particular workforce requirements of rural and remote areas.*

***Draft Proposal 10.1***

*The brief for the health workforce improvement agency should include a requirement for that agency to:*
*Assess the implications for health outcomes in rural and remote areas of generally applicable changes to job design; and*
*As appropriate, consider major job redesign opportunities specific to rural and remote areas.*

With the Draft Proposals dealing with numerical matters relating to the health workforce there are a number of underlying problems with the collection and analysis of data.

Firstly data is collected at a range of different places where patients engage with the health sector across a number of jurisdictions. Too often data collected is not collated and is therefore of little use in analysing trends and cannot be relied upon to determine outcomes.

Secondly divisions continue to exist between the State and Federal Government agencies collecting data which too often do not cooperate via data exchanges as each jurisdiction is reluctant to hand over data which may be used by the other party to exact political mileage. Thirdly too often academic researchers who have the skill and expertise to use such data in a way which could prove beneficial in the development of policy and so on are denied access to the data on the grounds of privacy breaches but also because Departments can be reluctant to release data which, for example, may reveal problems with current practices.

All of these issues need to be addressed and overcome if there is to be real improvement in the collection of data around workforce issues which necessarily includes usage by the community of particular health services.

***Draft Proposal 11.1***

*The Australian Health Ministers Conference should ensure that all broad institutional health workforce frameworks make explicit provision to consider that particular workforce requirements of groups with special needs, including Indigenous Australians; people with mental health illnesses; people with disabilities; and those requiring aged care.*

It is important to recognise the diverse health care needs of different groups in the community. However, as research now shows, mental illness affects 20% of the Australian population. Mental health is not a marginal health care issue. This Draft Proposal is discussed at length below.

**Chapter 11.3 Mental Health**

Mental illness is not longer a margingal health care issue, not only because research shows that mental illness will affect 20% of the population, but also with mental health services increasingly devolving into community health care settings.

Further, numerous inquiries have shown, and most recently that conducted by the Mental Health Council of Australia, the Brain and Mind Institute and the Human Rights and Equal Opportunity Commission, entitled, '*Not for Service: Experiences of injustice and despair in mental health care in Australia,*" that mental health services in the community are inadequate, forcing mental health consumers into general health care settings.

Additionally, increasing cases involving drug and alcohol (dual-diagnosis), and psycho-geriatric care illustrate even further that general health care is increasingly dealing with people requiring treatment for physical as well as mental health problems.

This increases the urgency for health care professionals to be adequately trained in mental health care.

HACSU agrees with the list of points cited on page 200,which detail mental heath workforce issues.

Specifically, HACSU is concerned that since direct entry into psychiatric nurses ceased in 1993 there has been a compounding of shortages of graduates seeking to specialise in mental health. This is why HACSU forcefully and successfully lobbied in Victoria for the Ministerial taskforce mentioned above to be established and developed and advocated a specialist mental health undergraduate nursing course.

Anecdotal evidence shows that there is a significant lack of mental health content in the undergraduate nursing courses which led to the Nurses Board of Victoria conducting a study into the issue in 2002. However, even though there was a recommendation that mental health comprise at least 15% of the undergraduate nursing content this has not been adequately enforced albeit 15% is inadequate. This issue is addressed in the Position Paper, and needs to be reinforced at all levels of government, and particularly if new agencies are to be established to look at health workforce education issues.

Given the serious shortages facing the mental health sector the fact that the average age of psychiatric nurses is 48 and there continues to be a negativity expressed towards the profession by some university lecturers, it is important that specific attention be given to this profession. Whilst HACSU appreciates that most of the draft proposals do, by their very nature, include mental health nursing, more specific recommendations would need to be made in order to deal with the myriad of complex issues facing the sector.

Also, since de-institutionalisation, the time consumers actually spend in in-patient facilities receiving treatment has fallen dramatically with most care being delivered by the community sector. Where a consumer could be in care for a few months in the past, now they tend to be discharged to community care after a couple of weeks.

There is a real need to ensure education and training keeps up with government policy in this regard, as the treatment processes of someone in care over a few months is very different to those receiving care over a couple of weeks.

There are significant occupational health and safety issues for psychiatric nurses which need to be considered in any workforce discussion including stress and occupational violence. For example, a study undertaken by HACSU has shown that 75% of psychiatric nurses experience verbal abuse and 30% have been physically assaulted in the workplace. Not only do such incidents breach occupational health and safety standards of health care workers they lessen morale in the workplace. Additional research and training needs to be done to address this issue.

In relation to the National Mental Health Strategy HACSU agrees that there should be a review undertaken. However it is important that there not be review after review of structures and processes which currently exist just for the sake of it. The 'Not for Service' report mentioned above goes into great detail analysing the Strategy. The Senate Select Committee in Mental health is due to hand down its report in March 2006 and has also analysed the Strategy. The Productivity Commission should consider those documents, including their recommendations, before conducting yet another review.

**Conclusion**

HACSU agrees that there is an urgent need to address workforce issues confronting the health sector in Australia. Numerous studies and research projects at a state, if not national, level have been undertaken by various and diverse groups and individuals, including government agencies, academics, professional associations and unions. The Productivity Commission study has contributed to this process. However in developing proposals to conduct further research an audit of what already exists should be done first to ensure that duplication not occur, and also that valuable dollars not be spent on consultants' reports that may not be needed.

Further, given the level of change recommended in some of the Draft proposals it is important to recognise that there are many excellent features of our current system and that to dispense with them could lessen the working conditions of health care professionals and health outcomes for the community.

There are many areas where change is needed including increased funding for education and training, increased support in the workplace for current health care professionals and a greater cooperation at a State/Federal Government level for example.

HACSU, through its extensive membership base, has an immense wealth of knowledge regarding the current health workforce in Australia including ways in which it could be improved. The Union welcomes this opportunity to contribute to the Study in the hope that meaningful and positive change will be implemented where needed and that the interests of health care professionals and the community will be the paramount consideration in this process over purely economic considerations.