Australian College of Critical Care Nurses

PO Box 219, Carlton South, Victoria 3053

The Chief Commissioner
Health Workforce Study
Productivity Commission
PO Box 80
Belconnen ACT 2616
healthworkforce@pc.gov.au

7th November, 2005

Dear Sir/Madam

Thankyou for the opportunity to comment on *Australia's Health Workforce: Productivity Commission Position Paper.* We commend the commission on a thorough and broad-reaching report that attempts to tackle some contentious issues.

We have deliberately made our responses brief, and have only commented on issues about which we have particularly strong views.

Yours sincerely

Gabrielle Hanlon
Chair
Workforce Advisory Panel
Australian College of Critical Care Nurses

ACCCN Response to *Australia's Health Workforce: Productivity Commission Position Paper*

DRAFT PROPOSAL 3.1
We agree the National Health Workforce Strategic Framework provides appropriate broad goals, and all efforts should be made to enhance cohesion between all those involved in health workforce policy.

However we don't believe the aim for self-sufficiency should be substantially broadened. Although natural migration brings benefits to all, specific recruitment, especially targeted at poorer nations, has many pitfalls, especially when Australian educational standards are not strictly enforced. The resources needed to facilitate the transition of these workers into the Australian workforce would possibly be better spent on local strategies of recruitment and retention that have been piecemeal in some instances, and have often not addressed underlying reasons of attrition. This is particularly the case in nursing.

In addition, in line with International Council of Nurses policy, ACCCN does not support recruitment of healthcare workers from third world countries where their need is so much greater than our own.

We are also dubious about principle five (p.33), which states "complementary realignment of existing workforce roles or the creation of new roles may be necessary". The USA has many more types of healthcare workers than in Australia, and yet they spend more on health than we do, and their outcomes are not as good (certainly this is the case in intensive care[1-6]). In general we support new roles to fill existing gaps in service, but do not necessarily support role substitution, especially where education for the new role would be less than that of the incumbent. Nevertheless, all new roles and systems must be honestly and objectively assessed for their impact on both the existing workforce and the quality of care; further burdening existing workers with supervising others will only lead to increased attrition.

DRAFT PROPOSAL 3.2
We agree that independent, transparent reviews should be performed, and the results publicly available.

DRAFT PROPOSAL 4.1
We support this proposal in principle*.

DRAFT PROPOSAL 5.1
We support any method of nationalising coordination and planning of education and training across all healthcare disciplines.

Although not specifically mentioned in the proposal, it is worth commenting on the discussion around the length of education, especially to get to specialist level in any field.

A generic health degree, with specific disciplines being pursued at post-graduate level has some merit, providing the generic degree is of adequate length and substance to produce a valuable "worker". This approach would have the added benefit of fostering inter-professional collegiality. However the suggestions that doctors could start specialising at undergraduate level, and that narrower specialist fields may decrease training times, ignores the fact that increasing technology, and the aging population will require all healthcare workers to have more skills, not less. This is equally true for nursing as it is for medicine. The introduction of narrower specialisation could easily lead to fragmented care, and subsequently to decreased quality and increased cost.

DRAFT PROPOSAL 5.2
We agree this council could provide useful direction if the stated safeguards regarding balanced membership and an independent chairperson are maintained*.

ACCCN Response to *Australia's Health Workforce: Productivity Commission Position Paper*

DRAFT PROPOSAL 5.3
We support this proposal

DRAFT PROPOSAL 6.1 & 6.2
We support both these proposals*. A more uniform output from courses across the country will facilitate worker portability and ensure appropriate standards are maintained.

* We are mindful three new health workforce bodies have been proposed (4.1, 5.2, 6.1), with only two to be disbanded. All the proposed bodies have merit and their roles would link well, however creating more layers of bureaucracy will further complicate an already cumbersome system, and work against the goals of the Commission. We suggest a review of all government health workforce bodies would be prudent.

DRAFT PROPOSAL 7.1
We support this proposal.

DRAFT PROPOSAL 7.2
We support this proposal, but only as an interim step towards a national registration system for all professions. We agree the current system is inefficient for all concerned.

We believe the process of registration should be maintained as a mechanism for ensuring uniformity at the entrance level to the respective professions, and to safeguard the public. The argument that registration restricts role expansion is not entirely true; many restrictions, such as those concerning drug administration are within other Acts and Regulations, all of which would need amending with the development of new roles. A move to national registration would also require new Acts governing nursing, medicine etc, and they could be worded appropriately to accommodate new roles. Credentialing and delegation could be additional mechanisms for particular procedures/circumstances.

The suggestion on page 115 that registration board membership be altered to decrease professional representation as a specific mechanism to facilitate the introduction of unpopular workforce "innovations" is of grave concern, and counter to the assertion that appointments should be transparent. However we certainly agree consumers should be represented, as the role of boards is consumer protection, not protection of the profession.

DRAFT PROPOSAL 8.2
We support this proposal as an interim step towards some health professionals being able to bill directly eg. physiotherapists.

DRAFT PROPOSAL 9.1 & 9.2
We support these proposals.

We also wish to strongly endorse the statements by AIHW in Box 9.7, page 153. Having been involved in the AHWAC *Critical Care Nurse Workforce in Australia 2001 – 2011*, we are very aware of the severe shortcomings in current data collection and timeliness of processing and availability. This is further complicated by the various bodies collecting the data, and the different collection methods. This is one of the most important issues in the position paper, as no accurate or meaningful planning can be achieved with inadequate data.

This data needs to be collected centrally by a single agency and available within six months of the end of the collection period. In addition, streamlining the data collection process would most likely have cost benefits of its own.

As we have previously stated, we support a rationalisation of bodies involved in health workforce planning. There seems to be a plethora of groups, often with overlapping purposes, producing a myriad of reports at great expense, many of which appear to have little impact. This is particularly the case when government changes and reviews/studies are repeated without the issues from previous studies being addressed. This is demoralising for the contributors and a waste of scarce resources.

DRAFT PROPOSAL 10.1, 10.2, 10.3, 11.1
We support these proposals

In general we support the key aims of the Commission, and acknowledge that change will be necessary for the Australian health system to maintain enviable patient outcomes compared to other parts of the world. Our overall views can be well summarised by the statement on page 39:

> In considering the case for change, it will … be important to undertake sound, evidence-based evaluation of the costs and benefits of alternatives …and the impacts….on the safety and quality of health services.

REFERENCES

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