JC:sw

17 November 2005

Ms Jill Irvine
Health Workforce Study
Productivity Commission
healthworkforce@pc.gov.au

Dear Jill,

Please find attached our response to the Productivity Commission position paper for the Commissioner's consideration and information.

For further enquiries please contact either Jill Clutterbuck, Marcia Gleeson or Jan Brownrigg at the ANF (Vic Branch) office on phone 03 9275 9333 or fax 03 9275 9344, or alternatively email jill@anfvic.asn.au

Thank you for your assistance

Yours sincerely,

Jill Clutterbuck
Senior Professional Officer, ANF (Vic Branch)

Australian Nursing Federation (Vic Branch)
Response to the Productivity Commission Position Paper
Australia's Health Workforce
November 2005

For futher information or queries, please contact
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ANF (Vic Branch) does not believe that the establishment of a further advisory agency at the Federal level would further the development of workforce innovation. We believe that existing mechanisms for consultation and advice could perhaps be enhanced and facilitated rather than yet another body established.

More Responsive Education and Training arrangements

Proposed Response
Consider shifting primary responsibility for allocating the quantum of funding available for university based education and training from DEST to DOHA.

RECOMMENDATION

ANF (Vic Branch) believes that shifting primary allocation of quantum funding for University based education from DEST to DOHA will not address the issues surrounding the mix of health course places unless at the same time the issues surrounding the quantum of funding is addressed, and the issues of transparency of the allocation and spending of the funding at the University level are addressed. We also believe that unless Universities are compelled to deliver Nursing courses then other Universities will move out of delivering the course – as did Sydney University.

Proposed Response
Establish an advisory health workforce education and training council to provide for systematic and integrated consideration of different health workforce education and training models and their implications for courses and curricula.

RECOMMENDATION

As previously stated we do not believe the establishment of another federal advisory body will necessarily facilitate health workforce education change. Current AMWAC and AHWAC groups have only been in existence since 2000 and strengthening links between existing structures may serve the health workforce needs better. Certainly greater transparency in process is not opposed.

RECOMMENDATION

The nature of the modern nursing workplace is such that there is little opportunity for clinical nurse experts to have the time to be involved in the education of the student. Provision must be made in funding for participating hospitals for incentives to facilitate clinical nurse experts to participate in clinical training of nurse undergraduates. As stated previously much work is being done in Victoria on these issues currently. As a result simulation laboratories will become a greater feature of Clinical training. We cannot see competition from new providers becoming an option for nursing.

A Consolidated National Accreditation Regime

Proposed Response
In a staged manner, move towards a single consolidated national accreditation agency for university-based education and training and post graduate training; subsuming existing accreditation functions as part of this process.

RECOMMENDATION

ANF (Vic Branch) strongly opposes a move towards a national accreditation agency for the following reasons:

- Costs of accreditation processes and monitoring of providers of education is currently met by the professions through registration fees.
- Costs to Universities of accreditation under a national system would still remain. Any streamlining of accreditation though a national system would only accrue to providers who cross jurisdictional borders.
- A national system would still either have to delegate monitoring to a state jurisdiction authority – or have state territory offices – hence reducing savings.
- National systems of accreditation may lead to rigidities that actually impede the development of innovative models to meet local needs.
- The dominance of medicine in such an agency could well reverse any cross professional innovation.

Supporting Change to Registration Amendments

Proposed Response
Introduce nationally uniform registration standards based on work of the proposed national accreditation agency. More focused role for registration board.
Improve operation of mutual recognition; explore alternatives to formal registration; consider consolidation of registration functions across professions; and improve governance structures for registration boards.
Amend registration Acts accordingly.

RECOMMENDATION

Given that nursing currently has National Competencies for entry to practice (1995) and has spent the last few years developing further competencies for advanced practice, ANF would feel that nursing is well advanced along the road being advocated by the Position paper.
We therefore do not believe that a National Registration system is required to achieve such ends – the existing systems in Nursing are meeting those needs.

Improving funding – related incentives for workplace change

RECOMMENDATION

Limited incentives under MBS for delegation of aspects of treatment and disease management to be delegated to other non-medical health professionals

Proposed Response
Establish an independent review body (subsuming existing committees) to advise on services to be covered by the MBS and on referral and prescribing rights
Progressively introduce (discounted) rebates for a wider range of delegated services.

RECOMMENDATION

In accord with the suggested rewording of the problem, ie *progressively introduce (discounted) rebates for a wider range of services provided by non-medical health professionals as part of the disease management process.*

RECOMMENDATION

Suggested amendment - delete "Allow the community to share in the cost savings from delegation".

Better focused and more streamlined projections of future workforce requirements

Proposed Response
Concentrate formal projections on the key workforce groups. Undertake scenario analysis as a matter of course.
Rationalise structure through abolition of AMWAC and AHWAC

RECOMMENDATION

There is a need to retain the current AMWAC and AHWAC – even perhaps to merge the two, but link them more closely. However, given, AHWAC has been in operation only since 2000 (prior to which there was no national recognition of non-medical health professionals workforce issues), there is a need to continue AHWAC in some representative form to ensure nursing and allied

health workforce issues are debated, with a direct line of communication with the Australian Health Ministers' Council.

More effective approaches to improving outcomes in rural and remote areas

Proposed Response
All system-wide frameworks in the health workforce areas to make explicit provision for consideration of rural and remote issues. Initiate a cross-program evaluation exercise.

RECOMMENDATION

ANF (Vic Branch) suggest the following are particularly relevant in some rural and, to an even greater extent, remote area communities. Many of the challenges associated with rural and remote health workforce recruitment and retention issues from a nursing perspective (and one would assume much is transferable to the needs of other health professionals) relate to work-life balance, and include the availability of child care, employment for spouses/partners, suitable and affordable housing.

Further, schools of nursing must be retained at regional universities/campuses, as there is sound evidence to suggest this prevents the migration of a significant number of nurses away from that region.

Ensuring that the requirements of groups with special needs are met

Proposed Response
All broad institutional frameworks to make explicit provision to consider the needs of these groups.

RECOMMENDATION

We concur with much of the chapter on the needs of special groups and offer broad support to the proposed response.

KEY POINTS

We again offer the key points of our earlier submission, and hope they may in some way be incorporated into a set of guiding principles:

- 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 highly skilled 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.

Preamble

ANF (Vic Branch) is pleased to further submit views on these important issues for the Victorian community and for registered nurses. We thank the Commission for the opportunity to participate in the Melbourne Roundtable, and we offer the following responses to support the views presented at that forum and those of our earlier submission.
We have formatted our responses focusing on the draft proposals released by the Commission as far as possible.

Facilitating Workplace Innovation

Current Problem
Lack of timely and objective processes to assess significant job redesign, leading to lost opportunities to make better use of available health workforce skills.

ANF (Vic Branch) are aware of past and ongoing job redesign within the health workforce for the past fifteen years. Much of this change has occurred at the workplace affecting workers who are educated in the Vocational Education sector. This has led to marked productivity gains in some sectors, in particular in Aged Care where deregulation and worker substitution has led to the shedding of thousands of nursing positions and replacement with a lesser skilled and unregulated worker. There has not as yet been an independent evaluation as to whether this has led to an impact on the health outcomes of our elderly in residential care, but constant anecdotal information from nurses is that standards of nursing care are increasingly difficult to maintain.

An example of job design across perceived professional boundaries may be the initiative to establish Nurse Practitioners. This initiative has not progressed to any significant extent with only four (4) currently registered in Victoria. For independent Nurse Practitioners to succeed Federal governments need to establish a system of payment to Nurse Practitioners in private practice

As Registered Nurses practice already includes elements of physiotherapy, occupational therapy, social work, counselling as well as that which may be considered medical work, we see little that would require adjustment in undergraduate nurse education to accommodate job redesign across these professional boundaries.

Issues may arise firstly in relation to Nurse Regulatory authorities accepting inroads into perceived traditional medical practice areas, and secondly employer insurers accepting liability claims against such work performed by registered nurses. Of course currently, medical practitioners are opposed to losing their position as fund holder and/or delegatee.

Proposed Response
Establish an advisory health workforce improvement agency to examine major workforce innovation opportunities, particularly those which would cross current professional boundaries.

RECOMMENDATION

ANF (Vic Branch) does not believe that the establishment of a further advisory agency at the Federal level would further the development of workforce innovation. We believe that existing mechanisms for consultation and advice could perhaps be enhanced and facilitated rather than yet another body established.

More Responsive Education and Training arrangements

Current Problem
Lack of coordination between the education and health areas of government, leading to mismatches between available education and training places and service delivery requirements.

In regard to nurse education the problem is the lack of growth of funded places in Universities which is not keeping pace with demand. Although it is a designated area of skills shortage the additional places designated for nursing by the Federal government is way below agreed needs which will do nothing other than create further skills shortage. This flies in the face of advice given by overseas experience and will create situations within the health sector leading to spiraling "crises" of workforce.

Please see our Appendix One for further detail on nursing places and EFT in Victorian hospitals.

Proposed Response
Consider shifting primary responsibility for allocating the quantum of funding available for university based education and training from DEST to DOHA.

RECOMMENDATION

ANF (Vic Branch) believes that shifting primary allocation of quantum funding for University based education from DEST to DOHA will not address the issues surrounding the mix of health course places unless at the same time the issues surrounding the quantum of funding is addressed, and the issues of transparency of the allocation and spending of the funding at the University level are addressed. We also believe that unless Universities are compelled to deliver Nursing courses then other Universities will move out of delivering the course – as did Sydney University.

Main Benefits of change
Better alignment of the mix of health course places with the health needs of the community and the workforce needs of service providers.

A "better use" of health course places will still be dependent on the lobbying power or otherwise of a profession whether it be focused on DOHA, DEST or government.

Current Problem
Longstanding practice a barrier to exploration of better ways of educating and training the future health workforce.

Given nursing education has only been in the university sector for approximately 12 years we do not believe that there are long standing practices which are a barrier to better ways of educating nurses. In fact in Victoria currently the nursing profession is just in the process of completing exhaustive consultation between the profession, academics and employers examining and developing better mechanisms of communication amongst stakeholders to ensure that graduate nurses enter the workforce as best prepared for the existing and future workplace as possible.
This collaborative work is best done at the State level ensuring needs of all stakeholders are addressed.

Proposed Response
Establish an advisory health workforce education and training council to provide for systematic and integrated consideration of different health workforce education and training models and their implications for courses and curricula.

RECOMMENDATION

As previously stated we do not believe the establishment of another federal advisory body will necessarily facilitate health workforce education change. Current AMWAC and AHWAC groups have only been in existence since 2000 and strengthening links between existing structures may serve the health workforce needs better. Certainly greater transparency in process is not opposed.

Current Problem
Current clinical training regime may not be sustainable over the longer term, due to lack of transparent and explicit funding and insufficient opportunities for competition in training delivery.

ANF have been involved recently in consultation with industry over the issue of clinical training of nurses in Victoria. A number of recommendations are under consideration to better prepare nurses for the future.

The issue of clinical training for nurses and medicine and other health professionals are complex and differ between professions. One important issue in the debate on clinical training for nurses – and not widely reported in debate is that changes to the nature of the workplace and workforce have exacerbated this issue. The higher the "throughput" of patients – the greater the "efficiency" expectations on nurses at the bedside – the less available they are to spend time with students and pass on their expertise. Our "expert" nurses at the bedside are the nurses who are needed to pass on their skills to the next generation of nurses, yet current fiscal approaches to provision of health leaves no room for this to occur.

Main benefits of Change
Better information base for policy formulation. Competition from new providers leading to more efficient delivery of training services and encouraging innovative training models.

ANF (Vic Branch) cannot see the above benefits applying in Nursing clinical training, we are aware that very few private Hospitals in Victoria take nursing students for clinical placement. There are

issues around the ability to provide a valid variety of experiences and there is no financial incentive for such work – other than the opportunity for recruitment of future workforce.

RECOMMENDATION

The nature of the modern nursing workplace is such that there is little opportunity for clinical nurse experts to have the time to be involved in the education of the student. Provision must be made in funding for participating hospitals for incentives to facilitate clinical nurse experts to participate in clinical training of nurse undergraduates. As stated previously much work is being done in Victoria on these issues currently. As a result simulation laboratories will become a greater feature of Clinical training. We cannot see competition from new providers becoming an option for nursing.

A Consolidated National Accreditation Regime

Current Problem
Profession-based accreditation impedes workplace innovation and job redesign. Inconsistent requirements of individual accreditation agencies impose costs on educational institutions and trainers.

ANF (Vic Branch) wishes to draw to the Commissions attention the fact that the Community Services and Health Industries Skills Council do not currently accredit courses for workers in the health sector (or any other industry). They develop competencies for workers, register and endorse "packaging" and assessment requirements. Further, learning resources and curriculum are not part of the endorsement process. Also, monitoring of the delivery of this training is a State function carried out by Government departments.

Nursing, which is currently the only health profession with significant numbers of students in the VET sector, relies on the Nurse Regulatory authority in each state for accreditation and monitoring of standards of education of student nurses.

Professions generally rely on accreditation of curricula and teaching resources to maintain consistent education outcomes for students – thereby hopefully ensuring (in part) maintenance of safe practice in the interests of community safety and good health.

In the VET sector, national systems have no mechanisms, or authority to carry out such roles, and indeed ANF is concerned that not enough monitoring of education providers in VET (both public and private) has led to questionable standards. A Victorian State Enquiry into these aspects of the sector some two years ago led to higher Regulatory and Monitoring imposts being placed on the providers by the Victorian State government. Also tighter fiscal measures have been implemented to attempt to control fraudulent behaviour by private education providers (or RTO's).

We draw all this to the Commission's attention so that you are under no allusions as to the problem currently inherent in the "National VET sector". To use it as a "model" for the Tertiary sector we could not recommend nor support. We would certainly agree to the VET sector being subjected to an accreditation process on curricula and learning material but that would be anathema to the current system.

Proposed Response
In a staged manner, move towards a single consolidated national accreditation agency for university-based education and training and post graduate training; subsuming existing accreditation functions as part of this process.

RECOMMENDATION

ANF (Vic Branch) strongly opposes a move towards a national accreditation agency for the following reasons:

- Costs of accreditation processes and monitoring of providers of education is currently met by the professions through registration fees.
- Costs to Universities of accreditation under a national system would still remain. Any streamlining of accreditation though a national system would only accrue to providers who cross jurisdictional borders.
- A national system would still either have to delegate monitoring to a state jurisdiction authority – or have state territory offices – hence reducing savings.
- National systems of accreditation may lead to rigidities that actually impede the development of innovative models to meet local needs.
- The dominance of medicine in such an agency could well reverse any cross professional innovation.

Benefits of Change
Lend further impetus to 'across profession' consideration of workplace innovation and job design issues.
Provide the basis for nationally uniform registration standards for health workers.
Reduce costs and inconsistencies arising from multiple accreditation agencies.

The ANF (Vic Branch) experience of workplace innovation and job design over many decades is that to succeed there are some critical elements:

- It must be owned by the workers in the workplace ie It will not work if imposed by management (let alone a National Agency)
- It must meet workplace needs

Nursing has had nationally uniform standards for Registration and practice since 1995. These were developed and are reviewed in consultation with the profession. They have been adopted by all state and territory Nurse Registering Authorities.

These standards do not restrict States/Territories from developing innovative and flexible approaches to education of the profession (for example Victoria has been delivering Traineeship courses for Div2 RN's (EN's) in the Private sector for over 5 years).

We believe this Nursing model of National Standards could be used in other professions.
In addition through the National Nursing Taskforce much work is currently being done on national consistency in terms of Scope of Practice for Registered Nurses.

Supporting Change to Registration Amendments

Current Problem
Current state-based regime involves duplication of effort, impedes professional, mobility, imposes costs on those practicing in more than one jurisdiction. Professions-based approach reinforces workplace rigidities and discourages job redesign.

The effort involved in registration by a regulatory authority, of health practitioners will remain the same – be it under a National or State system. The effort required by the Health Practitioner to register only increases if they move from jurisdiction to jurisdiction.

ANF (Vic Branch) knows of only one area in Victoria where Registered Nurses require dual registration – Albury/Wodonga – we estimate it affects a small number of RN's who work in both NSW and Victoria. We suggest it would be simply resolved by agreement with Regulatory authorities along the same lines as Mutual Recognition which has been in place in Nursing for some ten years. Mutual Recognition has resolved many issues of movement between jurisdictions. Of far greater cost to nurses who move interstate is their loss of workplace entitlements such as long service leave, experience payments, maternity leave entitlements etc.

We are not aware of how a jurisdiction based profession by profession registration system has reinforced workplace rigidities and discouraged job re-design. (Unless it is believed by the Commission and governments that having a national all professions approach would mean that governments and other agencies could have greater influence on one body).

It would seem to ANF (Vic Branch) that the arguments interspersed through the discourse on accreditation and registration have more of a flavour that "allowing professions to be regulated by Statutory authorities is perceived by some governments and other agencies as inhibiting rapid changes to practice". We would suggest that this is an issue that should be addressed directly – and in the public domain and that central to any debate on this issue must be the consumer of health services as the current model of Regulation of Health professionals though Statutory Authorities is based on the achievement of safe practice in the interest of the community. If governments or the Commission believes these Statutory Authorities are captive to the profession then that may need to be addressed – it is ANF (Vic Branch) view that capture by government would be equally destructive of professional standards.

Proposed Response
Introduce nationally uniform registration standards based on work of the proposed national accreditation agency. More focused role for registration board. Improve operation of mutual recognition; explore alternatives to formal registration; consider consolidation of registration functions across professions; and improve governance structures for registration boards. Amend registration Acts accordingly.

RECOMMENDATION

Given that nursing currently has National Competencies for entry to practice (1995) and has spent the last few years developing further competencies for advanced practice, ANF would feel that nursing is well advanced along the road being advocated by the Position paper.
We therefore do not believe that a National Registration system is required to achieve such ends – the existing systems in Nursing are meeting those needs.

Improving funding – related incentives for workplace change

Current Problem
No transparent process for considering the possible extension of MBS rebates to a wider range of practitioners, leading to some inefficient use of GP services.
Limited incentives under the MBS for delegation of routine tasks less highly qualified, but more cost-effective, health professionals.

RECOMMENDATION

Limited incentives under MBS for delegation of aspects of treatment and disease management to be delegated to other non-medical health professionals.

Rationale for suggested amendment:
The management of chronic illness is, and will increasingly continue to be, one of the greatest challenges facing our health care system. In a recent study, Older Patients Attending General Practice in Australia 2000-2002, the researchers state that, in 93.2% of older patients, chronic conditions were prevalent.[1]

Currently, GPs are able to apply for grants to employ Practice Nurses and allied health providers, and have a limited capacity to claim MBS rebates on certain items. In July 2005, the Chronic Disease Medicare Items were introduced to "make it easier for GPs to manage the care of patients with chronic medical conditions, including patients needing multidisciplinary team based care."[2]

The suggested rewording of the problem better reflects the reality that chronic disease management is a complex process which includes on going care planning, interventions and assessment, and involves a range of other health professionals.

To reduce it to the assigning of routine tasks is to ignore the fact that such a process involves complex decision-making by members of the multidisciplinary team, in consultation with the patient and/or their carer.

[1] O'Hallaron J, Britt H, Valenti L, Harrison C,Pan Y, Knox S. 2003 Older patients attending general practice in Australia 2000-2002. AIHW Cat No. GEP 12. Canberra: Australian Institute of Health and Welfare (general Practe Series No.12, page xv
[2] www.health.gov.au/internet/wcms/publishing.nsf/Content/pcd-programs-epc-chr

It is also to risk missing the opportunity to enable and encourage such non-medical health professionals to work to the level to which they were educated, and to provide them with professionally rewarding and sustainable career opportunities.

Examples of non-chronic conditions currently undertaken in GP clinics by registered nurses include immunisation, pap tests (as a component of women's health screening), care of pregnant women, with mental health nurses recently being employed in GP clinics.

It is reasonable to conclude there are many opportunities for GPs to work with registered nurses in collaborative arrangements, and that, variables such as context of the practice/clinic and client needs must be taken into account so that the full potential of these .positions may be realised,

In time, given appropriate government support and incentives, the numbers of Nurse Practitioners is set to increase and there will be opportunities to reconsider the role of the autonomous primary care giver in a broader/non-medical context. Certainly, the notion of "GP sovereignty" ought to be challenged, as we continue to strive to meet emerging challenges associated with the provision of quality, accessible primary health care.

With regard to nurses taking on roles in hospital settings that are currently the domain of doctors, ANF (Vic Branch) is able to offer 'in principle' support to projects that may be introduced to trial such expansions of role and scope of practice. Currently such projects are underway in the public sector in Victoria, however we would expect that ANF as a key stakeholder would be stongly involved in all aspect and stages of such initiatives, and that issues relating to indemnity and remuneration would be identified and negotiated to the satisfaction of the parties.

Proposed Response
Establish an independent review body (subsuming existing committees) to advise on services to be covered by the MBS and on referral and prescribing rights
Progressively introduce (discounted) rebates for a wider range of delegated services.

Referral and prescribing rights are already the domain of nurse practitioners employed in health care facilities. Such a review body would need to look at ways that would enable nurse practitioners employed (or who are self employed) in primary health care settings.

RECOMMENDATION

In accord with the suggested rewording of the problem, ie *progressively introduce (discounted) rebates for a wider range of services provided by non-medical health professionals as part of the disease management process.*

Main benefits of change
Facilitate transparent consideration of requests for changes in the coverage of the MBS that would help to improve workforce efficiency and effectiveness and enhance outcomes for patients. Encourage better use of available health workforce skills. Allow the community to share in cost saving delegation.

RECOMMENDATION

Suggested amendment - delete “Allow the community to share in the cost savings from delegation”.

Rationale for suggested amendment.
This Inquiry is concerned with Australia’s Health Workforce – what it should look like, how to achieve it. It is an unnecessary distraction to introduce notions such as “cost-saving”, particularly in terms of enabling the community to share such savings.

There is no guarantee there would be any cost savings, as presumably the time (and money) saved as a result of the assignment of various responsibilities to non-medical health professionals would assist the facility/clinic to increase their patient throughput. The issue is one of more efficient use of personnel and skills, rather than a cost saving exercise, and needs to be articulated as such.

Better focused and more streamlined projections of future workforce requirements

Current Problem
Current projections not always well focused on major education and training needs, reducing their policy relevance.
Current institutional structure cumbersome.

Proposed Response
Concentrate formal projections on the key workforce groups. Undertake scenario analysis as a matter of course.
Rationalise structure through abolition of AMWAC and AHWAC

RECOMMENDATION

There is a need to retain the current AMWAC and AHWAC – even perhaps to merge the two, but link them more closely. However, given, AHWAC has been in operation only since 2000 (prior to which there was no national recognition of non-medical health professionals workforce issues), there is a need to continue AHWAC in some representative form to ensure nursing and allied health workforce issues are debated, with a direct line of communication with the Australian Health Ministers’ Council.

Main benefits of change
Better use of resources to undertake projections. Greater transparency re the impact of policy settings on future workforce requirements.
Some cost savings. Addresses any residual concerns about undue professional influence in process.

We fail to see how the abolition of AMWAC and AHWAC would achieve the aim of “addressing any residual concerns about undue professional influence in process”.

More effective approaches to improving outcomes in rural and remote areas

Current Problem
Rural and remote issues not always properly considered as part of mainstream policy formulation. Limited evaluation of which specific approaches for improving outcomes in rural and remote areas work best.

Proposed Response
All system-wide frameworks in the health workforce areas to make explicit provision for consideration of rural and remote issues. Initiate a cross-program evaluation exercise.

ANF (Vic Branch) wholeheartedly supports both the articulation of the problems and the proposed responses, and places particular emphasis on the need to evaluate all programs (regardless of setting or context). In the main, we are in agreement of the Chapter 10.1 of the Position Paper, however our previous comments with regard to accreditation and registration requirements and MBS related matters still hold.

Further, the notion of major job redesign opportunities specific to rural and remote areas needs to be approached cautiously. As noted in the Position Paper, issues of access in some parts of the country are not greatly different from that in major cities, with remote mining communities not suffering levels of deprivation in terms of health care (unlike remote indigenous communities) there are indeed dangers associated with generalising.

Certainly, any efforts in terms of health workforce redesign that could be shown to contribute positively to the health of indigenous rural populations would be applauded, however, we do not support "major job redesign opportunities specific to rural and remote communities". As eloquently stated in the Position Paper, many in rural and remote Australia are disadvantaged because of inequity of access to health care. The invention of a new health worker will do little to redress this, and may well exacerbate the city/rural divide by the introduction of a two-tiered health workforce - the well and adequately qualified health professional for the city and attractive regional area, and a minimum qualified worker for the rest of the country. We echo the words of Professor John Humphrey, as quoted in the Position Paper, that "*The quest to get the right health professional to take up rural and remote practice should not be compromised*…."[3]

As mentioned in our earlier submission, efforts to widen the debate beyond that of a hospital/medical workforce are needed. Whilst in no way being able to be a substitute for what is perhaps most accurately described as illness care, more emphasis needs to be placed on primary health and health promotion approaches. The concept of healthy ageing, one of the national priorities set out in the National Strategy for an Ageing Australia[4] deserves particular consideration in rural and remote communities, where lifestyle (and not only limited access to health services),

[3]Australian Government Productivity Commission: Australia's health Workforce, Productivity Commission Position Paper, September 2005, p.169

[4] as quoted in O'Halloran et al, op cit., page 3

contributes to poorer health outcomes in regional Australia compared to those in the major population centres.[5]

RECOMMENDATION

ANF (Vic Branch) suggest the following are particularly relevant in some rural and, to an even greater extent, remote area communities. Many of the challenges associated with rural and remote health workforce recruitment and retention issues from a nursing perspective (and one would assume much is transferable to the needs of other health professionals) relate to work-life balance, and include the availability of child care, employment for spouses/partners, suitable and affordable housing.

Further, schools of nursing must be retained at regional universities/campuses, as there is sound evidence to suggest this prevents the migration of a significant number of nurses away from that region.

Main benefits of change
Greater consideration of opportunities to improve workforce services in rural and remote areas through system-wide changes. Better platform for determining the most effective ways of enhancing health workforce outcome in rural and remote areas.

Ensuring that the requirements of groups with special needs are met

Current Problem
Workforce requirements of groups with special needs not always addressed as part of mainstream policy formulation.

All too often the health needs of marginalised groups become themselves marganilised issues in the articulation of policy. Mental Health, indigenous health and the health care of the aged, disabled and those in prisons are not generally part of the health debate – workers in these specialty areas frequently report they are perceived by other health workers as having a lower professional status, and see this as a factor which militates against sufficient numbers of graduates being attracted to these areas of practice.

Certainly workforce requirements for these groups with special needs, need to be addressed as part of mainstream policy formation, with mandated minimum critical aspects of care contained within undergraduate and post graduate qualifications across all health professional groups.

The appalling health status of many remote area Aboriginal communities demonstrates the importance of recognizing - and acting on - the social determinants of health. Even if there were an unlimited pool of doctors, nurses and allied health professionals seeking to work in remote

[5] Australian Government Productivity Commission, op.cit, page 168.

indigenous communities, their ability to improve the health status of many would amount to little without resources being dedicated to the provision of housing, education and employment.

Proposed Response
All broad institutional frameworks to make explicit provision to consider the needs of these groups.

RECOMMENDATION

We concur with much of the chapter on the needs of special groups and offer broad support to the proposed response.

Main benefits of change
Guard against any marginalization of groups with special needs. Ensure that the specific initiatives for these groups are compatible with generally applicable arrangements.

Conclusion

We commend the Commissioners on their ability to produce a thorough, and comprehensive document in a short, tight time frame. Certainly, there is no quick fix to the challenges that lie ahead.

KEY POINTS

We again offer the key points of our earlier submission, and hope they may in some way be incorporated into a set of guiding principles:

- 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 highly skilled 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.

APPENDIX ONE

In the ANF (Vic Branch) submission in October 2005, we highlighted the achievements of the Nurse Recruitment and Retention Strategy in Victoria.

We now provide the Commission with some further data:

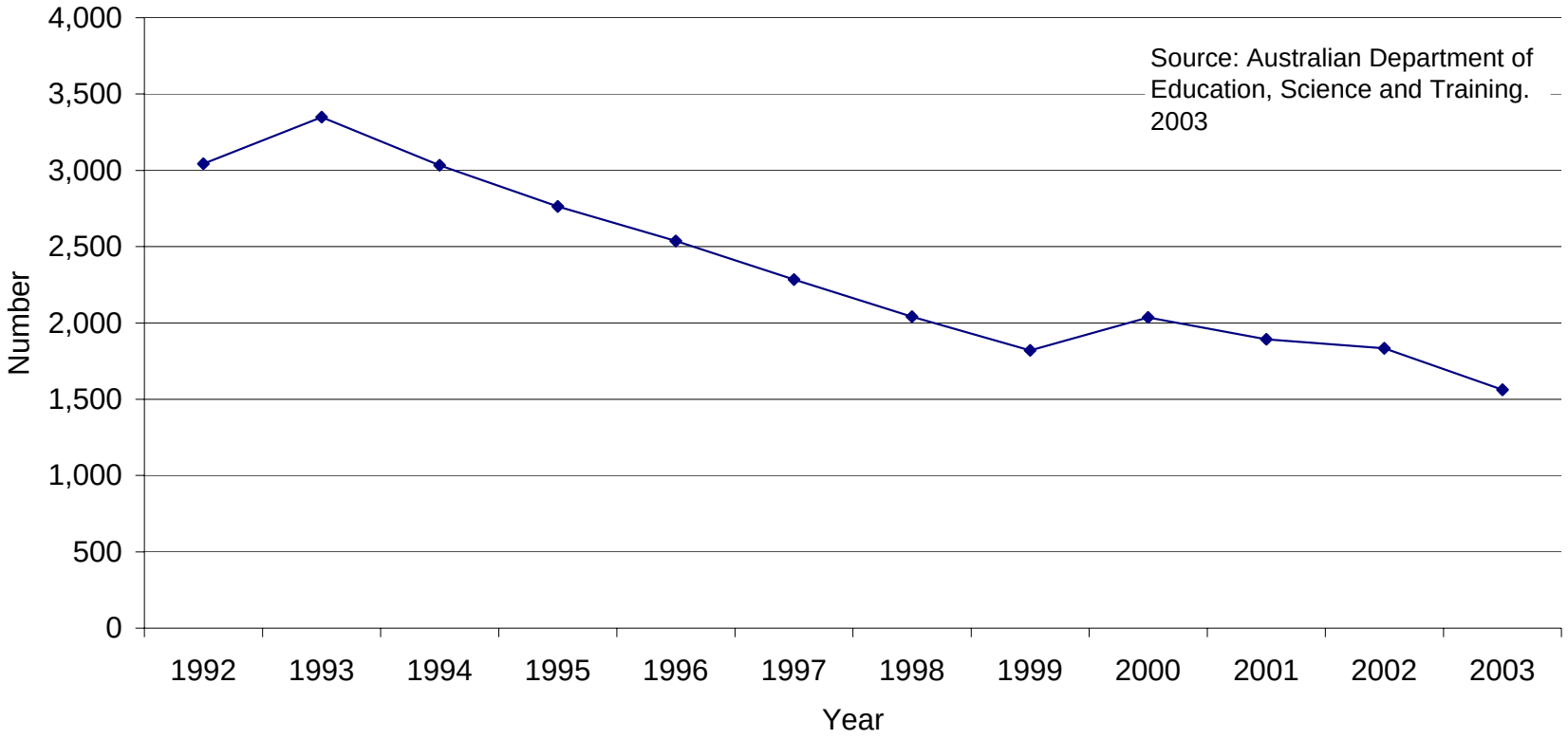
1. DEST data showing the continued decline of Undergraduate Nursing commencements in Victorian Universities from 1992 to 2003. A drop from 3,400 to 1,500.

2. Nurse Effective Fulltime Workforce in Victorian Public Hospitals etc 1992 – 2003.

3. Nurse EFT in Victorian Public Hospitals 1999 – 2003 showing in graphed detail the effect on numbers recruited in relationship to signing and implementation of EBA (better working conditions, nurse patient ratios etc) free refresher and re-entry courses and Nurse Agency Strategy implementation.

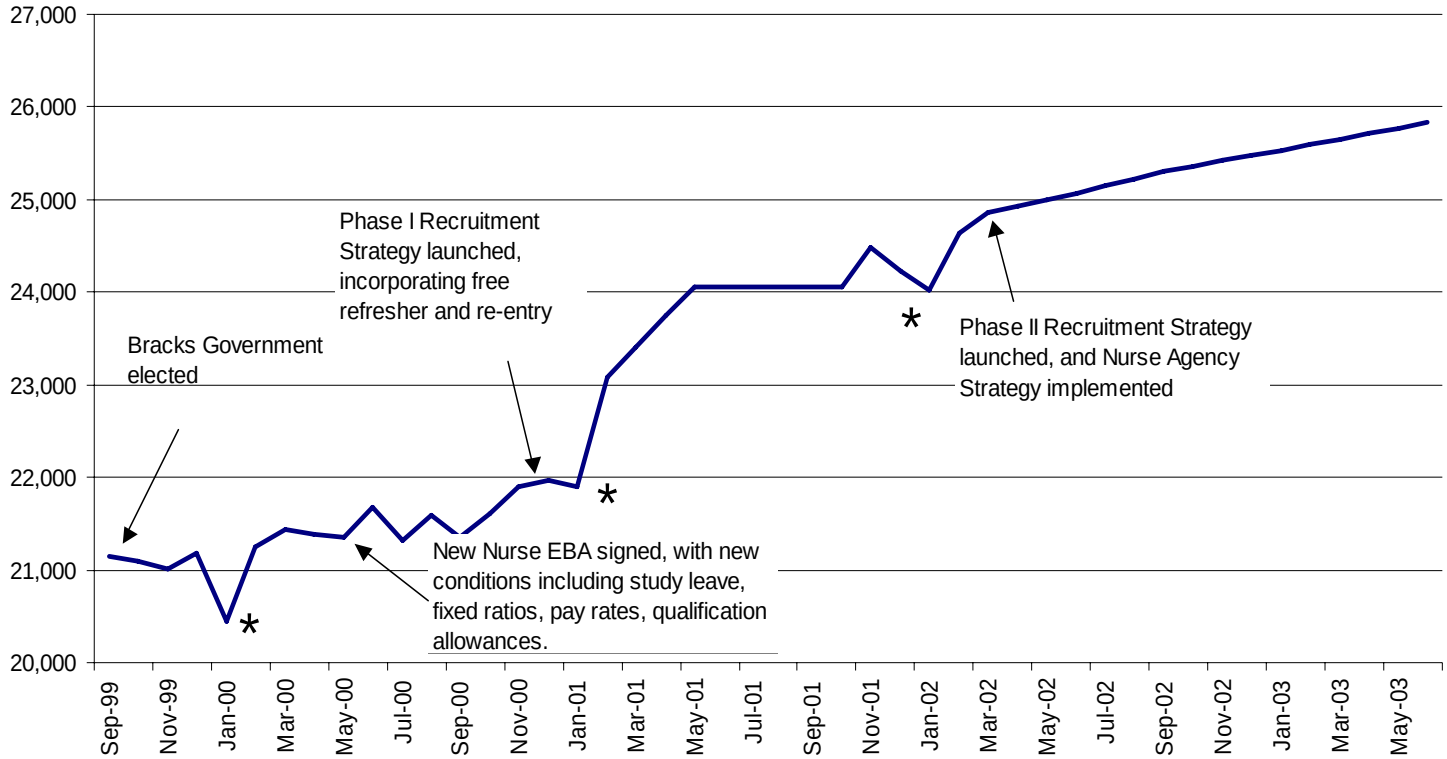
APPENDIX ONE

Domestic undergraduate pre-registration nursing commencements, Victorian universities, 1992-2003

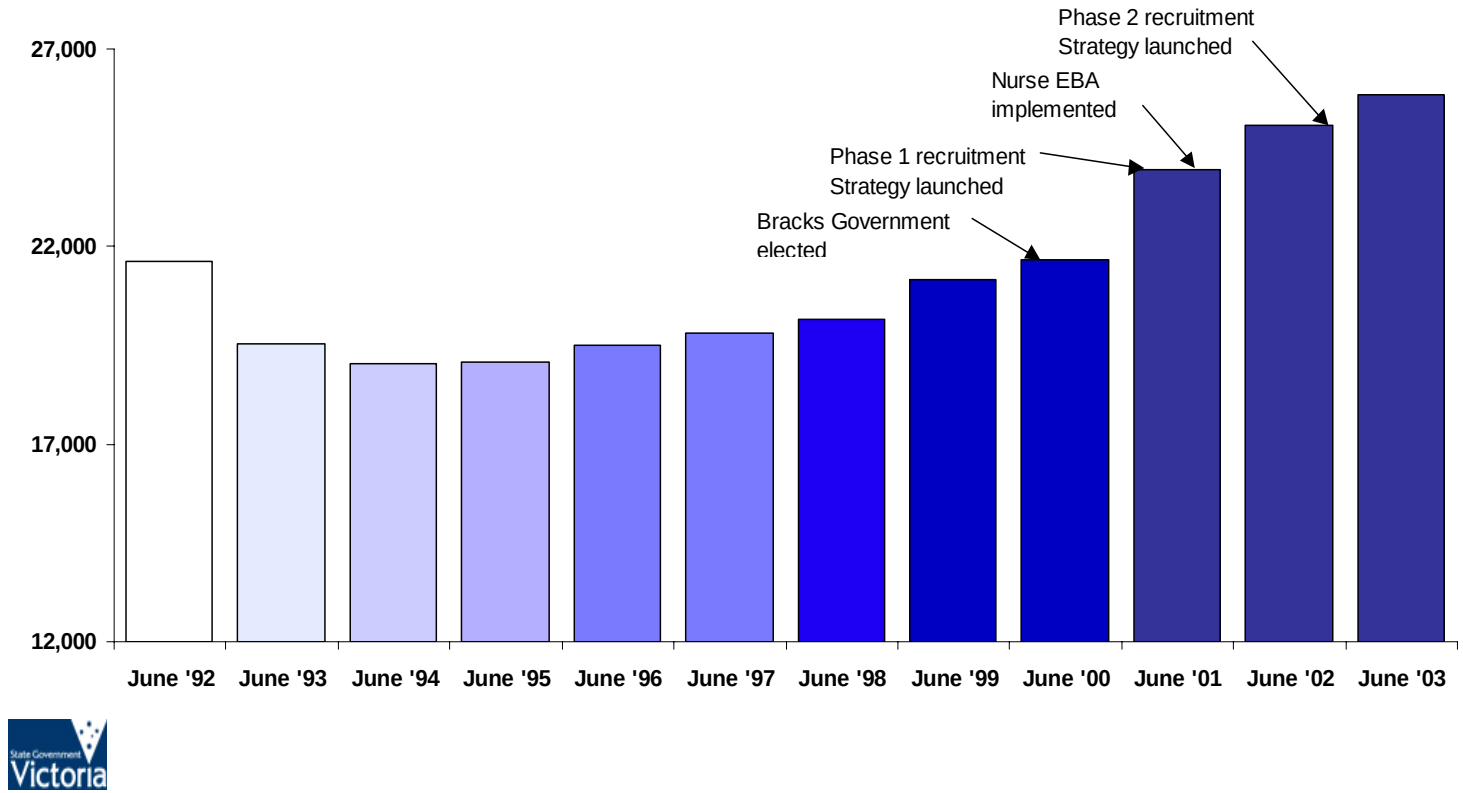


Nurse EFT in Victorian Public Hospitals, October 1999 to June 2003

21,684 EFT in June 2000, 25,831 EFT in June 2003 - 4147 extra EFT



* Normal annual seasonal variation (Christmas/ New Year). Note yearly improvement.



Nurse EFT in Victorian public hospitals, mental health and aged care services
June 1992 to June 2003