A Response to the Productivity Commission's Health Workforce Study

Draft Proposals

By

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Parkville, Victoria

November 2005

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Why is Melbourne Private Hospital (MPH) responding?

- MPH is committed to maximising educational opportunities for graduate and post-graduate nurses in an enhanced supported environment.

- MPH is keen to demonstrate the methodology behind successful staff retention and recruitment.

- MPH recognises the need for all stakeholders to actively participate in helping to manage and find solutions for a national and international problem – a growing decline in the available healthcare workforce.

Melbourne Private Hospital – who are we and what do we stand for?

Melbourne Private Hospital (MPH) was opened in 1995 and provides tertiary level care to nearly 11,000 private patient episodes per annum across Victoria, interstate and overseas. Melbourne Private Hospital specialty areas include: Intensive Care, Coronary Care, Interventional Cardiology, Neurosurgical High Dependency and Advanced Perioperative Services. MPH recognised early the need to create a supportive learning environment and establish a career pathway for new graduates through to experienced nurses. A dedicated Clinical Development Unit was established 9 years ago to address local needs.
The 'bandaid' measures ('refresher' courses, overseas recruitment, and 'skill substitution') traditionally employed over the last five to ten years returned little long-term benefit. MPH was not achieving sustained retention rates utilising these methods. Being a busy inner city hospital, there was not opportunity to draw upon a local 'catchment' of employees.

With corporate support, a purpose designed graduate program has been implemented to 'breed our own'. The culture of the organisation is to encourage and support inexperienced staff despite the labour costs associated with supernumerary time - savings across years could be measured in both staff retention, reductions in agency utilisation and clinical risk management. This has been MPH's experience and to date this program has delivered a 75% retention rate of graduates across 5 years.

In many instances the Private Sector is keen, able and willing to support the workforce needs of nursing. This commitment comes from a few organisations who dedicate themselves to the 'big picture' needs of the health sector. This willingness is unlikely to be sustained unless there is consultation, commitment and collaboration from all key stakeholders. Where MPH has created a structure for graduates to articulate to supported programs after their initial 12 months, there has been no matching of this support from government agencies. For example – the Department of Human Services (Victoria) offers a post-graduate scholarship for nurses wishing to undertake courses within key specialty areas, but currently this is only available to nurses in current

employment or currently seeking employment in the Victorian Public health sector. Much could be learned from the public and private sector school funding models, where both co-exist and participate in striving for common outcomes enjoying the support of government funding. A national approach to funding that includes both private and public sectors would increase training, supervision and practice environments to support options for universities to actively collaborate with workplaces.

What has gone wrong with nursing as a career choice for young school leavers is a question that is not answered by the desire to seek attractive salaries in 'new age' employment markets alone. Altruistic desires may have been replaced by a new generational thinking that gets little exposure to the 'old' world values of just wanting to help. For MPH leading by example and wanting to help new graduates succeed has been our biggest draw card – caring for the carers. Not just lip service, MPH has kept relevant data to demonstrate this approach. While at odds with the economic climate of rationalism and maximising shareholder returns, this approach is proving that sometimes more is better. More support, more supervision and more dialogue with those at the work coalface to learn what is needed.

DRAFT PROPROSAL 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.

Melbourne Private Hospital would like to be considered and invited to be either part of this board or make representation to such a board in the future.

DRAFT PROPROSAL 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 or 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.

Melbourne Private Hospital invests 2% of gross wages in training and development of its workforce. This priority of resources is given to support health care workers in the delivery of high quality care for complex medical and

surgical patients. Since 1996 we have demonstrated a commitment to the development of health professionals for Victoria. As a colocated hospital, along side the Royal Melbourne Hospital, we have supported medical registrars, nurses and allied health staff in accredited training programs and appointments. The nursing profession has been financially supported with programs for undergraduates, graduates, post-graduates, masters' candidates, and supervised practice and refresher programs for reaccreditation with the Nurses' Board of Victoria. Thirty-seven percent (37%) of permanent nursing staff have post graduate qualifications. Our focus and commitment to clinical training and development is unique.

For sustained support of growing health workforce needs, private organisations, who can demonstrate quality program outcomes, should be included in funding models.

Encouraging organisations like MPH to broaden successful programs, through access to funding opportunities to create such an expansion or 'roll out' would serve to be in the wider public interest.

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 later time in the light of experience with the national agency.

Current 'university only' education models are an impediment to providing reduced cost yet 'best practice' undergraduate and post-graduate courses to nurses. The origin of the qualification matters to prospective applicants and while in many instances workplace courses undertaken in association with accredited facilities are equal to their tertiary counterparts, their recognition is not given an equal footing. This is where a national accrediting agency, capable of recognising a myriad of qualifications gained across the country would allow industry and education facilities to become more creative in their approach to course provision. Currently joint ventures between the public and private sectors with universities are limited but are now emerging as a way of key stakeholders achieving common goals. The combination of:

- rigorous training standards that are essential to work performance and public safety;
- tertiary inspired education;
- increasing graduate and post-graduate student hours by the bedside & promote peer support,

allows an exchange of experiences to occur within a more 'true to life' environment, the workplace.

Royal Melbourne Hospital, Melbourne Private Hospital and Australian Catholic University have formed such a collaborative. In 2006 post-graduate courses in key specialty areas will be offered to nurses that are workplace based with a university focus that supports the rigors required by all organisations. This model differs dramatically to either pre-existing hospital based training or university undergraduate/post-graduate courses. This course is an amalgam of the best of both worlds and is aimed at addressing a perceived theory-practice gap that has left employers, educators and employees at odds over professional standards of care.

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 practise in different work settings.

Melbourne Private Hospital would support this position. The current convoluted system available to organisations to facilitate the assessment and employment of overseas-trained applicants serves to delay and frustrate both employer and potential employee alike. A single body with national authority would also encourage overseas applicants to work more widely while on temporary working holidays, in circumstances where 3 monthly employment periods are available while travelling.

DRAFT PROPOSAL 7.1, 7.2 & 7.3

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

Melbourne Private Hospital would support this position. Local authorities such as the Nurses' Board Victoria would ensure compliance with care provision and public safety but would not have a unique state-based accreditation system for recognition of qualifications and registration.

DRAFT PROPOSAL 8.1

The Australian Government should establish an independent standing review body to advise the Minister for Health and Ageing on the coverage of the Medicare Benefits Schedule (MBS) and some related matters. It should subsume the functions of the Medical Services Advisory Committee, the Medicare Benefits Consultative Committee and related committees. Specifically, the review body should evaluate the benefits and costs, including the budgetary implications for government, of proposals for changes to:
• the range of services (type and by provider) covered under the MBS;
• referral arrangements for diagnostic and specialist services already subsidised under the MBS; and
• prescribing rights under the Pharmaceutical Benefits Scheme.
It should report publicly on its recommendations to the Minister and the reasoning behind them.

Melbourne Private Hospital would support an extensive review of the Medicare Benefits Schedule & Pharmaceutical Benefits Scheme.

In particular MPH would like to see support for the following draft proposal.

DRAFT PROPOSAL 8.2

For a service covered by the MBS, there should also be a rebate payable where provision of the service is delegated by the practitioner to another suitably qualified health professional. In such cases:
• the service would be billed in the name of the delegating practitioner; and
• rebates for delegated services would be set at a lower rate, but still sufficiently high to provide an incentive for delegation in appropriate circumstances. This change should be introduced progressively and its impacts reviewed after three years.

Some progress has been made with regard to Community Health but little has been done to facilitate a system of delegation within the hospital setting. In instances where Attending Consultants are unable, due to time demands, to recommend and implement basic treatments, there would be opportunity to assist this process, if acceptable delegation is allowable.

There is currently opportunity for General Practitioners (GP) to be involved with hospitals to plan discharge care for their patients and bill medicare for this service via the Practice Incentives Program (PIP). Since the introduction of MedicarePlus, few GPs associated with MPH have availed themselves of this opportunity due once again to time restraints. Hospitals could assist both patient and doctor by creating partnerships with referring GPs and providing support for the delegation of this role to suitably qualified staff. This program could be expanded to include other variables that could be safely delegated to non-medical staff and thus enhance patient care and outcomes. MPH sees the flow on effect of such initiatives as having benefit in bed management, appropriate allocation of resources and ultimately the prevention of potential patient readmission.

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.

With the average age of nurses in the acute care sector in excess of 35 years, accurate planning is paramount to the success of MPH. To this end, MPH has been proactive in forecasting and projecting immediate and long-term needs for staffing. Natural attrition, & long service leave entitlements are offset by projections, increasing annual intake quotas of graduate and post-graduate students to achieve a long-term net increase in nurses across the organisation.

DRAFT PROPOSAL 11.1

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

MPH supports a funding review of aged care facilities so as to implement a cohesive interim care and 'slow stream' rehab service in Victoria and nationally to reduce the incidence of 'bed block' in the acute health care sector. A centralised system that is not reliant upon individual regional area 'rules' would provide a streamlined referral system for allied health professionals to attain patient assessment. The lack of access to existing services in this sector produces poorer outcomes for patients who are disadvantaged by waiting for specialist care – rehabilitation or geriatric care. Furthermore, patients awaiting immediate interventions are delayed by bed unavailability.