Submission to Productivity Commission

Response to "Australia's Health Workforce" Position Paper

CHAMBER OF COMMERCE AND INDUSTRY

WESTERN AUSTRALIA

Introduction

About CCI

The Chamber of Commerce and Industry of Western Australia (CCI) is one of Australia's largest multi industry business organisations. CCI represents small to large businesses across a diverse range of industry sectors including health and community services, manufacturing, resources, agriculture, transport, communications, retailing, hospitality, building and construction and finance.

Most members are private businesses but CCI also has significant representation in the not-for-profit sector such as in aged care and community services and the government sector. About 80 percent of members are small businesses and members are located in all geographical regions of WA.

At present, over 11% of Members are in the health and community services industry sector.

CCI Mission

CCI exists to serve its Members by:-

- Providing quality cost-effective support and services to help members build their business; and

- Lobbying government to promote an economic and legislative environment that encourages the development of responsible private enterprise.

Health Care Industry

The provision of quality cost-effective health care is a major priority of private health care providers around Australia. Adequate staffing of all occupational groupings is an essential component of health care delivery with approximately a third of all nurses and allied health staff, both nationally and in Western Australia, employed by the private sector. The majority of these staff work in acute/psychiatric hospitals or aged care.

Response to the Productivity Commission's Position Paper

CCI welcomes the Productivity Commission's Position Paper "Australia's Health Workforce" ("the Position Paper") examining issues impacting on the health workforce including the supply of, and demand for, health workforce professionals. We support the general direction of the Position Paper, agree with the current problems identified and accept many of the draft proposals put forward for change.

We generally support the description of what constitutes the state of play in the nation's health system in a contemporary context, the move to endorse the National Health Workforce Strategic Framework as the cornerstone for developing future policy and planning and the establishment of high level agencies to oversee the implementation of changes at a generic and global level.

At the same time, we have a concern that while on a global level the draft proposals should be supported and encouraged there do not seem to be sufficient mechanisms put forward to ensure the changes proposed are acted upon, measurable targets are set and ultimately changes to service are delivered at the local level.

In addition, we are conscious of the large discrepancy that exists between the current situation and what is envisaged from the draft proposals. So while we welcome the changes we are cautious because of the potential for both inertia and mistakes to be made if an overarching properly resourced implementation plan is not also included within the proposals and endorsed by the CoAG.

Comment has been made about the need to find answers to recruiting and retaining younger Australians. It appears that insufficient attention has been focussed on the broader impact of younger generations motivated by different values and choosing significantly different lifestyles to those of the large number of baby boomers many of whom are preparing to exit the workforce. It may be argued that investigating motivation factors for younger people is primarily a social infrastructure study not of key importance to the Commission here. However, we argue that a study of that type is critical to developing comprehensive strategies for medium to long term workforce planning.

While we acknowledge the last draft proposal that recognised the needs of special groups in which those requiring aged care were included, the significance of the sector has not been understood. The sector is growing with the ageing of the population and yet its workforce, currently insufficient in numbers and skill level, receives little attention. Careful attention must be focussed on the specific circumstances of the sector and its needs addressed as a priority by the health workforce improvement agency.

We note also that shortages are not confined to the nursing, medical and allied health workforce but are also affecting our members in the recruitment and retention of third level carers (unregulated employees).

We have the following specific comments in response to the draft proposals:

DRAFT PROPOSAL 3.1

In its upcoming assessment of ways to improve the level of integration within the health care system, the Council of Australian Governments (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 areas and levels of government involved in health workforce policy.

We accept the first draft proposal as the necessary first step in laying the foundation for reforms. The National Health Workforce Strategic Framework (NHWSF) should be endorsed by Council of Australian Governments (CoAG).

We agree with the Commission's assessment that principle 1 of the NHWSF requires broadening or enhancement to firmly acknowledge that Australia's health workforce has always comprised professionals from throughout the global market. It would be unrealistic to set a target that cannot be met. Further, such a principle does not recognise the value that welcoming professionals from across the globe brings. The value can be looked at in terms of cross-cultural influences and other important benefits such as different education and training regimes and organisational systems.

It seems foolhardy not to take advantage of the opportunities presented by our geographic location and economic circumstances. Australia can compete well with other countries because of the features of our lifestyle and climate notwithstanding any peaks and troughs in the economic environment.

We acknowledge that endorsing the NHWSF is an important first step and support many of the draft proposals that establish a structure around each of the principles. However, the effectiveness of outcomes is dependent on appointments made to each of the agencies recommended, the requirements made for formal reporting links to and from advisory bodies and accountability for results required by Australian Health Ministers' Conference.

Further, each of the advisory bodies and agencies will be as effective as the infrastructure built to provide support and accountabilities required.

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. CoAG should commission regular reviews of progress in implementing NHWSF.

While we support the need for regular reviews by CoAG, there is no clear idea of what the scope and parameters will be for the regular reviews.

We urge the inclusion of complimentary and comprehensive reporting requirements for process, quality measures and a time frame for the reviews to take place. An annual review would be appropriate.

Accountability mechanisms and a process for rectifying or problem solving when difficult issues emerge (things go wrong) also need to be included.

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 agency should consist of an appropriate balance of people with the necessary health, education and finance knowledge and experience.***

We support the establishment of an advisory health workforce improvement agency on the basis that it reports directly to the AHMC. Membership appointed as individuals should be open widely to health, education and finance experts across the public and private sectors.

As in other proposals, the success of the agency will be in large part dependent on the selection of members. Care must be taken to ensure no one single group, profession or sector is more heavily represented than any other.

The terms of reference should include a transparent reporting requirement back to stakeholders in industry, government and education.

The agency's broad objective should centre on making the most efficient and effective use of the available health workforce with particular regard for access, quality and safety and the legitimate needs of the workforce itself. It must concentrate on job redesign and find opportunities for delegation of tasks across all professions and occupational groups. The agency must give urgent and special consideration to the needs of the special groups already identified: aged care, mental health, disability and indigenous Australians. These groups should be dealt with in the initial stages of the investigation with a plan developed to meet short, medium and long term needs.

The aged care sector represents the largest area of growth. This sector is reliant on a majority workforce of trained but unregulated workers (carers) with oversight and specialized functions performed by registered and enrolled nurses and therapy professionals. As the dependency profiles in this sector continue to grow, the need for qualified registered staff will also grow. In this sense it will intensify the competition with the acute sector for qualified registered staff.

While many of the needs of the aged care sector will be common with the acute sector, job design will be in many cases significantly different to the acute sector. This happens, for example, because of the reliance on carers looking after residents with relatively low levels of care and the highly specialised skills, often not recognised, required of registered nurses looking after dementia patients and those with difficult behaviours.

Changes that are occurring in the acute sector where the length of stay is rarely more than 3-4 days are not congruent with the needs of the aged care sector. This has a major impact on job design for employees such as registered nurses in both sectors. It is an area for critical examination by the health workforce improvement agency at an early stage.

Where sub-committees are formed they should be set up so that there is a practical but formal mechanism by which they have access to and can utilise the information obtained, where appropriate, by the other groups proposed to be set up under the draft proposals such as the advisory health workforce education and training council. Hence avoiding silos to ensure effective links and providing a proper basis for reform.

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 function would encompass the mix of places across individual health care courses, and the distribution of those 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 Education, Science and Training, other relevant Australian Government agencies, the States and Territories and key non-government stakeholders.***

In view of the special circumstances that prevail in the health industry because of the significant workforce shortages there seems some justification in treating health care courses differently from other university-based disciplines. The role of governments in funding the bulk of the costs of services provided by health workers as indicated in the Position Paper together with the fact that DOHA is already involved in the allocation process for medical places means that the transfer would be simply an extension of its current role. Of primary importance, however, is the linking of university courses with health service skill requirements.

We support increasing the role of health departments in the allocation of funding for university-based health workforce education and training; integrating university and VET funding; providing a vehicle for independent and transparent assessment of "directional" change in health workforce education and training; and providing for a more sustainable clinical training regime over the longer term.

It is agreed that DOHA should focus primarily on setting the mix of places across the various health science courses and the distribution of those places across universities, in dialogue with vice chancellors as at present. However, scope should be given to DOHA, in consultation with the universities, to make revenue neutral changes to the course subsidies used to set overall funding levels to help address some concerns about current course funding relativities.

Any shift in allocation responsibility must be accompanied by a formal requirement for DOHA to consider the needs of all university-based health workforce areas and to consult with DEST, other relevant Australian Government agencies, the States and Territories and private sector stakeholders.

In addition, industry stakeholders should have an opportunity to provide input into areas such as curricula development and review.

DRAFT PROPOSAL 5.2

The Australian Health Ministers' Conference should establish an advisory health workforce education and training council to provide independent and transparent assessments of:

- ***opportunities to improve health workforce education and training approaches (including for vocational and clinical training); and***
- ***their implications for courses and curricula, accreditation requirements and the like.***

The success of an advisory education and training council would be dependent on a number of factors described in the Position Paper. In particular,

- The membership of the council. Members need to be carefully chosen across all professional areas and include experts from universities and industry.

- An independent chairperson must be appointed.

- If the council is to be advisory with no formal role in the accreditation of courses it must work with and be a source of information and rigorous advice to both the advisory health workforce improvement agency referred to in draft proposal 4.1 and the national accreditation agency referred to in draft proposal 6.1.

- The council's assessments cover all forms of health workforce education and training, vocational and clinical.

- It report to the policy making body, AHMAC.

- It is vital that vocational education opportunities are explored.

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 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.***

The need for transparency and contestability in funding frameworks is significant.

As with other draft proposals its success will depend on the success of the linkages between the proposals. For example, the workforce improvement agency referred to in proposal 4.1 will need to play a role drawing the attention of governments to the clinical training ramifications of job redesign. In addition, as suggested, the proposed health workforce education and training council should play a role in advising on the ramifications of new approaches to the delivery of clinical training.

It is assumed, although it is not clear, that the work required by this draft proposal will be overseen by AHMAC.

The issue in relation to who pays for clinical training needs to be addressed in a manner suggested by the Australian Private Hospitals Association (footnote subm 109, p2) ie through the development and implementation of a model that is coherent and equitable. In principle we

support the notion that public funding should follow the trainee. Additional funding sources are needed to ensure that, for example, appropriate levels of supervision are provided.

Further, before the private sector can become increasingly involved in the training of medical practitioners a well co-ordinated and funded infrastructure needs to be put in place to ensure the ongoing quality of training continues.

One improvement that will assist the private sector in funding training places would be to remove the restrictions imposed during the 1980s for access to Medicare rebates. As trainees providing medical services to private patients within private health facilities require access to Medicare rebates to generate revenue to fund their private hospital posts, they will not be offered posts if they do not have easy access to such rebates.

While access does exist currently the processes required by section 3GA of the *Health Insurance Act 1973* and regulation 6E of the *Health Insurance Regulations 1975* are convoluted and therefore unlikely to be utilised.

If private hospitals are to be encouraged to fully contribute to the training of medical practitioners a fundamental first step is to improve the processes required for access to Medicare rebates.

In addition, medical indemnity increases will reduce opportunities to attract doctors into the private sector on an ongoing basis. Accordingly specific measures need to be identified to provide some certainty.

DRAFT PROPOSAL 5.3

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.***

The development of a single national accreditation agency supported by a national data base is strongly supported and welcomed to address lack of consistency between Australian States and Territories and the effect of current accreditation requirements in reinforcing traditional professional roles and boundaries.

At the same time, if a single national agency is to be established replacing all existing accreditation and registration boards for all professions, a measured and staged approach should be adopted.

It is agreed that the accreditation agency should not be charged with such functions as developing new scopes of work and redesigning jobs. However, it should cooperate with other bodies organising such work and develop relevant accreditation procedures to respond to the changes. It should also have power to facilitate education and training changes on its own initiative, with proper advice, and to refer proposals with broader implications to the workforce improvement agency and relevant bodies.

Care needs to be taken in selecting suitable appointments to the agency to ensure no one profession is favoured over others and to ensure equity between all states and territories.

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.

It is appropriate that the new accreditation agency have a duty to develop a national approach to the assessment of overseas trained health professionals.

DRAFT PROPOSAL 7.1

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.

We support this proposal and agree with the Commission's view that if implemented the national accreditation body referred to in proposal 6.1 should provide national standards which registration boards should be required to adopt.

A system for independent peer review including a mechanism for initiation should be introduced for access in relation to certain overseas and local doctors particularly where doubt exists over credentials. The system must be transparent where all parties involved understand what is expected and the limits of what can be achieved.

DRAFT PROPOSAL 7.2

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.

We support moves to remove duplication and inflexible practices. We understand that many registration bodies have already moved to waive fees where, for example, a registered nurse is required to have registration in more than one jurisdiction as a result of working across jurisdictional borders. Mutual recognition is a short to medium term response with national registration as the proper solution.

A national data base is needed for all professions where a fee is paid at the point of registration in whichever state the person completes their training. Subsequent renewal fees can be paid in whichever state the person is employed thereafter.

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.

We support a policy framework for task delegation; one which facilitates, supports and encourages delegation. Regulation may not be the solution.

In the case of nursing there is already in some states a Scope of Nursing Practice that sets down a process for delegation of tasks in nursing. These approaches already developed should be fostered, encouraged and further developed to apply to all members of the health care team such as, in an acute environment, from doctors through to care staff (unregulated).

Processes should be developed to ensure delegation is effective. For example, the delegating employee must ensure that the person to whom they are delegating tasks and responsibilities is clearly aware of what has been delegated, why it has been delegated, where the accountability lies and is provided with appropriate support and authority to undertake the delegated tasks and responsibilities. Such a process if implemented correctly and supported by a formal policy framework would remove or reduce reluctance to embrace and accept delegated tasks.

IF national regulation is to occur in keeping with draft proposal 6.1 the current registration boards such as the Nurses Board of WA could have an enhanced role in educating, promoting and developing the Scope of Nursing Practice – Decision Making Framework.

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.***

We support this proposal and while we acknowledge the comments made several times in the Position Paper in respect of not proposing major changes to the coverage of MBS and funding arrangements on the basis of workforce considerations alone, there is an urgent need to create flexibility in scope of practice by a range of health practitioners before genuine reform can be addressed to benefit service delivery.

Review of both the coverage of MBS and funding arrangements are at the heart of the reform process to which we refer.

This was clearly argued by many parties submitting responses including the Department of Health and Ageing (submission 159, p29 and 31)

A staged approach for introduction of changes may be a more realistic and acceptable means of achieving improvements. For example, the following could be fast tracked:

- Practice nurses already have some scope to act on behalf of medical practitioners (referred to on page 127, Box 8.3). It may be possible to extend the same service and access to the same item numbers to which they currently have access into other

metropolitan community areas (beyond rural and remote) to provide a better resource for general practitioners.

- Counselling and emotional support could be provided by social workers;

This would have the benefit of immediately relieving some of the burden on general practitioners while the matter is fully addressed.

Further, it may be possible to arrange trialling of limited access to MBS item numbers in certain restricted areas to demonstrate that access to the MBS will not result in cost blow-outs eg to nurse practitioners in aged care (where few doctors are available) beyond the scope of the limited trial currently operating in 3 states.

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.***

We support this proposal on the basis that delegation of services is poorly supported by the MBS. We agree that there are clear benefits in changing the MBS regime to facilitate greater delegation of less complex tasks to other suitably qualified but more cost-effective health professionals.

The example of practice nurses has already been used. Its extension is supported. The mechanism suggested by Duckett is also supported:

> *"In this way, for example, an anaesthetist would be able to bill for the work of a nurse anaesthetist using the anaesthetic items of the Schedule. Assuming salary costs for the substitute professional are lower than the medical specialist, this would then put a financial incentive on medical practitioners to utilise other health professionals for service delivery."*

In rural and regional areas with small population centres where few staff are often employed to provide a wide range of services the staff could not manage to run a service without a flexible and multi-disciplined approach to how it is delivered. GPs in these areas would be assisted by physiotherapists and other allied health employees providing specific services that are currently provided by a single GP.

Flexible practices already in place in aged care include where physiotherapists, for example, refer patients for simple X-rays removing the need and the cost to the patient of having to seek a referral by a GP. The patient is then able to return to the physiotherapist for follow-up. This has proven a good service freeing up GPs for more critical work. Further benefits would be obtained for both patients and GPs if a similar approach could be taken for routine ultra sounds of joints including patient report back to the physiotherapist for follow up rather than the GP. The physiotherapist could refer to the GP if problems were identified.

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 and the Australian Health Workforce Advisory Committee. A single secretariat should undertake this function and report to the Australian Health Ministers' Advisory Council.

This proposal is supported provided there are clear formal links between the new single secretariat, the other new groups and agencies recommended in other proposals (advisory health workforce improvement agency, advisory health workforce education and training council, the independent standing review body to advise the Minister for Health and Ageing on the coverage of MBS) and existing bodies and committees including the Australian Health Workforce Officials Committee and the Australian Health Ministers Advisory Council.

If all bodies recommended in the Position Paper and all existing bodies that remain are technical bodies and co-ordinated through the Australian Health Ministers Advisory Council there is more likelihood of successful planning projections.

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.***

We support prioritising areas of demand acknowledging that collection of data needs to be managed according to a benefit-cost assessment and following a gap analysis to properly determine priority for areas of need.

At the same time, we strongly advocate for the continued development of information sharing and ongoing improvement in health workforce data collections through putting in place common language, minimum data sets and consistent collection and processing arrangements.

Further, we support in particular the sponsoring through AHMAC and AIHW the development of formal data exchange protocols between jurisdictions, registration bodies and relevant agencies especially those proposed as new agencies under the draft proposals put forward in the Position Paper.

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.

We support this proposal.

In its considerations the Australian Health Minister's Conference should take into account the significant inequities manifest in rural and remote areas whereby those filling positions in occupational groups in short supply are paid disproportionately high salaries compared with those in the same township in a stable workforce group receive proportionately low salaries. The rates of pay which result are in these circumstances driven entirely by the market and not at all related to skill levels brought to the respective position.

DRAFT PROPOSAL 10.2

The brief for the health workforce improvement agency (see draft proposal 4.1) 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.***

We support this proposal.

The agency will need a subtle approach taking into the account the vastly different approaches that have been adopted in rural areas compared with remote areas and between remote areas.

For example, the type of employment arrangements entered into in fly-in fly-out communities are significantly different to those provided to employees of traditional wheatbelt townships in rural or developing communities. The circumstances are even more complex in some remote locations where personnel fly in and out from overseas and where families don't accompany the employee to the township but remain in the city.

DRAFT PROPOSAL 10.3

The Australian Health Ministers' Conference should initiate a cross program evaluation exercise designed to ascertain which approaches, or mix of approaches, are likely to be most cost-effective in improving the sustainability, quality and accessibility of health workforce services in rural and remote Australia, including:

- ***the provision of financial incentives through the MBS rebate structure versus practice grants; and***
- ***'incentive-driven' approaches involving financial support for education and training or service delivery versus 'coercive' mechanisms such as requirements for particular health workers to practise in rural and remote areas.***
- ***There should also be an assessment of the effectiveness, over the longer term, of regionally-based education and training, relative to other policy initiatives.***

Further to the comments made in the Position Paper support is provided to concentrating efforts on attracting local people into health care professions rather than providing incentive and other "coercive" mechanisms to require health professionals to work in areas where they would not otherwise choose to practice, the latter being more likely to produce only costly short term benefits.

A combination of initiatives needs to be pursued including:

- Providing infrastructure in regional areas to enable education to be provided at regional centres through both the "hub and spoke" model suggested and also improved access to online learning methods;

- Exploring telemedicine as a technique for all health practitioners;

- Developing a better understanding of what will attract young professionals to rural and remote areas acknowledging that while the majority of people brought up in metropolitan areas prefer to work in the city there are some who would enjoy rural life. For example, the paper refers to salaried employment as the preference of younger professionals over commercial business practice. This strategy would include developing initiatives in response to new information gained.

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.***

We support ensuring that all broad institutional health workforce frameworks make explicit provisions to consider the requirements of the above groups.

In relation to mental health, we do support a change to the qualifications for mental health nursing to reinstate the direct entry psychiatric nursing program or to consider other options such as streaming from comprehensive nursing programs to enable some emphasis on mental health during the program.

New models of care including to facilitate judicious delegation of certain tasks from registered to unregistered workers and improvements in regulatory frameworks (some of which are already catered for under the draft proposals) are essential foundations to making a difference to the problems currently facing aged care organisations in meeting the demands caused by significant labour shortages in this sector. The urgency for such changes in the sector is so great that the changes need to be timetabled ahead of some other areas.

We seek the setting up of special working groups as subgroups of the advisory health workforce improvement agency to make specific recommendations in relation to aged care, mental health and disability sectors. They should have access to the resources being generated through the agency and the advisory health workforce education and training council. However, as these special areas require some priority they may need to be resourced separately.