COLLEGE OF NURSING - PROFESSIONAL EVENT

30 MARCH 2006

Australia's Health Workforce: Reforms needed to meet health workforce pressures

Links to the National Nursing & Nursing Education Taskforce

Good evening. It is lovely to be here and participate in tonight's activities - thank you for inviting me.

I have been invited to provide a view on the Productivity Commission Report entitled "Australia's Health Workforce" released in December 2005.

I wish to note that the views I am presenting this evening are my own and not necessarily those of the Taskforce members.

The Taskforce - Experience and a Helicopter View

The Taskforce was established in mid-2004 to monitor and implement 22 of 36 recommendations from the National Review of Nursing Education (2002): *Our Duty of Care* report, as well as recommendations from the Critical Care, Midwifery, Mental Health Workforce Reports, and a piece of work on Specialisation (to develop an agreed definition of specialist nursing and an agreed framework for nursing specialisation and the development and attainment of postgraduate qualifications).

Currently, there is no national agreed specialisation framework for nursing and midwifery in Australia and the absence of such a national framework has been identified as contributing to difficulties in developing a clear understanding for future nurse workforce planning, determining workforce requirements, and the development of appropriate education programs.

The Taskforce's work program is broad and encompasses things such as:

- Clinical education funding
- National consistency in nurse practitioner policy and nurses practice
- National consistency on nurse practitioner workforce data collections
- National priorities for nursing & midwifery research
- Building capacity in education through funding, models and pathways
- A national audit of inter-professional work and best practice examples of undergraduate interdisciplinary learning
- Identifying where there are opportunities to maximise education articulation opportunities, including cross-sector articulation and articulation to nursing from other health and community streams and
- A Report to Ministers outlining opportunities for greater national consistency in regulation of nursing & midwifery practice through amendments to jurisdiction based legislation, regulatory standards and regulatory authorities processes.

As many of you are aware, the Taskforce has been given two years to complete its work and we are funded by the Commonwealth and the States and Territories (both Health & Education) and report to the Health and Education Ministers, both Commonwealth, State and Territory.

So... the fact that we provide a bridge, if you like, between Education and Health, is a good place to start in terms of the Productivity Commission Report.

One of the challenges for the Taskforce has been the fact that our work crosses over both Education and Health portfolios and navigating the communication pathways up to Ministers has been an interesting journey, although that being said, it has provided us with opportunities to develop working relationships with various people and groups.

Just as the NRNE found, the Productivity Commission Report shows us that one cannot look at the health workforce and nurses practice without looking at education - they are inextricably linked.

Pleasingly, the Productivity Commission recommendations flag closer cooperation between Education and Health. From our work, this is absolutely necessary.

One of my observations is that we repeatedly call for greater teamwork amongst healthcare professionals. Whilst we do have

effective interdisciplinary teamwork in some clinical areas, it is not the norm, particularly in hospitals. From a workforce shortage and workforce perspective alone, notwithstanding the economic argument, it makes clear sense to work smarter. Research substantiates that health services are improved when health care professionals work together in teams. In terms of the "good employer", effective teamwork enhances staff motivation, job satisfaction and mental health, and improves retention and reduces turnover.

It stands to reason that if we educated health professionals together, rather than in separate professional silos, at an undergraduate level, we might be better positioned to work in teams.

The Taskforce has found that there is evidence of preliminary forays into inter-professional education, however, to my mind, it makes enormous economic and practical sense to look very closely at implementing different models of undergraduate learning for all health professionals, notwithstanding concern about funding diversion in universities and perceived potential professional identity loss. My view would be that the position of the various health professions would actually be strengthened by collaborating together to manage the future.

The Productivity Commission proposal to establish an advisory health workforce education and training council to facilitate

consideration of education and training issues on an integrated rather than profession-by-profession basis is to be commended.

One of the challenges that we have become increasingly aware of is the plethora of emerging policy around education by regulatory authorities that has the potential to stifle reform. This factor is certainly having an impact on the cost of undergraduate placements in nursing.

There is a growing and prevailing view that regulatory policy and frameworks should enable (rather than restrict) health professionals in their work.

Our mapping work on the legislation and regulation with regard to nurses' practice is calling into question whether all the regulatory rules (policy, guidelines, standards) are actually evidence based and embedded in a policy framework and we have identified some examples where they could be identified as short-sighted reactive edicts that reinforce traditional roles and boundaries and arguably restrict practice.

The Productivity Commission Report identifies current approaches and processes to regulation and education and training as reinforcing traditional roles and boundaries, which only serve to constrain workplace innovation and job redesign.

We have also identified that current regulatory approaches do not facilitate workforce mobility in Australia - for example, we do not currently have mutual recognition for Nurse Practitioners.

The Taskforce is guided by the National Health Workforce Strategic Framework - this is the key document for us and it is pleasing to see the Productivity Commission and COAG endorse the Ministers' Vision for the health workforce for the next 10 years.

Guiding Principle 4, from the Strategic Framework, which refers to "cohesive action" between health, education, vocational training and regulatory sectors has influenced the Taskforce's processes whereby we have a clear strategy about bringing people together to enable collaborative action. We have a number of projects, which bring academe, regulatory authorities, government representatives and professional organisations together as key stakeholders in solutions, process and outcomes.

Clearly, other aspects of our work are guided by the principles in the NHWSF, eg national consistency (Principle 7), which is a central theme for us.

With regard to national consistency, the Taskforce has completed a review of re-entry programs and has provided a Report to Ministers. Our findings included that:

- Legislation regarding re-entry in each state and territory varies considerably

- Despite provisions for mutual recognition, there are considerable differences in the re-entry requirements, practice and policies stipulated by the eight NRAs
- Four general approaches or pathways for re-entry were identified and there were significant differences in the structure, duration, content and eligibility criteria of the different pathways in each jurisdiction
- Data collection differences between NRAs limit the ability to effectively compare and evaluate re-entry programs.

It is clear that there is work that could be done now to achieve national consistency and we have made three recommendations to rectify this - the Report is with AHMC now. The Chief Nurses have also seized the opportunity to begin work together to achieve some national consistency in this important area and are working with the Taskforce, regulatory authorities, ANMC and Deans of Nursing and Midwifery.

Facilitating health professionals to return to the workforce is a key policy plank for the Commonwealth and the jurisdictions. However, data in relation to "churn", or turnover, is not always collected or analysed for improvement purposes and I believe there is a lot of unnecessary expenditure in "churn".

With regard to nursing turnover, my view is that not many health services around Australia actually measure, investigate or monitor it and I believe this requires greater attention.

Whilst I am on the National Health Workforce Strategic Framework, it is worthwhile at this point to comment on the Productivity Commission's recommendation (3.2) regarding workforce self-sufficiency.

The Commission's Paper identifies that the self-sufficiency principle in the NHWSF should be re-examined in terms of whether the formulation of same is unduly restrictive in the context of the international nature of the health workforce. The Commission is of the view that access to internationally trained health workers provides a valuable avenue for skills transmission and through this productivity gains.

In the shortage debate, many myths abound in relation to retention of nurses. Indeed the Taskforce has explored the issue of attrition in its Myth Buster series and found that there is little good data to support this. In 2002, 91% of all nurses who were registered were employed in nursing and of the 9% who were not employed in nursing, more than half were not looking for any work or were overseas.

That there is a shortage of nurses, is a given, and there has been a great deal of modelling and predictions in relation to this.

Unfortunately, it is easier to focus on overseas recruitment rather than tackle the local issues. In a recent ICN Report by the Burdett Trust and Florence Nightingale International Foundation entitled, "The Global Nursing Shortage: Priority Areas for Intervention", it is

stated that the main cause of the relatively high levels of nurse migration today is nursing shortages in developed countries, combined with "push" factors that cause nurses to leave their home countries. In addition, the Report notes that there have been reports of "unethical" behaviour on the part of some recruitment agencies, including providing misleading information to nurses about conditions in destination countries, or charging nurses unnecessarily inflated fees for travel.

To exemplify, we know that internationally there has been considerable recruitment from countries such as Zimbabwe. Zimbabwe has one of the highest incidences of AIDS and is one of the poorest countries. In 2001, there were 12,500 RNs and midwives (all categories) in Zimbabwe - about 1/3 of which were classified as "general nurses". Numbers registered in Zimbabwe have been declining and at the same time the number in the UK has been increasing. In Australia, data from just two jurisdictions in 2003/04 showed that there were 400 nurses newly registered from Zimbabwe.

If there are approximately 4,000 "general" nurses in Zimbabwe, then we in Australia must have about 10% of them. There is evidence that there has been active recruiting by firms in this country. Is this right? I am not concerned about those nurses who choose to immigrate, but I am very concerned about active unethical recruitment from a country that desperately needs health professionals.

I am increasingly of the view that overseas recruitment is essentially about shifting the deckchairs and I consider that there is a better spend of the money by focusing on things we can address at home. Having said this, I agree with the Productivity Commission that we are part of a global market, but with this comes a responsibility to ensure the working environment enables safe practice and that all recruitment processes are ethical.

With regard to other recommendations from the Productivity Commission's Report, I support Recommendation 4.1 - the establishment of an Advisory Health Workforce Improvement Agency. My view is the time is critical in terms of workforce reform.

We simply cannot go on doing things we are today without losing more of our health professionals to burn out and disillusionment.

It is not longer appropriate to hang on to tradition and defend it, for a variety of reasons, most importantly for the people who access or try to access timely health services.

Even if we had all the university places we wanted for doctors and nurses, it would not make a great deal of difference. At some point, we have to look at whether we can sustain inefficient practice and whether we can endorse educating more and more people only to lose them from the workplace. In addition, people are simply not going to choose to work/study in health unless we get our act together.

I am reminded of a powerful statistic that many of you would have heard me use before:

> "*In Australia today, the national workforce grows at an annual rate of around 170,000 per year. By 2020, this is predicted to be just 12,500 per year; or put another way, for the whole of the decade 2020-2030 the workforce will grow by less than it currently grows each year (Department of Health and Aged Care 2001).*" NHWSF, AHMC 2004, p9.

Clearly, there is more we could do in terms of retention, but there is also more we could do in terms of removing impediments to innovation. That there will be new roles is a given but we also need to ensure that we are using existing roles to their full capacity. Arguably, both nurses and doctors are doing things that other health workers could do safely.

Holding on to everything, and protecting professional turf, yet wanting to do more, is a recipe for disaster and when the public is disadvantaged it is even worse.

Why should I, if I am a patient, suffer in pain waiting for a Registered Nurse to give me medication when an Enrolled Nurse could attend to me in the interim?

Alternatively, why do I need to see a doctor about my asthma or diabetes management when I could see a Clinical Nurse Consultant or Nurse Practitioner.

There are many opportunities for innovation in healthcare that would result in greater efficiencies and there are pockets of innovation, but what we need is system-wide innovation and this requires a national body with a head of power, and adequate resources and funding. The Health Workforce Improvement Agency, as recommended by the Productivity Commission, that would differ from existing bodies, be dependent, have a whole of community perspective, and an effective governance structure, is necessary and much needed, in my view. I look forward to this work commencing and outcomes from this initiative - it is long overdue.

With regard to the establishment of a single national registration board for health professionals, our work has clearly demonstrated the need for a nationally uniform approach to the regulation (rather licensure) of health workers.

I am of the view that existing processes with regard to nurse registration are <u>not</u> adequate. There are differing standards on a number of fronts and, as mentioned previously, despite huge policy work on NP, we still do not have mutual recognition in place.

There is confusion about regulation and licensure. There is also confusion around regulating to protect the public versus regulation to protect the public interest.

Calls for PCAs to be regulated for example is topical. Arguably, these workers are already heavily regulated - they are just not licensed and would licensure guarantee quality and safety?

In summary, I support the Productivity Commission's recommendations. I believe it is essential that we grapple with the issues raised in the Report and there is a great deal of good will across the health and education sectors to do this.

The Productivity Commission provides us with vehicles and strategies to progress the work. All that is needed is resources and commitment. Much of the work will disrupt and challenge the natural, historic order and we can ill afford to be "precious" and custodians of convention.

In the words of Christensen, Bohmer and Kenagy (2000), it is time for disruptive innovation - the sort of innovation that disrupts the conventional order and forces us to do thing differently.

It is a different way of thinking. We have to view the nursing workforce as part of, and articulating with, a larger health care workforce. We have to create and embrace a system where the clinician's skill level is matched to client needs, and the difficulty and nature of the work.

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