CDNM COUNCIL OF DEANS OF NURSING & MIDWIFERY
AUSTRALIA & NEW ZEALAND

Response

from the

Council of Deans of Nursing and Midwifery (Australia & New Zealand)

to the

Productivity Commission's Position Paper on
Australia's Health Workforce

November 2005

The Council of Deans of Nursing and Midwifery (Australia & New Zealand) [CDNM] commends the Position Paper *Australia's Health Workforce,* prepared by the Productivity Commission, for the breadth of its coverage of issues and its readiness to confront entrenched attitudes and practices. The CDNM does not agree with the whole of the Paper but it does regard the Paper as a positive measure and hopes that after responses to it have been considered by the Commission the final recommendations will lead to notable improvements in the organisation and delivery of health care in Australia.

The Council supports the following positions of the Commission's Paper:

- An ageing population and an ageing workforce place strains on the health workforce
- Supply and demand projections should be based on differing scenarios
- There is a need to allocate more funding to educate more nurses (and other health professionals)
- It recognises that the shortage of nurses is caused largely by failure to retain them in their profession after graduation and registration. We submit that this can only be addressed by changes in workplace relations and conditions
- It advocates a peak national body to advise on all aspects of ensuring an adequate health care workforce. This could help to address proposals such as the Nurse Practitioner without such developments getting blocked by political debate or turf wars such as has been the case for the NP. Issues of national importance do deserve to be decided at such a level rather than as in the current system.
- It advocates a peak national body to oversee all aspects of accreditation and registration. We would expect that nursing is represented on all panels and that nursing courses were accredited by nurses. The issue of credentialing is linked to accreditation/registration but not mentioned by the Commission. This is important; we do not want a proliferation of credentialing bodies being set up in the near future. Perhaps competency assessment also fits here.
- It supports an increase in the number of Nurse Practitioners. For every one per cent of RNs qualified as Nurse Practitioners, on the 2001 figures that would mean 1740 NPs – a useful supplement to the 52000 medical practitioners
- It suggests that rural and remote health care would be helped by greater delegation of tasks, and by provision of education and training opportunities in these areas
- It suggests block funding of communities for health care rather than top-up payments to providers for individual services
- It proposes wider scopes of practice for Aboriginal Health Workers and increased education and training for Indigenous students, in or near their communities
- It recognises that there should be more evaluation of all health care measures and initiatives

The Council has misgivings about the proposal to transfer responsibility for allocating funding for health care education from DEST to DOHA. The core business of DOHA is health care, that is, to oversee and provide funds for care - whereas the core business of DEST is education. In our view the Department which has the expertise in funding education in other fields should allocate the funds to deliver the education in the field of health care. If the funds go to DOHA we will have again the mix of service and education - which did not work well especially for nursing education in previous times. The importance of a sound pedagogy and research based education might be lost.

The big issue here is control - who has the funds will control the system so this would mean that DOHA would control all health education. The Position Paper notes DOHA's traditional focus on medical practitioners rather than other providers of health care, so it is not surprising if Deans of Nursing and Midwifery are apprehensive. In any event, why should the control of health education be different from the education of lawyers, business managers, scientists and other professionals? We do not provide to the Department of Industry control of the funding of Engineering education, nor to the Department of Primary Industry control of funding of education in Agriculture or Veterinary Science.

Student equity issues arise if funding from DOHA were to be the only funding into the university health programmes; what mechanisms would there be to support students via centralised university systems, and would the DOHA monies include those elements? Furthermore, reporting mechanisms would differ between disciplines in the university setting. What DEST information would still be required for health funded programmes- that is what are the interface requirements? What assurances are there that existing health programme profiles would be funded adequately? How would growth and development be managed? What might contestable clinical placement funding mean for Nursing programmes?

The Council would prefer to go further than "delegation" of tasks from medical practitioners to appropriately qualified nurses and midwives. "Delegation" simply continues medical dominance in areas related to fee for service and government subsidised health provision. The Council advocates a system where skill enhancement is supported rather than delegation by doctors. Suitably qualified nurses and midwives need to be recognised as autonomous practitioners, not mere workers under delegation of a medical officer. Delegation perpetuates the medical dominance of health care in this country. The problem with delegation is that it could just increase the number of GPs who have RNs doing work under their delegation for which the GP gets paid. That would not solve the problem we have of under-servicing in particular areas/groups and GPs would increase their share of the health dollar. It would be better to give nurses their own rights to perform functions under the scheme and to be paid accordingly. Interestingly midwives seem to be rather left out of the Position Paper.

The Council would see possible advantages through greater involvement of the private sector in providing clinical training, provided certain conditions were met. These include guarantees to maintain academic quality measures; to maintain research activity informing academic content and contributing to the generation of new health knowledge; to provide comprehensive student support services; and to ensure an opportunity of even competition for all providers. If these guarantees cannot be provided, the Council would not favour such a step. The involvement of the private sector could be problematic as it might end up having the States mass produce health care workers with an emphasis on systems that provide a quick fix to meet current needs rather than providing a sound and well educated workforce.

For-profit providers may mount programs which produce a workforce with lower levels of educational attainment. If this were allowed to occur the consequences for health care could be negative for Australian society. Recent research studies by Professor Linda Aiken and colleagues have shown that Registered Nurses educated through university degree programs provide superior quality of care (compared with less educated contributors to the nursing workforce) and that where they are present in clinical units in adequate numbers adverse patient events are reduced. This has implications for morbidity and mortality of client groups, health care system costs and expenditure, and quality and safety of patient care. (Aiken, Clarke, Sloane, Sochalski, Silber *Hospital Nurse Staffing and Patient Mortality, Nurse Burnout and Job Dissatisfaction* JAMA 2002; 288: 1987-1993).

We think it worth mentioning that the special needs groups are almost ignored by the Commissions so far. That is disappointing, to say the least and, as nurses are often their main advocates, we recommend the Commission reconsider their place in the outcomes of this work. In particular, we suggest they look at the workforce issues around specialist areas that work with special needs groups, for example mental health nurses, and identify ways to integrate them into the overall workforce plan. It might also be useful to address the skills required for working with special needs groups or look at skill elevation related to this area of need.

The Council would be happy to cooperate in examining measures to retain nurses in their profession. It would also be glad to assist in evaluations of the various initiatives flowing from the Commission's final report.