



RESPONSE TO "AUSTRALIA'S HEALTH WORKFORCE" (A Productivity Commission Position Paper)

As an aged care service provider and employer we have read this paper seeking an appreciation of what proposals will directly impact on aged care workforce needs. We are therefore disappointed with its minimal reference and consideration of the aged care workforce. The Commission acknowledges it has had limited time to consider such "special areas" and within its final proposal (11.1) further reaffirms the lack of any clear direction with respect to the aged care workforce needs.

In this context the title of the paper itself is challenging, given it has not considered a significant element of the health workforce related to special need areas such as aged care. Interestingly however, in a comparative sense the residential aged care workforce comprises the 9th largest of all workforce sectors within Australia (Hogan Chapter 11, page 219). When the community aged care services component is added within the context of future growth of aged care specific services, the aged care workforce clearly warrants the attention of the Commission, COAG and Government.

The key issue arising from a workforce analysis that has an acute hospital sector paradigm is that it risks defining needs by way of promoting the current models as the answer to pressures within the wider health sector in the future. Few, if any, commentators would suggest the answers to the challenges of the future are to be found by expanding the acute sector model to meet greater perceived health care demands. On the contrary, given the difficulty of changing a health environment dominated by acute care perspectives, the areas identified as essential, which should be further propagated by papers such as this relate to:

- a broadening of models outside the acute sector
- the move to find quality alternatives to hospitalisation (such as hospital avoidance and substitution programs)
- a much stronger primary care system working effectively with community based service providers (in which we would include both the Residential and Community Aged Care service provider system).

In essence, the paper's response to the needs of the aged care workforce in an ageing Australia is contained in the lack of substance of proposal 11.1, which requires the Australian Health Ministers Conference to ensure "all broad institutional frameworks to make explicit provision to consider the needs of these groups". The Commission does not appear to appreciate that aged care services funded by the Australian Government are not a priority for State governments. State governments also have a form of conflict because they are a major employer within the health sector and compete in the employment market with other health sector employers such as aged care services. State government Enterprise Bargain outcomes also set the benchmark in the wage setting processes for all other enterprise bargain outcomes in the health-related sector.

The paper therefore appears to have adopted a perspective on the health workforce that relates predominantly to the needs of acute care/hospital (with its focus on health professionals) and primary care/medical practitioners. Some relevant principles will inevitably impact or flow into the aged care workforce. However, it is not clear how, if at all, such matters will take into consideration the impact on aged care and other special

need areas in key proposals arising from this paper. Furthermore, the paper inadvertently risks reinforcing existing perceptions within the health workforce that aged care is a work environment with less value and appeal and a "poor sector image" (page 204).

A number of the proposals arising from the paper will require significant changes to established practices, for example national accreditation and registration agencies, and may require longer timeframes than the current Government's term of office and related budgets.

1. Facilitating workplace innovation

The key proposal is the establishment of the workplace improvement agency as the vehicle through which job re design and innovation opportunities will be considered particularly those across professional boundaries.

- *Our view is that an AHMC advisory health workforce improvement agency will likely be dominated by perspectives defined by the acute sector. Therefore, we believe any such strategy of establishing a health care workforce improvement agency should be accompanied by a Federal Government-managed agency that deals specifically with aged care workforce improvements (with a specific budget to facilitate job redesign and undertake specific research relative to aged care workforce, such as impact of the reduction of carers on community aged care service).*
- *We also note discussion focuses on State government authorities and State workforce responsibility areas, hence such a health workforce agency that is under the direction of the Australian Health Minister would not appear to have any key interest in aged care workforce issues – as experience in the past would appear to reflect.*

The paper tends to overly emphasise technology options as the key strategy to resolve new challenges within the workforce and focuses its comments on the acute sector.

- *Acute care offers its unique environment but does not reflect the day-to-day issues that arise in the wider community, and it is within the community context that new service models will need to be developed and trialed. On this point, the paper would be improved if it included greater attention to developing the community workforce competency and skill base to manage the future service needs. Such needs will arise with the increased incidence of chronic conditions (such as diabetes), dementia and generally the increased demand for aged care services, that are managed in a community service sector.*
- *An Aged Care Workforce Improvement Agency should be established that reports directly to the Australian Government Minister for Ageing and liaises directly with the health workforce improvement agency and the Australian Health Ministers.*

2. More responsive education and training arrangements

The proposals within this area move towards a national advisory health workforce education and training council.

- *With respect to the aged care workforce, the key theme of our response will be how such a new system of allocating funding to Universities will also impact on the workforce within aged care which has a large non-University graduate component compared to other health sector environments such as hospitals.*

3. A consolidated national accreditation regime

The related proposals are towards the staged establishment of a single consolidated national accreditation agency for university-based education and training and post graduate training. Proposal 6.1 highlights the possible extension to VET should be assessed at a later time in the light of experience with the national agency. However, the proposal indicates the agency should develop uniform national standards for professional registration.

- *Overall it does not seem to have considered in any detail how the nature of aged care workforce is predominantly affected at the VET level, nor how issues around registration of workers and job redesign will overlap some of the historic professional boundaries that are policed by registration bodies.*
- *It is important that any such initiative does not ignore the impact and needs related to the aged care workforce rather than a convenient separation of health workers by way of whether or not they are University qualified.*
- *Given it seems the paper is based on an acute sector perspective of workforce challenges, the topics around training and accreditation do not deal with the need for undergraduate level training to create greater understanding and focus on the interface between community aged care services, primary care and the acute sector. Undergraduates need to be enlightened during their training so that they form early views on these matters and are encouraged to facilitate such developments and alternative service models to those they will experience in a traditional acute sector environment.*

4. Supporting changes to registration arrangements

The proposal is to introduce nationally uniform registration standards based on the work of the proposed accreditation agency. This appears to assume regulation of workers is, and will only be, at a professional level.

- *Within aged care there are variable state approaches to the regulation of direct care workers (such as assistant nurses, personal care workers, or home support workers). The Australian Health Ministers have elsewhere adopted a recommendation that those unregulated health workers will require a minimal qualification at the VET certificate 3 levels by 2008.*
- *The issue of qualification and regulation of direct care workers in aged care may have low significance in the context of this proposal. However, it is obvious that the paper does not understand either the potential overlaps that currently or may exist in these areas, or the potential impact of emerging proposals related to national regulation of practices. These would need to be*

factored into the work of the proposed national accreditation agency (which it is suggested will not involve VET level courses) and the proposed national uniform registration standards.

There will be inevitable tensions and debate as the health workforce considers areas of job redesign that will be forced upon us by the changing nature of the workforce.

- *A critical issue will be how this debate separates artificial barriers that have been established within certain professions from those that signify real risk to individuals and therefore require a specific form of quality control or public protection underpinning when such roles are redesigned.*
- *Will the system move towards increasing the scope of workers who are then regulated by various registration boards or will it respond to these tensions in other ways, by for example the credentialing of individual workers in well defined competency-based skill areas?*

Such increased flexibility will be required in the future in areas of medication management (but not dissimilar to the flexibility that is allowed between a parent and their children and the elderly and their carers in a home environment) and may evolve from a more formal provision of a medication competency credentialing process that would be required to be provided to persons of an appropriately trained and qualification level such as a nurse.

- *The role of national accreditation or registration bodies may include the approval of such competency-based programs in specific areas under defined conditions or protocols as a means of creating greater flexibility across health worker roles whilst maintaining quality and not requiring a significant growth in the regulation process by way of registration of individuals but rather linked to the accreditation and quality monitoring processes of the service provider.*
- *Proposal 6.2 should be strengthened to ensure that the national approach to the assessment of overseas trained health professionals ensures that the level of attainment and command of the English language is of a sufficient level that ensures an effective participation in the workforce. Current approaches, as evident in the registration of overseas nurses, clearly do not ensure a satisfactory assessment of this critical need.*

5. Improving funding – related incentives for workplace change

The proposal is to establish an independent review body to advise on services to be covered by the MBS and on referral and prescribing rules, and to progressively introduce rebates for a wider range of delegated services.

- *We believe this is a key proposal and one that has considerable potential importance to the aged care workforce and related requirements in rural and remote environments.*
- *Our concern is to ensure the review body appreciates the differences within the health sectors when such matters are considered. Given this paper does not specifically deal with aged care workforce and related service delivery issues, it would appear that such aged care specific aspects have not been considered within this proposal.*

Page L1 and Chapter 8: the report considers how certain professional groups are currently eligible to claim for services under the MBS system. The paper explores how the eligibility requirements for certain defined services in the MBS system may be more broadly accessible to other groups of workers who have the competency to undertake specific tasks. One option that seems to be given some emphasis in the paper is a model where a general practitioner delegates the ability for other health practitioners, for example nurse practitioner, to do certain defined tasks within the MBS system and payment for these tasks is provided at a discounted level via the general practitioner.

- *Collaboration with general practitioners will be an essential part of any broadening of the MBS system.*

- *There is a danger in the extent to which the paper appears to focus on the delegation model as a preferred pathway through the issues surrounding broadening access to the MBS system. The danger is the reinforcement of models that render the general practitioner as gate keeper for the MBS system, which may unreasonably restrict the degree to which certain individuals can access the MBS system and therefore restrict the community from benefiting from such initiatives, as it depends on the involvement and approval of general practitioners who may not be readily available in a range of areas, for example rural and remote, outer suburbs and residential aged care facilities.*
- *General Practitioners are key individuals within the provision of medical services in the primary care arena; however there are a number of procedural matters that can be undertaken by other appropriately qualified and certified groups in their own right. A mixture of delegation and independent access pathway options to the MBS system by these new groups would seem appropriate in models emphasised by the Commission. This would ensure those responsible for the care of the elderly (such as an aged care service provider) can explore a range of options to ensure timely care is offered in situations where general practitioners are unable to make themselves available or are simply not available to provide some basic care requirements that could be managed by a Nurse Practitioner in collaboration with a Medical Practitioner. Some of these options are currently being explored within the aged care sector as an Australian Government initiative in response to aged care workforce needs.*

In chapter 12 issues around GP services and overnight doctor access are considered broadly.

- *Within aged care there are some specific issues impacting on access and supply to general medical practitioner services. For example, doctors earn less for successive consultations at a residential aged care facility (for more than one resident consultation per visit) and they are not paid for travel time. The impact is evidenced by the difficulty new residents have in attracting a doctor who will follow them to an aged care facility. It raises the risk that financially disadvantaged residents are subject to non bulk bill charges to ensure access to doctors.*
- *There is also concern that the current few "champion" doctors who take on heavy workloads in aged care facilities are ageing and it is not clear how their work in aged care will be replaced when they retire in the future. Although there have been some reported improvements in this area arising from the Government Aged Care panels, the view is that these disincentives remain a significant issue and the response of the market place has been detrimental to the elderly.*
- *We believe this aspect of access to general medical practitioners should be highlighted within the body of the paper as it impacts on residents living in aged care facilities and staff working within aged care facilities seeking to obtain timely advice and outcomes for residents from doctors.*

6. Better focused and more streamlined projections of future workforce requirements

This proposal tends towards the traditional workforce needs of health professionals and the related training of these areas. As an example, even with Department of Health projections about the enormous projected shortage of nurses within South Australia and recommendations such as those in the Hogan Review of Pricing Arrangements in Residential Aged Care, there have been unacceptable responses by State and Federal governments to increase the training places required in these areas to adjust to the drop-out rate of undergraduate nurse numbers in training and the faster retirement rates of an older workforce relative to graduate nurses entering the health workforce.

- *The lack of resolve of governments in the past to such data projections in key workforce areas is a key issue that should be highlighted in relation to this proposal.*

7. More effective approaches to improving outcomes in rural and remote areas

It is relevant that the paper should consider the needs of rural and remote workforce issues.

- *Within the broader aged care workforce needs, rural and remote needs are a special group. These issues should be seen within the broader context of aged care workforce needs and then what is and will be required in the rural and remote areas.*

8. Ensuring that the requirements of groups with special needs are met

Our views about the way the paper deals with special groups are noted in the introduction and in other responses associated with comments on other proposals.

- *In essence the paper does need to deal more specifically with the aged care workforce needs rather than simply propose all institutional frameworks should consider this need.*
- *The lack of consideration of aged care workforce needs, and the other special areas, has the impact of not recognising the key importance that community service models will play in the health workforce needs of the future. By the absence of any consideration of these health workforce considerations the paper does not acknowledge the fundamentally critical roles adopted in the aged care sector outside of the acute health sector, which involve non-professional direct and indirect care workers, as well as professional health care workers.*

The paper's three-page consideration of aged care (pages 203 to 205) is brief and simply refers to the Government's current policy, or repeats selected findings of other reports, such as the Senate Committee Inquiry into Nursing and the Hogan report on the Review of Pricing Arrangements in Residential Aged Care.

- *We agree with the Senate and Hogan Inquiry views about the shortage of nursing and the potential impact such a shortage may have on aged care services in the longer term. However we do not believe the Senate Inquiry's*

comment that the growth of unregulated care workers has reduced the quality of care in aged care is a view held by employers or the Australian Government. We do not understand this emphasis being repeated in this paper as it leads the reader to a simple solution of submitting the aged care workforce to greater regulation by way of registration of the workforce.

- *The key issue is not regulation, but the various aspects associated with ensuring that aged care has access to an ample supply of skilled workers with relevant experience.*
- *This view would have had the paper consider more pertinent points such as*
 - *How aged care competes in a competitive health sector employment market (with state Government as the price leader in wage outcomes),*
 - *Whether there should be a minimum qualification requirement for direct care workers (which we assume would be managed by way of the quality accreditation system already existing in aged care that includes human resource considerations)*
 - *Consideration of the more specific aged care issues arising from the critical nurse shortage that has been allowed to develop,*
 - *The challenges of redesigning roles in aged care that will include some traditional defined nurse tasks (such as medication administration) and how these could be repositioned to Enrolled Nurses and care workers so that Registered Nurses focus their expertise in the clinical outcomes and leadership areas,*
 - *It would also acknowledge the great potential of Nurse Practitioners working in collaboration with General Medical Practitioners.*

These various issues would also have been considered within the challenges associated with existing regulation in the aged care and health sectors that are a barrier to changes required in the future. It would also have acknowledged that although there are important and welcome responses in the Investing in Australia's Aged Care: More Places Better Care measures, these are only the first installment to the initiatives that Government will be required to implement in response to the aged care workforce needs in both the residential and community service areas in relation to building and sustaining a skilled workforce.

The need for increased workforce participation at the 56 to 60 and 61 to 65 year cohorts is highlighted in this paper and others (Economic Implications of an Ageing Australia). However, few if any reports are considering the issues around risk of injury in the work place. The work environment in the aged care sector rates as a higher risk to injury than others in Australia.

- *There are a range of matters that should be investigated relating to the impact of a greater participation by older workers with respect to*
 - *their risk of injury,*
 - *the impact on the cost of care if injury rates were to increase due to greater participation rates of older workers,*
 - *the impact that the current workers compensation schemes may have relative to changing eligibility requirements being forecast for access to disability pension systems, unemployment benefits and carer pension systems,*
 - *the need for greater understanding and consideration of how injury levels can be reduced.*

RICHARD HEARN
Chief Executive Officer

12 October 2005