The Health Workers Union Response to the Victorian Government's Health 2040 Discussion Paper 2015

HEALTH WORKERS UNION

About the Health Workers Union-Victoria

The Health Workers Union has a proud history since its inception in 1911 of fighting for workers' rights and better work conditions in Victoria's hospitals and other healthcare facilities. We are a strong and growing union that aims to use its combined power to improve working conditions and to maintain reasonable wages and benefits for our members. The Health Workers Union (HWU) of Victoria represents a broad spectrum of workers employed in hospitals, pathology, dental, aboriginal, disability and aged care services.

For further information please contact:

Kamal Bekhazi
Research & Project Officer
Health Workers Union
Level 5/222 Kings Way
South Melbourne 3205
Telephone: **03 93413300**
Email: **Kamal.Bekhazi@hwu.org.au**

David Eden
Assistant Secretary
Health Workers Union
Level 5/222 Kings Way
South Melbourne 3205
Telephone: **03 93413300**
Email: **David.Eden@hwu.org.au**

Contents

Introduction

The Health Workers Union (HWU) welcomes the opportunity to make a submission in response to the Victorian Government's Health 2040 discussion paper. Our submission will focus primarily on workforce planning, system governance, health funding, health promotion, prevention and early intervention, Victoria's aged care system and Worker to Patient ratios and accountability mechanisms. Our submission will attempt to incorporate a number of the key principles (to guide future reform) that were identified at the Victorian Health reform Summit (September 2015).

Our submission has been informed by a review and examination of Victoria's and Australia's health system and encourages the adoption of good policy currently used by other Australian state and territories. This submission will present case studies that provide compelling examples of how certain components of our health system have failed our health workers and to appropriately treat the general public. It also provides solutions and options that, if applied, could result in a significantly improved Victorian health system.

In order to ensure that this submission represents the diversity of the HWU membership, workers' from a broad range of occupational backgrounds that work within metropolitan, rural and remote areas of Victoria's health system were invited to provide verbal or written feedback to the HWU. We have included their feedback in our submission. These individuals are representative of health workers nationwide and we thank them for taking the time to share their stories.

Australian trade unions have fought hard to ensure that our health system is adequately funded and staffed and that each of our citizens can receive high quality best practice health services. The HWU will continue to work to modernize Victoria's health system, with the view of making the thousands of worksites throughout the state healthy and functional places to work in.

According to a report released by the McKell Institute (2013) and the OECD Better Life Index, Australia (2014), Australian's work some of the longest hours in the developed world and are spending more years in the workforce than ever before. In an interview with Jessica Irvine, the National Economics Editor, News Corp Australia Network (2014), the secretary of the Australian Council of Trade Unions, David Oliver stated that "As Australians, we work hard, and we deserve our holidays and sick leave".

Working long hours over a prolonged period of time has been found to have a negative impact on relationships with family and friends and adverse effects on mental and physical health (The Australian Psychological Society Limited, 2015 & Ping, Chung & Hu' 2014). This is particularly true for hospital and essential services employees, including people that work within aboriginal, aged, disability and the mental health sectors.

Moreover, health workers are often required to cope with some of the most stressful situations found in any workplace. For instance, people that work in hospital Emergency Departments and Psychiatric wards are exposed to patients that are experiencing life threatening injuries. These frontline workers experience the life and death scenarios that regularly play out in our Emergency Departments across Australia. They are also exposed to patients experiencing severe mental illness, such as psychotic episodes, bipolar disorder, depression and anxiety, and post-traumatic stress disorder.

Clinical, anecdotal and research evidence suggests that it is not uncommon for a hospital worker to incorporate or absorb some of the psychological symptomology expressed by patients within hospital settings. Furthermore, hospital workers are also exposed to physical illness brought about by viral and bacterial infections present within their work environment. The rate of physical and emotional illness is greater amongst hospital workers when compared to workers from the finance or other industries (Victorian Department of Health, 2014 & 2007; Ping, Chung & Hu' 2014). Workers must be compensated for this work hazard by financial and other means.

Stress has been associated with loss of appetite, anxiety and depression, migraines, difficulty in sleeping, disruption of social and family life, and the increased use of drugs, such as cigarettes, alcohol, and other illicit drugs (The Australian Psychological Society Limited, 2015; Centers for Disease Control and Prevention, 2014; Better Health Channel, 2013; Subha and Ahmad, 2011). Stress can also affect worker attitudes and behaviour. Some frequently reported consequences of stress amongst Hospital workers include, sick days, anxiety, depression, and difficulty maintaining pleasant relations with co-workers (The Australian Psychological Society Limited, 2015; Centers for Disease Control and Prevention, 2014; Better Health Channel, 2013; Subha and Ahmad, 2011).

In Victoria, workplace health and safety is governed by a system of laws, regulations and compliance codes which set out the responsibilities of employers and workers to ensure that safety is maintained at work. The Fair-Work Act 2009, the Modern Award system, current Enterprise Agreements and Victoria's Occupational Health & Safety (OH&S) Act 2004 (The Act) are commonly used to ensure that workers are safe in their workplace.

The objectives of Victoria's OH&S Act 2004 (The Act) are:

- To secure the health, safety and welfare of employees and other persons at work;
- To eliminate, at the source, risks to health, safety or welfare of employees and other persons at work;
- To ensure that the health and safety of other members of the public is not placed at risk by the conduct of undertakings by employers and self-employed persons; and
- To provide for the involvement of employees, employers, and organizations representing those persons, in the formulation and implementation of health, safety and welfare standards.

Unfortunately, OH&S Act does not cover or regulate every aspect in the workplace. For example, a Carer to Worker patient ratio is not specified within the Aged care Act 1997 or the Disability Act 2006. Additionally, the abovementioned Acts and industrial instruments do not seem to be able to prevent health workers within the aforementioned sectors being assaulted by patients or overworked by their employers.

The following section of this submission presents some factual details about Victoria's aged care system and makes some suggestions that can significantly improve the Aged care sector for patients and workers alike.

Victoria's aged care sector and Worker to Patient ratios

The Australian aged care sector is projected to be the fifth largest employer and its workforce is required to triple by 2050 to keep up with demand. According to the Australian Bureau of Statistics (2013b) there were some 216,300 workers in residential care services in May 2013, mainly in the aged care sector. Over the next ten years, the number of residents is projected to grow significantly and the

highest area of growth will be among residents aged 95 or over. About 6.1 million Australians are aged over 55, but only 6.0% live in retirement villages or residential aged-care facilities (Aged Care Residential Services Market Research, 2016 & King et al., 2013).

The Australian Institute of Health and Welfare (2014) and the Productivity Commission (2011b) found that Australia's aged care sector is beset by multiple problems and requires significant changes to deal with future challenges associated with an ageing population.

Australia's aged care sector has struggled to attract and retain workers and is often understaffed. This phenomenon can be attributed to low wages, high workloads, and a lack of job security, training and career development opportunities (Australian Institute of Health and Welfare, 2014; Nursing Careers Allied Health, 2014; Victorian Department of Health, 2014; Australian Bureau of Statistics, 2013b; Productivity Commission, 2011b).

In 2013, the Federal Government introduced a Dementia and Severe Behaviours Supplement to assist residential aged care provider's better care for their residents. This supplement provided additional financial assistance to approved providers in recognition of the additional costs associated with caring for people with severe behavioural and psychological symptoms attributed to dementia and other conditions.

Unfortunately, the Federal Government cut the dementia and severe behaviours supplement on the 31st July 2014. Aged and Community Services Australia, an independent community based peak body representing Not for Profit residential care providers, stated that the loss of the supplement would impact adversely on most aged care service providers and could result in reduced staffing levels.

To make matters worse, the Federal Government cut the Payroll Tax Supplement (paid to some residential aged care providers) from the 1st of January 2015 (2014-014 Budget). Aged care facilities have started to factor in the effect of the loss of the Payroll Tax supplement on their operating budgets.

The HWU has successfully negotiated dozens of aged care Enterprise Agreements with numerous aged care providers over the last several years. EBA negotiations with aged care providers have proved extremely difficult and in some cases discussions were delayed due to the federal government's termination of the above supplements

Moreover, many aged care providers have reneged on 'in principle agreements' approved prior to the abovementioned funding cuts. The HWU is concerned that aged care providers will attempt to reconcile their budgets and endeavour to lower their operating costs. We fear that this will result in a reduction in the number of aged care workers, a deterioration of workplace conditions, rates of pay and ultimately poor service provision to aged care recipients.

The HWU believes that the federal government should reinstate the Dementia and Severe Behaviours Supplement. Over 70 per cent of aged care residents require a high level of care for a spectrum of multifaceted medical conditions such as dementia, chronic conditions such as diabetes, blood pressure complications and so on (National Aged Care Alliance, 2012; Productivity Commission 2011b; Department of Health and Ageing, 2006).

At present, in Victoria, we have a confusing status quo when it comes to worker to patient ratios within the aged care sector. According to The Aged Care Act 1997, Private and Not for Profit aged care providers are not required to meet a Care worker to Resident ratio. In contrast, the public aged care sector does have mandated Nurse to Resident ratios.

The Health Workers Union believes that one of the most significant factors in providing quality residential aged care is to ensure that there are sufficiently skilled care workers on hand to provide that care. We recommend uniformity across the aged care sector in relation to Resident to Care worker ratios that apply to both public and private (for-profit and NGO's) residential aged care facilities.

Victoria introduced patient to staff ratios in the public hospital sector in 2001, normally 4 to 1. Although Victoria's public aged care sector has in place a Nurse to Resident ratio, these ratios do not apply to other care staff such as patient services attendants or care workers in general. Aged care workers have frequently reported that due to the lack of Care worker to Resident ratios both residents and workers have struggled to cope. That is, residents are not receiving adequate attention from staff members and staff members are experiencing high workloads and inadequate support and supervision (Lateline, 2013; Nursing Careers Allied Health, 2014) leading to burnout rates almost as high as ED rates (Aged care workers usually last about one year in their job).

Specifically, care workers frequently report that they are not able to adequately care for residents due to the conditions and time constraints imposed on them by private aged care administrators. Care workers from the private aged care sector have been quoted as saying:

"Even when we try our hardest to make sure every patient is fed during lunch, we fail. This means that many patients do not get to have their cold lunch until after 2pm!" From, Appendix A case study 3, Letter from Aged Care Worker (LE2).

Furthermore, feedback from HWU members and a survey conducted by Nursing Careers Allied Health (2014) revealed that aged care workers were exposed to significant Occupational Health and Safety risks whilst carrying out their day to day duties and functions. Many of our members have reported that residents and their families often become irritable and can be verbally and physically

abusive toward care staff (Please refer to Appendix A of this report for further information).

The HWU has noticed that an increasing number of care staff have been sustaining injuries due to the lifting and transportation of residents. Even though many aged care facilities possess manual handling aids-designed to reduce the incidence of injury to workers-staff are not able to use these devices due to the inadequate number of workers rostered for any particular shift. For example, one member reported that slide sheets/boards are not being used because two staff members are required to carry out the procedure and that finding two staff members in the same place to complete this process was not always possible.

Health workers frequently sustain musculoskeletal disorders (MSD) due to the nature of their work that can be repetitive and involve lifting, pushing and dragging. The HWU has represented members that have sustained injuries and disorders of the muscles, nerves, spinal discs, joints, ligaments and other soft tissues. Unfortunately, many aged and disability care workers are forced into early retirement due to ongoing pain and loss of function associated with MSD.

The HWU cannot sit by and watch our members and other health workers sustain unnecessary workplace injuries and accept that MSD's come with the job! MSD are the most common workplace injury and the HWU believes that preventing MSD should be a key part of every workplace health and safety program. We are concerned that as a result of federal government funding cuts, employers will attempt to circumvent costly occupational health and safety procedures in an attempt to recover lost funding.

We appeal to healthcare employers to respect current occupational health and safety laws and to make their workplaces safer by enforcing the following guidelines:

- identify and assess job-related MSD hazards
- provide manual aids (to reduce workers' exposure to MSD hazards)
- and maintain the equipment
- ensure adequate staffing numbers
- advise and train workers on MSD hazards in their jobs and workplaces
- encourage workers to participate in their workplace's Occupational health and safety program
- follow up to ensure preventative measures are working
- document MSD injuries and report them to the Victorian Workcover Authority
- support injured workers

Over the last two decades we have witnessed extremely unwell patients being admitted into high care aged care facilities that require palliative care treatment (McAnelly, 2014; National Aged Care Alliance, 2012; Giles, Cameron, & Crotty, 2003). Further, during the same period, the proportion of people dying in high care residential aged care facilities within six months of admission has increased substantially (McAnelly, 2014; National Aged Care Alliance, 2012; Department of Health and Ageing, 2006).

Many aged care patients suffer from chronic conditions such as terminal cancer and require significant care and resources to treat and manage their symptoms. Conditions such as constipation, nausea, pain, shortness of breath, emotional and psychological distress require a range of health professions, medication and other resources to be treated effectively and in line with evidence based practice.

The HWU believes that elderly Australians admitted to high care aged care facilities suffering from the aforementioned conditions should be considered as palliative care patients and be afforded the proper care and dignity that they

deserve! In order for this to occur, Patient to Care worker ratios need to be substantially increased!

That is, high care aged care facilities should aim to improve the overall quality of life of their patient's by applying evidence-based practice treatment. This process would entail early assessment and treatment of pain, the provision of appropriate physical, mental, and emotional comfort, as well as social support. We appeal to the administrators of high care aged care facilities to hire more Care workers belonging to all the relevant occupations!

Health Workers Union Proposal: Resident to Care Worker ratios

The Health Workers Union believes that good quality residential aged care services should have:

- mandated Resident to Care Worker ratios
- appropriately trained employees and career development opportunities
- appropriate equipment, facilities and programs

We recommend mandatory minimum Resident to Care Worker ratios within public and private or Not for profit residential aged care facilities. We believe that the following recommendations will substantially increase the quality of care that residents receive and allow care workers to work within a safe environment where they are able to practice their profession of caring without fear of injury or assault.

Morning Shift
One Care Worker for every six residents in addition to Nursing staff.

Afternoon Shift
One Care Worker for every seven residents in addition to Nursing staff.

Night Shift
One Care Worker for every fifteen residents in addition to Nursing staff.

The literature, clinical and anecdotal evidence suggest that unreasonable workloads within the residential aged care sector, such as 30 residents to 1 care worker, are having an adverse impact on staff retention rates and quality of care. We believe that in order to turn this trend around, aged care facilities need to adopt the aforementioned recommendations and provide on-going training, professional development opportunities and a career path for their workforce.

Statistics in relation to money spent on health in Victoria and the forecast critical staff shortages in Victoria

According to the Health 2040 Discussion paper (Department of Health & Human Services, 2015), the Victorian government funds more than 500 healthcare organisations within Victoria that provide healthcare to Victorian's. This includes hospitals and emergency services, and services provided in the community and in people's homes. Many of these services require specialised buildings and equipment. Victoria's public health infrastructure is worth around $11.3 billion.

Victoria's public health workforce is one of the largest in Australia. The 100,000 people who work in our public health services provide a broad spectrum of services and procedures for the public. The private health system employs another 160,000, including those working in primary healthcare; general practice, allied health, community pharmacy, specialist care, diagnostic services and private hospitals (Department of Health & Human Services, 2015).

There have been multiple reports that have forecast critical staff shortages within the Victorian and Australian health system (National Commission of Audit, 2014; Health Workforce Australia, 2012a, 2012b; Productivity Commission, 2011b; National Health Workforce Taskforce, 2009). Specifically, they envisage a shortage of over 100,000 registered nurses, Doctors, support staff (Aged and disability support workers) and specialist staff (allied health) by 2025. This situation is predicted to worsen and extend well into the coming decades. The

aforementioned authors found that reform to our health system was essential to maintain a sustainable and affordable future health workforce.

Is the hype about Australia's 'unsustainable' health spending a myth?

Professor Richardson (2014) Founding Director, Centre for Health Economics Monash Business School states that:

"the unsustainability of government health expenditure in Australia is a myth that has been carefully nurtured to justify policies to transfer costs from government to the public" (From Australia's 'unsustainable' health spending is a myth, 2014, pg. 1).

The HWU believes that it is important for the government and others to consider alternative opinions about the level of and impact of health expenditure on the economy and to challenge the dominant discourse in relation to these matters. Professor Richardson makes compelling arguments that may go some way to challenging people's thoughts in relation to these matters and to help people consider the marginalised-counter discourse.

Professor Richardson goes on to report that as a percentage of GDP, when compared to the 33 OECD countries on the database (Public health spending Public social expenditure as a percentage of GDP) only 9 other countries spend less than Australia on health (OECD, 2013). For example, the US government spends 8.3 per cent of GDP on its health system. This figure is much higher than the 6.4% spent by the Commonwealth and state governments in Australia.

Moreover, when it comes for value; the number of people per capital accessing the health system and physical and health outcomes, life expectancy (Australian Life expectancy was 82 years in 2011 for males and females at birth combined-ranking seventh among (OECD) countries) and quality of life, Australia's health system is significantly better than the US health system- a two tier health system

that is an embarrassment for such a rich and powerful nation (Australian Institute Health Welfare, 2015).

Professor Richardson (2014) also disagrees with federal and state government arguments that total health expenditure (government and private spending) are unsustainable. He reports that Australia spends about 9.5 per cent of GDP on health services; the United States spends 17.7 per cent. And while US spending may or may not be good value for money, it hasn't undermined its economy or sapped the vitality of the country.

Professor Richardson further contradicts the dominant discourse that the rising share of GDP spent on health will harm the economy or our standard of living. This fear has been expressed or echoed in numerous reports for the government, including the recent National Commission of Audit (2014). He states that the above fears may be a result of bad arithmetic and that it is entirely possible for spending on health to rise more rapidly than GDP and for the amount of non-health GDP to continue to rise.

If GDP growth per capita fell to the annual average of 1.4 per cent per annum, which occurred between 1970 and 1990, then by 2050 per capita GDP would rise by 65 per cent. And if health expenditures rose to the US level of 17.7 per cent, there would still be a 50 per cent increase in non-health GDP per capita (Richardson, 2014).

One possible explanation for the "unsustainability myth" may be related to the way statistics have been viewed and interpreted. For example, focusing on percentages and not on the absolute level of resources available can result in governments and experts being misled or the facts being distorted.

The HWU does not advocate an open budget, and we understand that it's desirable that health spending should be efficient. However, it have become quite evident that there are many areas within our health system that require

additional funding, especially since the federal government recently cut health expenditure by hundreds of millions of dollars!

The following section of this submission concentrates on health workforce planning. This area urgently requires additional funding from both federal and state governments. We will begin the following section by briefly stating some of the reform initiatives that have been recommended and instigated.

Health workforce planning

In 2008 the Council of Australian Governments (COAG) acknowledged the need for a nationally coordinated approach to meet the future health requirements of the Australian population. COAG established the Health Workforce Agency (HWA) to manage and oversee major reforms to the Australian health workforce. The HWA commenced operations in 2010 focusing on building a sustainable health workforce for Australia. The HWA has lead the implementation of this reform effort and worked in partnership with state governments, tertiary institutes and registered training organisations, professional associations, hospital administrators and other health service providers.

More recently, in an attempt to tackle the future challenges facing our health system, the Commonwealth, states and territories have recognised the need for coordinated healthcare reform focused on increasing the number of health workers and better balancing their distribution throughout Australia (National Commission of Audit, 2014). In order for this reform to occur, the state and federal governments need to significantly increase funding.

The Health Workers Union welcomes the approach adopted by the HWA and strongly believes that workforce planning is an essential responsibility of governments, trade unions, academic institutions, health services administrators and professional associations or body's. It is imperative that these organisations

collaborate together and that funding is made available to facilitate research, planning and implementation of strategies designed to meet future health system demands

It has become apparent that the Victorian state government has been facilitating the immigration of overseas trained health professionals, in particular medical Doctors and nursing staff. Overseas-trained doctors now make up 25% of the medical workforce compared with 19% a decade ago (Productivity Commission, January 2006; Health Workforce Australia, 2014). Many of these Doctors are brought to Australia using the 457 or other visa schemes. There is concern that these professionals are being exploited by multiple employers!

Although this approach may help fill the current vacancies in the aforementioned professions in the short term, the HWU does not regard this approach as a long term and viable option.

The Australian Health Ministers' Conference developed the National Health Workforce Strategic Framework in 2004 to address these issues, but its implementation has faltered because of an absence of national leadership and the lack of integration across health and education bureaucracies, governments and public and private training sectors (Health Workforce Strategic Forum, 2007).

We recommend improving the work conditions and benefits of existing health workers and to increase the number of training places of required health professionals within our own tertiary institutions. Further, if health workers notice that the government and hospital administrators are serious about improving work conditions and benefits, they will be more likely to continue working within the health system for longer periods of time.

The Health Workers Union believes that in order to deal with the current health workforce challenges it is crucial to provide career pathways for prospective and current health workers. We believe that potential health workers will be more

likely to seek a career within the health sector (both in metropolitan and rural and remote regions of Australia) if they are provided with training and career development opportunities.

Even though most Enterprise Bargaining Agreements have a clause within them that states the employer must facilitate an employee's request for professional development opportunities, in reality being granted study leave isn't as straight forward as most people would expect and many employees are prevented from doing so.

The following is an example of a clause found within most EBA's in relation to study leave and further training: "The employer shall facilitate completion of the Certificate (area related to classification) either through financial assistance, flexible rostering or supervised practice and/or study leave.

The above clause prevents an employee from broadening their horizons and applying for study in an area that is not related to their current classification. Furthermore, most employees report that their work rosters are often inflexible and their employers hardly ever provide financial assistance or release their workers for significant periods to pursue study leave.

The Health Workers Union has been working closely with hospital representatives and other employers as well as tertiary institutions and community groups to in an attempt to improve industrial instruments governing the health sector.

The HWU has been working with its members and Victorian public hospital representatives to alter outdated classifications/occupations that exist within numerous Enterprise Bargaining Agreements. Ultimately, our aim has been to improve working conditions, pay rates and to facilitate training and career pathways for health workers. For example, clause 11(Classification Review) of

the Victorian Public Health Sector (Health Professional, Health and Allied Services, Managers & Administrative Officers) Multiple Enterprise Agreement 2011 – 2015 has given the HWU an opportunity to review multiple classifications/occupations.

The classification review has enabled the HWU, in consultation with its members and hospital representatives, to alter and improve the classification structures of multiple occupations. The following classifications have been the subject of extensive review: Food and Domestic Services Assistant's, Patient Services Assistants', Clerical workers including Safety Link workers, Interpreters, Personal Care Workers, Allied Health Assistants, Instrument technicians, Theatre technicians, Anaesthetic technicians, Administrative officers, Managers, Drivers and Laundry hands.

We are currently reviewing other occupations that were not included in the Classification review in the current negotiations relating to the renegotiation of the Victorian Public Health Sector (Health Professional, Health and Allied Services, Managers & Administrative Officers) Multiple Enterprise Agreement due to expire in December 2015.

The HWU plans to review the following classifications: Sorter/Packer of linen, Seams-person, Car park attendant, Orderly/Cleaner, Gardener and Assistant gardener, Maintenance/handyperson, Store person/Advanced, Housekeeper, Laundry operator, Hospital attendant, Security officer, Printer-trade, Driver articulated, General services supervisor, Instructor/Careers Advisor, Window cleaner, Clerical worker, Interpreter/Translator, Food monitor, Other cook, Chef, Dietary supervisor, Diet cook, Sweets cook, Pastry cook, Butcher, Trade cook, Second cook, Cook employed alone, Recording attendant, Social work/Welfare aide, Orthotic technician, Red cross aide, Laboratory assistant, Personal care

worker, Pathology technician, First aid attendant, Pathology collector, CSSD attendant, Theatre attendant, Nursing attendant and Diversional therapists.

Overall, the HWU has negotiated hundreds of Enterprise Bargaining Agreements. And we continue to negotiate with a variety of employers; metropolitan and rural hospitals (private and public), pathology services, aged and disability, aboriginal and community healthcare service providers.

The aforesaid negotiations are necessary to ensure productive, efficient and safe workplaces. The HWU has represented our members and ultimately the rest of the health workforce through EBA negotiations on a range of issues, including but not limited to: wages, allowances, security of employment, training, professional and career development, leave entitlements, staffing/workload, recruitment processes, health and staff resources, occupational health and safety and organisational change issues.

Even though the HWU has completed a significant amount of important and crucial work, there continue to be areas of concern that require attention. For instance, certain classifications such as the Anaesthetic technician (AT) that operate within the hospital system require review. The AT works closely with the anaesthetist in hospital operating theatres.

However the anaesthetic technician cannot undertake their duties and functions as effectively and efficiently as possible due to the absence of sufficient medication training in their current qualification- Diploma of Anaesthetic Paramedical Science-as per the relevant EBA. This has been the case for many years and I understand that tertiary institutes do not include advanced medication training in the AT qualification because of opposition from "nursing lobby" groups.

For example, during a typical days work, the anaesthetist will ask the AT to prepare specific mediation types and doses for an upcoming operation. The AT is required to take the anaesthetists medication requests and patient medical charts to a Division 1 nurse who accommodates the anaesthetist's request. We aim to work with academic institutions and hospital administrators to make the necessary adjustments to the AT qualification to ensure that the AT can work as efficiently and productively as possible.

Another example that has been a cause for concern to the HWU, our members and others involves the dispensing of medications by non-medical health workers employed within aged care facilities. Victoria's health care laws were changed in 2010 to allow Registered nurses with a three year degree to delegate medication administration to Enrolled Nurses and Personal care workers (PCW) and others in high care facilities or facilities that work with people suffering from dementia and end of life care.

The Registered Nurse can delegate the administration of medication to workers that she/he deems appropriately trained and competent. However, the relevant legislation does not specify or define what amounts to an appropriate level of training for PCW or Enrolled nurses. Decisions about the supervision of delegated tasks within the medication administration process must be made by the nurse managing the process

Given that most aged care facilities are underfunded and resourced, it is possible that certain facilities may attempt to reduce costs by delegating certain duties and functions to care workers that do not have adequate training. Mistakes can easily be made in relation to medication types and doses that can result in serious harm to residents.

If we are serious about rectifying the aforementioned issues and creating a more productive and efficient system of operation within our hospitals and aged care facilities, then the AT and the PCW classification will need to be reviewed by hospital representatives, trade unions, tertiary institutes and professional societies. Essentially, the AT and PCW classifications will need to be varied so that their duties and functions actually match their job descriptions.

The Health Workers Union has been working closely with Victorian health services representatives and Registered Training organisations. We aim to substantially increase the availability of traineeships, apprenticeships, scholarships and other training opportunities to people interested in a career within the health sector.

The Health Workers Union recognises that education and training is the key to improving employment opportunities. However, many of our members cannot afford to undertake the necessary training or education that will help them further their careers. Together with our partners at HESTA and SGE Credit Union, the HWU is offering a fully funded scholarship program, providing 10 members $1000 each to help them with the cost of their training.

The HWU also recognises that in order to develop a suitable and sustainable and appropriately qualified health workforce, it is important to reach out to Secondary school students. We believe that Secondary schools should offer their students' an array of subjects and seminars that will allow them to develop a better understanding of the diverse classifications or occupations that work within our health system. In addition, traineeships and work experience placements can further compliment the above attempts to foster a future health workforce.

The health Workers Union believes that it is in the national interest to maintain and amplify efforts to develop the nation's health workforce. We are concerned that Commonwealth and state funding cuts may impair our and others efforts in this regard. We appeal to Commonwealth and state authorities not to cut funding to programs that offer our youth an opportunity to become part of Australia's future health workforce.

Given the current government funding criteria for higher education, we believe that it is important for government funded tertiary institutions to reintroduce or increase the availability of entry level qualifications such as the Certificate II qualification in Health Services Assistant (currently offered by Victoria University). Entry level qualification could act as a platform for prospective health workers to pursue further studies and ultimately a career within the healthcare sector.

Specifically, entry level qualifications allow students' to become accustomed with the duties and functions associated with multiple classifications or occupations. That is, students' can be introduction to the health system via fortnightly placements encompassing hospital or ward based occupations, diagnostics, pathology, dental, disability, aged care and community healthcare. Entry level qualifications like the Certificate II in Health Services Support are also suited to Australian Apprenticeships pathways.

The Victorian Department of Health (2014) has implemented a range of projects and approaches to facilitate pathways or careers in the health sector.
Of particular interest to the HWU is the positive approach adopted by the Victorian Department of Health (VDOH) to facilitate partnerships within rural and remote regions of Victoria and to attract secondary school students and young people that have chosen not to pursue higher education opportunities.

The following links to the Victorian Department of Health website provides more information about the variety of initiatives developed by the VDOH:

- Northeast Health Wangaratta VET in Schools and VCAL Program - Innovation Story
- Northeast Health Wangaratta - A Student's Journey
- Central Gippsland Health Service - AHA Traineeship Program - Innovation Story
- Central Gippsland Health Service - A Student's Journey

The HWU acknowledges the importance of the Allied Health Assistant workforce in Australia and supported the work that the Victorian Department of Health (DOH) and the Alfred Hospital undertook during 2009-2011 to improve the utilisation of the allied health workforce. The project developed guidelines to facilitate the introduction of new allied health assistant (AHA) roles.

During 2012-2013 the Victorian DOH rolled out the first stage of the Allied Health Assistant Implementation Program. The aim of the Program was to support Victorian health and community services in their attempt to better shape their AHA and allied health workforce and to identify new roles for AHA's.

Additionally, the program focused on the efficient and productive utilisation of the AHA workforce to maximise their skillset and to expand their scope of practise to encompass a variety of duties and functions that would better position the workforce for future demands. This was achieved by providing direct supervision and delegating duties and functions.

In an attempt to complement the work of the DOH and to provide a career path for AHA, the HWU has begun consultations with a Victorian tertiary institute to develop a Diploma in Allied Health. We believe that such a qualification is necessary to assist AHA's that want to further their qualifications and specialise

in an allied health classification. Students' that complete the prospective course will receive credit toward the Bachelor of Applied Science in their chosen allied health speciality.

Health workforce planning is essential for safeguarding an adequate and qualified workforce. It is also crucial to help deliver a cost effective and productive health service. It is important for the Australian government to continue to fund the Health Workforce Agency and other health workforce planning organisations that manage and oversee major reforms to the Australian health workforce.

Cutting funding to health planning is contrary to our national interests. Funding cuts to this important area will reduce our ability to identify and deal with workforce challenges and will ultimately compromise the high quality of healthcare that Australians have become accustomed to.

Gender inequity within the Australian healthcare workplace

Women account for almost 75% of Australia's health workforce and tend to be employed on a casual or part time basis (Victorian Department of Health, 2014; Health Workforce Australia (2012a & 2012b). Moreover, according to the Australian Bureau of Statistics (2015a), Average Weekly Earnings report, the gender pay gap increased markedly over the last year in the following industries: Administrative and Support Services (+7.8 pp), Wholesale Trade (+6.5 pp) and Manufacturing (+3.9).

Further, females were significantly more likely to engage in voluntary work within the healthcare sectors when compared to males (Australian Bureau of Statistics, 2015b). Notwithstanding, men continue to hold the majority of Australia's top leadership positions according to the most recent Gender Indicator figures released in August this year by the Australian Bureau of Statistics (2015b). This

trend includes leading positions within the private sector, the judiciary, federal and state parliamentarians and managers in the Australian Public Service.

The ACTU has called for workplace rights to be strengthened for women and millions of Australians in casual and insecure work in its submission to the Productivity Commission inquiry into workplace relations. The ACTU also called for the minimum wage and penalty rates to be protected and for greater rights for workers to allow them to bargain collectively, including labour hire and temporary workers (ACTU Submission to the Productivity Commission, 2015).

The aforementioned facts paint a rather disturbing trend for women in the Australian workplace, in particular within the health and administrative sectors. Current Long Service Leave (LSL) arrangements and employers preference to employ women on a casual and part time basis has resulted in women missing out on their LSL entitlements. It is necessary for the Victorian government to introduce a much fairer portable LSL scheme that attempts to redress the gender inequity within Victoria's current LSL provisions and provides an incentive for health workers to maintain a career within the health sector.

The need for a Victorian PLSL scheme for Victorian health workers

Unfortunately Victorian health workers inability to qualify and therefore access long service leave entitlements has been an ongoing issue of concern for Victoria's health workers, including Health Workers Union members. It is for this reason that the HWU recommends that a Portable Long Service Leave (PLSL) scheme be developed for Victorian health workers.

Continual service with one employer has become increasingly rare, and the move between employers is often dictated by changes to business structures or funding models. Therefore, we need to make sure that workers are not disadvantaged by current workplace laws and that long fought for workplace

entitlements such as long service are altered to reflect the changing nature of the Australia work culture.

Unfortunately, only one in four of us will ever qualify for long service leave (Australian Bureau of Statistics, Labour Mobility, Australia, February, 2012 & 2013b). Australia's changing workplace practices, in particular, employer's preference of employing workers on a casual or part time work status has led to the evolution of our current unstable work places. Workers have been forced to frequently change their jobs or career paths, resulting in fewer workers qualifying for LSL!

There are many factors that contribute to workers changing their employer or leaving the health sector for significant periods of time. In some instances, employees may leave their work in a disability or aged care service due to injuries sustained on the job or due to vicarious trauma or stress disorders that emerged during their work within their work environment.

It is relevant to note that the industries in which mobility is high are also predominantly those that are more physically and/or emotionally demanding, and which have a disproportionately high rate of work-related illness and injury (Safe Work Australia (2012).

To combat the difficulties faced by many workers in these industries in qualifying for LSL entitlements, we recommend the introduction of a PLSL scheme for Victorian health workers.

The need for adequate funding for health promotion, prevention and early intervention

The Victorian health system needs to strengthen its focus on early intervention if it is to have any chance of meeting its priority of "preventing and treating chronic disease" outlined in the Health 2040 discussion paper. The Victorian

government needs to champion a multifaceted approach that involves the investment of additional funds into health promotion, prevention and early intervention and the creation of effective partnerships throughout Victoria's community.

This task has become much more difficult since the Federal Government released its May 2014/2015 Budget. The budget has resulted in the withdrawal of hundreds of millions of dollars allocated to state health budgets by the previous federal government. To our dismay, the budget specifically stipulated a reduction in Commonwealth funding in the areas of health promotion, prevention and early intervention.

In response to the Federal Government May 2014/2015 Budget, the president of the Australian Health Promotion Association (2014) wrote a scathing letter to the Prime Minister of Australian. She made it clear that funding cuts to organisations such as the Australian National Preventive Health Agency, National Partnership Agreements and the Australian Institute of Health and Welfare would have an adverse impact on our nation's economy and population.

Moreover, the Health Workers Union believes that decisions to cut funding to important and essential health promotion, prevention and early intervention services and campaigns will significantly increase the burden on our public health system and the health workers that keep our health system going.

In the interests of all Australian's we urge the Prime Minister of Australia to reverse funding cuts made to the aforementioned organisations and to avoid politically or ideologically motivated decisions. We also urge the Victorian government to immediately allocate additional funding to this important area until the federal and state governments can agree on a long-term funding model for this area.

The Health Workers Union is concerned that Commonwealth funding cuts and the lack of additional funds from the Victorian government has resulted in the termination of "healthy lifestyle" programs designed to support the health workforce, individuals, families and the community in general. The ramifications of cutting funding to such essential programs cannot be understated! Cuts of this magnitude can adversely affect the management and prevention of chronic disease.

The Health 2040 discussion paper suggests that the provision of seamless, integrated care and person-centred medical home care could significantly improve the treatment outcomes of people with chronic disease. The paper goes on to suggest that patients would like to see pharmacists have a greater role in patient care, including the provision of services such as immunisation and blood pressure checks in an attempt to help people with chronic disease better manage their mediation.

Although these ideas may make a patients treatment regime more convenient and might result in the Victorian government saving some money, these suggestions may not solve the problems that people with chronic conditions experience or significantly improve their treatment outcomes. For instance, anyone that has visited a pharmacy (for example Chemist Warehouse) would immediately notice that the pharmacist is so busy that they do not have any time to attend to any matters other than to the dispensing of scripts.

Furthermore, if a pharmacy hired extra staff to implement the aforementioned ideas/suggestions the cost of providing this service would be passed on to the consumer and or government. Furthermore, if this plan were to be implemented it would result in an additional health workers being involved in a patients treatment and additional costs beared by the consumer. In many instances, adding another clinician or health worker to a patients list of service providers would only complicate and confuse matters.

The HWU is concerned about the impact of funding cuts on the provision of preventive health and other programs. Preventive health programs have been designed to prevent people from becoming unwell and enable health workers to intervene early to reduce the impact of health complications. This work has clear economic, mental, physical and social benefits for the whole nation (Australian Health Promotion Association, 2014). We believe that current programs must be adequately funded and the NGO's or not for profit organisations can improve their services they offer by better coordinating their work with primary healthcare practitioners.

Managing illness and chronic disease within Australia's multicultural community

Australia's most recent Census in 2011 (Australian Bureau of Statistics, 2012a) revealed that Victoria is the most Culturally and Linguistically Diverse (CALD) state in Australia, comprising of people that have immigrated from over 200 countries and that speak more than 400 languages and follow more than 120 religions. Although this diversity makes Victoria one of the most culturally rich in the world, it also presents many challenges, especially in regard to the provision of health services.

For many people from culturally and linguistically diverse backgrounds, accessing health care can be problematic (Henderson & Kendall, 2011). The average Australian can struggle to navigate the health system and to access relevant information about health services. This can be especially true for people from non-English speaking backgrounds as well as socially isolated people.

To further complicate matters, very few bi-lingual health workers exist and many health workers struggle with cross cultural issues and the delivery of culturally sensitive services (Henderson & Kendall, 2011). Interpreters can play an important role in linking people from CALD communities to the health care system and informing them about certain procedures that they may need to

undergo.

However, hospital based interpreters and translators are often overworked and understaffed and struggle to keep up with the demands placed on their services. The following quote was taken from a letter written by an Interpreter that works for a Victorian metropolitan hospital.

I cannot imagine how much more can be squeezed out of us. If the areas of Interpreting/ Translating are in any way reduced because of further funding cuts, it will have a very adverse impact on the running of the Hospital (Appendix B, KB 02/10/2014, p. 32).

In a report published by the Ethnic Communities' Council of Victoria (2012) the author emphasised the importance of health promotion and prevention initiatives targeted at Australia's diverse multicultural society. Specifically, they reported that such interventions need to focus on the key factors that prevent culturally and linguistic communities accessing and fully utilising current health services.

Furthermore, a report published by Mental Health in Multicultural Australia (2014) has identified the need for the establishment of a framework for the delivery of mental health services to Australia's multicultural communities, especially for newly arrived immigrants. They have invested a considerable amount of time, effort and money attempting to work with the CALD community with a focus on promotion, prevention and early intervention.

Mental Health in Multicultural Australia's predominate goal has been to promote mental health and wellbeing, prevent mental illness, provide culturally appropriate early intervention and to provide culturally responsive mental health care (Mental Health in Multicultural Australia, 2014). These objectives can only be achieved if commonwealth and state governments continue to fund the important work that the above named organisations are engaged in.

Moreover, the impact of reduced Commonwealth funding for health promotion, prevention and early intervention has resulted in the abovementioned organizations winding back important programs and shedding their workforce. Consequently, we can expect to see a decline in the health of people belonging to CALD communities and an increase in the number of people presenting to emergency departments with serious health conditions that could have otherwise been prevented.

Managing illness and chronic disease within socio-economically disadvantaged people

People living in socio-economically disadvantaged areas experience increased health risk factors, such as lower levels of physical activity and higher levels of smoking compared with other Australians (AIHW 2014b). Additionally, they are more likely to experience higher rates of cancer when compared to the rest of Australia (COAG Reform Council 2014).

The HWU is also concerned about the impacts of funding cuts on other health promotion, prevention and early intervention programs that focus on disadvantaged groups within our community. Specifically, we fear that funding cuts to programs assisting disadvantaged youth both in metropolitan and rural areas of Australia could exacerbate their situation.

Australia has one of the highest youth suicide rates in the world (Australian Bureau of Statistics, 2014, 2012b; World Health Organisation, 2014) and we cannot afford to see the suicide rate continue to climb. An Australian Bureau of Statistics (2014) survey cataloguing cause of death in Australia found that suicide was the major cause of death for young people aged 15-24 and that self-harm (for example, self-mutilation and medication overdose) was 40 to 100 times more prevalent in the same age group.

We are concerned about the impact of funding cuts on early intervention

programs focused on identifying young people at risk of suicide and or self-harm. We fear that funding cuts to this important area will result in an increased rate of youth suicide and self-harm in Australia, especially in rural and remote regions. We believe that any government prepared to cut funding to essential programs and services that address Australia's high youth suicide rate is playing a game of Russian roulette with our youth!

Additionally, the HWU believes that government funding cuts to health promotion, prevention and early intervention programs that target young disadvantaged people that have been identified to have drug and alcohol abuse issues will result in a higher rate of drug and alcohol use amongst our youth. We also believe that cuts to such programs will eventually result in higher crime rates as our youth seek funds to continue their drug use.

Community workers predict that as a result of commonwealth government funding cuts, young and disadvantaged people will suffer from more severe and prolonged mental illness and hardship and will be more likely to end up in hospital emergency departments, in police cells and sleeping rough on the street. Maintaining funding to such programs not only assists young disadvantaged people and their families but also benefits the community at large.

In addition to the aforementioned, commonwealth government funding cuts to health promotion, prevention and early intervention programs that were targeted at socio-economically disadvantaged people have resulted in the following:

- Positions such as the Indigenous Sexual and Reproductive Health Worker, and the Healthy Lifestyle Program Co-ordinator will become a thing of the past.
- Elimination of the Medicare local: Mental Health Clinicians Suicide Prevention Service and other comparable positions.
- Multiple Aboriginal and Torres Strait Islander groups will lose funding for initiatives such as nutrition promotion and alcohol and drug prevention, resulting in further harm to these vulnerable communities.

- Family Planning Organisations across Australia will lose some of their funding. This will have an adverse impact on the people that use these services.
- Not for Profit organisations that engage young people that suffer from a range of complex problems associated with mental illness, victims of domestic violence and homelessness will be forced to close or significantly wind back their services.

The need to improve health services in rural and remote Victoria

Over the last decade or so it has become increasingly obvious that rural and remote Australia's highly disadvantaged Indigenous population and cultural complexity and dispersed settlement pattern requires a dedicated policy and service delivery response (2040 Discussion paper, Department of Health & Human Services, 2015; National Commission of Audit, 2014; National Strategic Framework for Rural and Remote Health, 2012; Commonwealth of Australia, 2010). It is blatantly obvious that the federal government's cuts to health funding to rural and remote health services will be counterproductive when it comes to advancing our rural and remote health system.

Issues such as redressing the geographic inequitable distribution of healthcare professionals, poor workforce retention and service coordination need to be tackled in order to improve service delivery. Additionally, we need to focus of educating Australia's healthcare workforce about cultural practises and we need to facilitate economic opportunities within rural and remote regions of Australia (National Strategic Framework for Rural and Remote Health, 2012).

In December 2012 the Health Workers Union members elected a new team to lead the union. Within months of their election, the executive, namely, Diana Asmar (HWU Secretary) and David Eden (HWU President) hired multiple organisers (living in rural Victoria) to provide a service to members working in rural and remote areas of Victoria.

The HWU executive made available additional resources to rural and remote regions of Victoria because it was apparent that rural and remote health services were very different to their city counterparts. Rural hospitals are generally smaller (fewer beds and specialist clinicians) and have fewer resources even though they provided services to catchment areas several times the size of their city counterparts.

People living in Gippsland and the Grampians have worse five-year cancer survival outcomes than people living in all other areas. Furthermore, survival from cancer for residents of metropolitan Melbourne (68 per cent) is generally better than that for residents from the rest of Victoria (64 per cent) (2040 Discussion paper, Department of Health & Human Services, 2015).

People living in rural and remote areas often need to travel great distances to access health services. It is important for government to acknowledge the strain that long distance travel places on patients and family alike and to increase the availability of accommodation facilities and financial support for patients and their families.

Furthermore, rural and remote communities are generally more dependent on the roles performed by local General practitioners, who often work with little or no support from specialist practitioners (National Strategic Framework for Rural and Remote Health, 2012; Health Workforce Australia, 2012b). It is important that the rural and remote General practitioner be supported by local, state and federal governments, in multiple areas (see below).

Rural and remote communities throughout Australia urgently require additional clinicians in multiple areas, including the following:

- drug and alcohol rehabilitation and support programs
- dialysis
- antenatal and post-natal health
- dental facilities

- significant investment in the mental health workforce (clinical area mental health services and community health and other Not for profit/NGO's and community support groups)
- significant investment in inpatient facilities, respite and carer resources
- diagnostic and pathology services
- chronic disease management (to assist rural and remote patients suffering from the following common difficulties-high blood pressure, diabetes, and obesity)
- chemotherapy services
- Allied health services in the following areas- clinical psychology, social work, physiotherapy, occupational therapy, dietetics, speech therapy, podiatry, optometry, orthotics audiology and prosthetics).

Health administrators and workers belonging to rural and remote health services recognise the need for flexibility within the workforce (Victorian Department of Health (2014). It is essential for the health workforce to work across multiple disciplines, roles and areas, irrespective of their classification or occupation.

Even though multi-skilled health worker roles often lead to longer working days and more complex roles for the average health worker, unfortunately, in many instances, workers have not been compensated for their efforts. We believe that hospital administrators need to recognise, commend and reward their workforce via remuneration and supporting training and career development opportunities.

It is important for health administrators to fund more senior positions within various health occupations. Ideally, the senior health workers role would involve the provision of comprehensive supervision to health workers within their classification, facilitating access to further study, including assistance with arranging time off work to attend class/seminars and support with associated course costs.

The Health Workers Union believes that it is important for the government to work in consultation with Unions, professional associations and tertiary institutes to overcome the aforementioned disadvantages that patients and health workers

are currently enduring in rural and remote areas. In particular, we recommend that the allied health workforce should be strengthened by the use of Allied Health Assistants and that the nursing workforce should be aided by assistant's in nursing. That is, we can envisage an advanced scope of practise for Patient Services Assistants, Personal Care Workers, Personal Care Assistants and other care workers.

The Victorian Government has developed a number of Innovative and important projects that aim to increase and retain health employees working within rural and remote Australia. We believe that the federal and state governments need to ensure additional funding for the projects that they have been conducting in partnership with secondary schools and tertiary institutes (National Strategic Framework for Rural and Remote Health, 2012).

The following projects need ongoing funding:

- Region Health Pathways Project
- VET in Schools Allied Health Pathways Program
- Central Gippsland Health Service Allied Health Traineeship Program

The need to improve healthcare for indigenous Australians

We believe that by making health occupations more attractive to prospective employees, (refer to previous recommendations) health administrators would be able to make inroads with the constant struggle to attract and retain rural and remote health workers. The HWU acknowledges that Commonwealth and state governments have been attempting to address these issues.

Overall, people from Indigenous backgrounds are more likely to experience health complications and die earlier when compared to the rest of the Australian population and have higher rates of newborn mortality and child death compared to non-Aboriginal Victorians, as well as higher rates of hospitalisation (National Commission of Audit, 2014; Australian Bureau of Statistics, 2013a; National

Strategic Framework for Rural and Remote Health, 2012; Commonwealth of Australia, 2010). The factors contributing to these tragic facts are complex and multifactorial.

The Australian Institute of Health and Welfare (2013) and the Productivity Commission (2011a) suggest that a combination of factors such as education, employment, housing, income and socioeconomic status and access to appropriate health services contribute to the current status of Indigenous health in Australia. Significant funding and resources are required to address the above factors.

Aboriginal people are exposed to higher rates of stress when compared to the rest of the community (Productivity Commission, 2011a). High stress levels can often lead to psychological disorders and suicide. In fact, according to the Australian Bureau of Statistics (2010) one in every 24 Aboriginal or Torres Strait Islanders peoples die by suicide.

Overall, about 1.6 per cent of all Australians die by suicide (Australian Bureau of Statistics, 2014). In contrast, more than 4.2% of Aboriginal and Torres Strait Islander peoples die as a result of suicide. Still, the Australian Aboriginal and Torres Strait Islander youth suicide rate is the highest in the world (Australian Bureau of Statistics, 2010, 2012b, 2013a, 2014). Essentially, this means that most Aboriginal families are affected by suicide. But not enough has been done to tackle this problem and to support the families of victims of suicide.

Multiple reports have highlighted the underlying causes to Aboriginal suicide and poverty, yet there is no current effective suicide prevention strategy being funded and administered! The HWU urges the state and federal governments to urgently address the ongoing health issues that Aboriginal and Torres Strait Islander peoples are experiencing.

In relation to improving the health and welfare of Indigenous Australians, we recommend focusing on the overall goals of increasing life expectancy and quality of life. We believe that Indigenous health can be improved if state and federal governments work collaboratively with Indigenous groups and attempt to promote better access to health and support services, work and educational opportunities.

The HWU recommends that both state and federal governments adopt the strategies outlined in the framework of the Closing the Gap initiative agreed by the Council of Australian Governments (COAG). Walker, Porter and Marsh (2012) stated that it is essential for government to develop a working relationship with the indigenous community and its community elders.

Waker et al. (2012) asserted that retaining the right workforce is essential. That is, Aboriginal healthcare workers must be able to work with particular cultural norms and be responsive to the needs of indigenous Australians. Ideally, Australian governments should promote programs that involve the training of indigenous people (with or without relevant work experience) in specialist areas such as medicine, mental health and social work. After graduation, these individuals would return to their communities with skills that would slowly enable them to change the health landscape for their communities.

Over 75 per cent of Indigenous Australians reside in urban and regional locations (Australian Bureau of Statistics, 2011). The Australian Institute of Health and Welfare (2011) reported that Australia's Indigenous community do not fully utilise existing primary healthcare services. If federal and state governments are serious about achieving the Closing the Gap targets, then they will need to develop policies and procedures that successfully integrate Aboriginal and Torres Strait Islanders to mainstream services.

Given the above, it is essential that the federal and state governments maintain funding to mainstream health services. The success of the Closing the Gap initiative depends on Aboriginal and Torres Strait Islanders utilising mainstream services. In fact, we request that the federal government increase funding to the health system so that it can accommodate an increase in Aboriginal and Torres Strait Islander patients.

Towards a fairer and more objective Human Resource Apparatus

Victoria's health services Human Resource (HR) departments are failing the workers that they were set up to protect and advocate for! Our submission includes a proposal to override this very important area- health services human resources/system governance- because the actions of the HR department can make or break employees and in some instances, destroy a health service. The most recent example of this can be seen in the Victorian Ballarat health Service Crisis triggered by a HR department that allegedly bullied and harassed a large number of employees. This was done with the alleged approval of the HR manager and the hospital CEO.

The health service HR apparatus are not the decision-makers, but they often advise management. In a healthy workplace culture, they can be a conduit or a facilitator, so employees could benefit from cultivating a relationship with HR because it can help them further their career prospects. In a perfect world, HR helps workers strategize different approaches. This may include help with coping and stress management strategies (a referral to the services Employee Assistance program), developing skills and strategies for working with or around difficult co-workers or managers, requesting HR to step in to create awareness and advise in relation to healthy workplaces, or pursuing more formal investigative processes.

Unfortunately, the reality in most of Victoria's health services is very different from that vision. When we ask our members and their associates if they thought

HR was the employee's friend or foe, the overwhelming majority chose the latter, with replies such as: "they exist to protect the company from liability and are therefore anti-employee by nature" and: "HR are a bit like estate agents – they pretend to be on both sides but really they are on the side that's paying them".

One look at an average HR recruitment advert indicates where the responsibilities lie; with job requirements such as "the candidate must align the people agenda with the overall business strategy" and "provide support and guidance to line managers with disciplinary and grievance investigations and hearings".

A common trend within Victoria's health service has been the tendering of our services and management cutting staff numbers. The health service HR apparatus is almost always involved in this process but often fails to pursue their duties and functions in a humane way. HR departments appear to have resorted to firing workers without support and are subsequently attracting a bad reputation.

For many workers, the HR department cannot be trusted and unless they have a union representative, any worker who cannot afford a lawyer faces a huge advice gap and the prospect of being unfairly treated and dismissed.

Proposal for the Creating of the Independent Victorian Human Resources Commission/Authority

Our proposal to improve the Victorian health service Human resources system may sound radical but is grounded in practicality! Victorian health services HR departments cannot be objective in relation to dealing with and investigating workplace incidents. They are employed and paid by the same employer as the employees that they apparently attempt to assist or resolve grievances and complaints, such as bullying and harassment and other workplace issues.

In some instances Human resources managers or CEO's may decide to hire an external Industrial relations or Human resource company to investigate particular grievances or complaints. For example, Ballarat health service recently hired a H/R company called the "Peacemaker", spending many thousands of dollars to help solve the problem that they created.

The hospital or health service may claim that this process is objective because an external company is investigating the matter. However this claim can be challenged given that all businesses or companies aim to maximise profits and the best way that they can do this is by pleasing the client or the person or company that pays the bills. In this case, the particular hospital or health service pays for the external company to come in and conduct an investigation.

As an employee of a business, the external investigator may be under significant pressure to please the client (the health service) by making sure that the hospital or health service is not found to be liable and that the worker is found to have breached the EBA or in some way guilty and requiring some form of punishment or disciplinary action.

Therefore, we propose the creation of an independent H/R authority that has the power to investigate complaints and grievances that arise within the public sector health system. This authority must have independence from government and the healthcare system in order to ensure that the results of investigations are truly objective.

We propose that the Victorian HR Independent Authority be led by a commissioner or similar office holder and that the authority be established using the money that will be saved from the closing down of H/R departments within the Victorian health system. We suggest that one or two H/R employees remain to work with staff in relation to specific matters that do not relate to investigating complaints or grievances.

Human Resources Worker Exclusion Scheme

In many instances HR employees can become quite bias and actually resort to bullying and harassing workers identified as belonging to a union or as a "trouble maker". Their ability to work objectively and carry out their duties and functions can be questioned. In many instances they become an instrument of a manager or CEO, compromise their objectivity and thus, should not be able to work in the health services HR department. In order to make reference to this type of HR worker throughout this submission we propose a name that describes this type of HR manager- the Serial Human Resources Abuser (SHRA).

Unfortunately, a SHRA can be found within almost every health service HR department and if the health service does recognise that they have a SHRA working for them, they may eventually encourage them to resign/or to go quietly from their positon (with a good reference from their manager or the CEO) in order to save the health service from unhealthy attention. Unfortunately, the SHRA usually ends up working in another Victorian Health service HR department, usually in a country town, far from the health service that they were persuaded to leave.

This scenario is quite common and The Royal Commission into Institutional Responses to Child Sexual Abuse has found that some known clergy or offenders were usually recycled and sent to another service where they continued their pattern of abuse. In order to prevent such an occurrence in our health service, the HWU proposes the establishment of the Human Resources Employee Exclusion Scheme.

The scheme will work in a similar way to the Victorian Department of Human Services Disability Worker Exclusion Scheme. The scheme must be created to stop the hospital administrators recycling HR managers that have been stood down from turning up in another hospital or health service.

The aim of the Human Resources Worker Exclusion Scheme (HRWES) will be to collect, store and use information about people who are unsuitable to work with Victorian health services employees. Human resources managers/workers that are found to be unsuitable will be placed on the Human Resources Worker Exclusion Scheme and will be prevented from obtaining employment in Victoria's health system-Human Resources departments or an organisation funded or registered by the department of health.

The HRWES has been designed to protect people employed in Victoria's vast health services by ensuring that SHRA that are found to be unsuitable or inappropriate are placed on a Human Resources Worker Exclusion Scheme (HRWES) and prevented from obtaining further employment in a Victorian health Service Human resources department or an organisation funded or registered by the department of health.

Service providers are required to check prospective workers against the list before a person is allowed to work in a Victorian health service Human resources position or have access to employees that work within Victoria's health services and to notify the Human Resources Worker Exclusion Scheme Team if they become aware that a worker, or a prospective worker, may satisfy the Human Resources Worker Exclusion List criteria (to be spelled out during the formation of the HRWES).

The requirements imposed apply to all people who work in direct Human Resources roles at Victorian health services that are provided, funded or registered by the department of health/human services, regardless of their employment status. This means that the requirements of the scheme also apply to labour that is provided to service providers by labour hire agencies.

References:

Australian Bureau of Statistics (2014). Causes of death, 2012 Cat. no. 3303.0. ABS: Canberra.

Australian Bureau of Statistics (2013a). Australian Aboriginal and Torres Strait Islander health survey: First results, Australia, *2012-13*. Canberra.

Australian Bureau of Statistics (2015a), Average Weekly Earnings, Australia, Nov 2014, cat. no. 6302.0, viewed August 2015: http://www.abs.gov.au/ausstats/abs@.nsf/mf/6302.0.
Australian Bureau of Statistics (2015b). Catalogue 4125.0 - Gender Indicators, Australia, Aug 2015. Viewed August 2015, http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4125.0~Aug%202015~Main%20Features~Work%20and%20Family%20Balance~3411

Australian Bureau of Statistics (2013a). Labour Force, Australia, Detailed, Quarterly, May: Catalogue 6291.0.55.003.

Australian Bureau of Statistics (2013b). February, Catalogue 6209.0-Labour Mobility, Australia.

Australian Bureau of Statistics (2012). February, Catalogue *6209.0*—Labour Mobility, Australia.

Australian Bureau of Statistics (2012a). Victorian Census 2011. **http://www.censusdata.abs.gov.au/census_services/getproduct/census/2011**

Australian Bureau of Statistics (2012b). Aboriginal and Torres Strait Islander Suicide Deaths. Catalogue 3309.0 - Suicides, Australia, 2010.

Australian Bureau of Statistics (2011). Estimates of Aboriginal and Torres Strait Islander Australians, cat. no. 3238.0.55.001, ABS, Canberra.

Australian Council of Trade Unions (2015). Submission to the Productivity Commission: Inquiry into the Workplace Relations Framework. 365 Queen Street Melbourne VIC 3000.

Australian Health Promotion Association (2014). Budget Response, Letter to The Hon. Tony Abbott, MP Prime Minister. By Gemma Crawford ,President, May 2014

Australian Institute of Health and Welfare (2014). *Australia's health 2014*. Australia's health series no. 14. Cat. no. AUS 178. Canberra: AIHW.

Australian Institute of Health and Welfare (2013). Aboriginal and Torres Strait Islander Health Performance Framework 2012: Detailed analyses. Cat. No. IHW 94. Canberra: AIHW.

Australian Institute of Health and Welfare (2011). Opening the Door on Health Services for Indigenous Australians, *ACCESS Online Magazine*, Issue 30, AIHW, Canberra.

Australian Health Ministers' Conference Health Workforce Principal Committee (2007). Emerging priority health workforce issues: Presentation to Inaugural National Health Workforce Strategic Forum. Accessed from http://www.health.nsw.gov.au/amwac/pdf/issues.pdf.

Australian Institute of Health and Welfare (2015). Life Expectancy [internet]

<www.aihw.gov.au/deaths/life-expectancy/>, accessed 23/10/2015.

Australian Institute of Health and Welfare (2014). *Australia's health 2014*. Australia's health series no. 14. Cat. no. AUS 178. Canberra: AIHW.

Better Health Channel (2013). Work related Stress-www.betterhealth-Vic.gov.au.

Centers for Disease Control and Prevention (2014).*1600 Clifton Rd. Atlanta, GA 30329-4027, USA, 800-CDC-INFO (800-232-4636).*

Chou, L., Li, C, & Hu, S. (2014). Job stress and burnout in hospital employees: comparisons of different medical professions in a regional hospital in Taiwan. *BMJ Open*2014;4:e004185 doi:10.1136/bmjopen-2013-004185.

Department of Health & Human Services (2015). Health 2040 A discussion paper on the future of healthcare in Australia. State of Victoria, Department of Health & Human Services September 2015.

Commonwealth of Australia (2010). Australia to 2050: Future Challenges - the 2010 Intergenerational Report. Canberra.

Department of Health and Ageing (2006). Guidelines for a Palliative Approach in Residential Aged Care Enhanced Version. Approved by the National Health and Medical Research Council

Ethnic Communities' Council of Victoria Inc. State-wide Resources Centre (2012). An Investment Not an Expense: Enhancing health literacy in culturally linguistically diverse communities. ECCV Policy Paper.

Giles, L. C., Cameron, I. D. & Crotty, M. (2003). Disability in older Australians: projections for 2006–2031. *Medical Journal of Australia*, 179, (3), 130–133.

Health Workforce Australia (2012a). Health Workforce 2025 – Doctors, Nurses and Midwives – Volume 1 and Volume 2.

Health Workforce Australia (2012b). Health Workforce 2025- Medical specialties in Australia-Volume 3.

Henderson, S & Kendall, E (2011). Culturally and linguistically diverse peoples' knowledge of accessibility and utilisation of health services: exploring the need for improvement in health service delivery. *Australian Journal of Primary Health* 17(2) 195-201.

Irvine, J. (2014). Unions to push for portable long service leave as Aussies work harder than ever. National Economics Editor, *News Corp Australia Network,* June 14.

Jackson, L. & Clements, R. (2015). The Australian Psychological Society Limited. Workplace stress: What's causing it and what can be done?

Lateline (2013). Television program, ABC National, Melbourne, 14 August 2013.

McAnelly, K. (2014). Clinical Newsletter of the National Rollout of the Palliative Approach Toolkit for Residential Aged Care Facilities, Issue 2: September 2014 Predicting prognosis within a Palliative Approach Framework

Mental Health in Multicultural Australia (2014): Towards culturally inclusive service delivery. Version 1 Published by MHiMA.

National Health Workforce Taskforce (2009). Health Workforce in Australia and Factors for Current Shortages April 2009 Printed in Australia. KPMG

National Aged Care Alliance (2012). Aged Care Reform Series: Palliative care. Kingston ACT. Australia.

National Strategic Framework for Rural and Remote Health (2012). Commonwealth of Australia standing council on health Department of Health and Ageing, GPO Box 9848, Canberra ACT

McKell Institute (2013). The Case for a National Portable Long Service Leave

Scheme in Australia.

National Commission of Audit (2014). The Report of the National Commission of Audit, Phase one: Towards Responsible Government, Commonwealth of Australia.

Nursing Careers Allied Health (2014). Aged Care wages can't be ignored http://www.ncah.com.au/news-events/aged-care-wages-cant-be-ignored/1856/.

Organisation for Economic Co-operation and Development (2014). OECD Economic Surveys: Australia, OECD Publishing. Viewed at:http://dx.doi.org/10.1787/eco_surveys-aus-2014-en.

Organisation for Economic Co-operation and Development (2013). Public health spending- Public social expenditure as a percentage of GDP)'http://www.oecd-ilibrary.org/social-issues-migration-health/public-health- spending-2013-1_healthxp-table-2013-1-en Source: Social expenditure: Aggregated data, OECD Social Expenditure Statistics (database).

Organisation for Economic Co-operation and Development (2014). Better Life Index (2014), Australia 2 rue André Pascal 75775 Paris Cedex 16 France. Viewed at: http://www.oecdbetterlifeindex.org/countries/australia/.

Productivity Commission (2011). Caring for Older Australians, Report No. 53, Final Inquiry Report, Canberra.

Productivity Commission (2006). Australia's health workforce. Research report. Canberra: http://www.pc.gov.au/study/healthworkforce/finalreport/index.html

Safe Work Australia (2012). Compendium of *Workers'* Compensation Statistics, Australia 2009-10, p6.

Subha, I & Ahmad, S. (2011). Impact of Stress On Employee Productivity, Performance And Turnover; An Important Managerial Issue. Department of Management Sciences Institute of Information Technology, Attock Campus, Pakistan.

Victorian Department of Health (2014). People in Health, Developing Victoria's Workforce: Pathways into Careers in health 2014. State Government of Victoria, Australia.

Victorian Department of Health (2007). Immunisation for healthcare Workers.

APPENDIX A: Case Study 1

(Address and name Censored or altered for Confidential purposes)

Samantha is a 45 year old female that has worked as a Pathology Collector in rural Victoria for a well-known company Pathology company, Healthscope within a Public hospital- Warrnambool Base Hospital. The hospital tenders out its pathology services to private companies such as health-scope.

The tendering process has resulted in many different problems in relation to service provision and in relation to works entitlement and continuity of employment. In this instance we will focus on the LSL entitlements.

Warrnambool Base Hospital recently awarded a new tender to Dorevitch Pathology-to run and manage its pathology services. Although Linda was able to obtain employment with Dorevitch, many other workers were not so fortunate. In many cases, companies retrench parts of their workforce in an attempt to save money; rid its ranks of trade union members and so on.

Unfortunately for Linda, because she moved from one private employer to another, she ends up losing her LSL entitlements. They do not carry over to the new Pathology company!

APPENDIX A: Case Study 1 continued

Imagine having worked for nine years with an employer, counting down the days until you reach your 10 years of loyal service so that you can access your LSL entitlements and all of a sudden, you're told that your LSL has been void and reset. Obviously Linda was upset and felt that the system was not fair and needed to be changed to make sure that others in a similar positon do not have their LSL entitlements voided because of the tendering processes that our Public and Private hospitals use to provide services to members of the public.

APPENDIX A: Case Study 2

(Address and name Censored or altered for Confidential purposes)

Joan has worked for almost 30 plus years within the aged and disability care.

"The care staff are working too hard as we are understaffed mainly due to our employer not hiring enough Aged Care workers.

Even when we are fully staffed, it is hard to find Care staff when they are on their tea and lunch breaks.

Worker to Patients ratios, at the best of times are 30 Patients to 1 worker.

The dementia ward is always understaffed, in particular when it comes to feeding the patients. Workers need to rush from one patient to another to make sure that they don't go hungry. Even when we try our hardest to make sure every patient is fed during lunch, we fail. This means that many patients do not get to have their cold lunch until after 2pm!

Care staff also struggling to keep up with laundry demands. That is, the laundry piles up in the facility because we do not have enough care staff to transport dirty laundry to the laundry.

I find it very hard to stay focused on the job due to all the concerns I have about the workplace.

Even though it's something I'm good at and love and have been doing for years, every once and a while I need time out and leave my employer for months or in the last case I left for more than a year.

APPENDIX A: Case Study 2 continued

I need to do this to prevent burning out or having an episode.

Even though I have worked in disability and aged care for almost 30 years, I have yet to qualify for long service.

When I speak to my manager about this she or he tells me that their hands are tied and that they cannot do anything about it.

Can the Senate please change the rules so that people like me and I know of many people in the same boat, can finally earn time out with pay from our employers.

Thank you.

Appendix A: Case Study 3

(Address and name Censored for Confidential purposes)

Letter from Aged Care Worker (LE2)

To
Members of the Victorian Government
And HWU

Dear Representatives,
Thank you for giving us (Metropolitan Aged Care Workers) an opportunity to voice our concerns to your committee.

The **care staff are working too hard as we are understaffed mainly due to our employer not hiring enough Aged Care workers.**

Even when we are fully staffed, it is hard to find Care staff when they are on their tea and lunch breaks.

Worker to Patients ratios, at the best of times are 30 Patients to 1 worker.

The dementia ward is always understaffed, in particular when it comes to feeding the patients. Workers need to rush from one patient to another to make sure that they don't go hungry. Even when we try our hardest to make sure every patient is fed during lunch, we fail. This means that many patients do not get to have their cold lunch until after 2pm!

Care staffs are also struggling to keep up with laundry demands. That is, dirty laundry piles up in the facility (smells quite bad) because we do not have enough care staff to transport dirty laundry to the laundry.

We hope that the Senate hears us and recommends to the Government not to cut funding to the health sector and to reduce the Worker to

Appendix A: Case Study 3 continued

Patient ratios from 30 to 1 to a more manageable 15 Patients to 1 worker.

Thank you.

(Worksite Censored due to contractual obligations and fear of retribution by management)