1. INTRODUCTION

1.1 It is generally accepted that over the next forty years, the need for health services for older people and aged care specific services, including dementia and palliative care services, will increase. Without a workforce that is adequate in both numbers and educational preparation, governments and providers of health services will be unable to meet the demand. This submission from the Australian Nursing Federation focuses on the steps necessary to ensure that an adequate nursing workforce will be available to meet the future health care needs of older people in Australia. Part 3 outlines some of the workforce issues if nurses are to be available and appropriately prepared to care for Australia's ageing population. Part 4 looks at issues for nurses themselves as they age.

1.2 The ANF is the national union for nurses, with branches in each State and Territory of Australia[1]. The ANF is also the largest professional nursing organisation in Australia. The ANF's core business is the industrial and professional representation of nurses and nursing. The ANF's 120,000 members are employed in a wide range of enterprises in urban, rural and remote locations in both the public and private sectors, including hospitals, residential aged care facilities, health and community services, schools, universities, the armed forces, statutory authorities, local government, offshore territories and industry. Membership of the ANF includes registered and enrolled nurses who are regulated by specific State/Territory legislation and regulation in order to protect the health and safety of the public. The State and Territory nurse regulatory authorities maintain and promote professional standards of nursing practice by all nurses licensed in that jurisdiction.

1.3 The ANF also provides industrial and professional coverage to a third level worker (assistants in nursing and other classifications). These workers are increasingly educated in the vocational education sector at a Certificate III level and work predominantly in the aged care sector. If you add the estimated number of these workers to the total workforce providing nursing and nursing support services, then 70.3% are registered nurses, 19.0% are enrolled nurses, and 10.7% are assistants in nursing or related classifications[2].

[1] ANF Victorian Branch, ANF Tasmanian Branch, ANF SA Branch, ANF WA Branch, ANF NT Branch, ANF ACT Branch, Queensland Nurses Union, and the NSW Nurses' Association.
[2] ABS 1996 Census ABS Canberra.

1.4 The ANF has a comprehensive capacity for involvement in the development of policy in nursing, nursing regulation, health, community services, veterans' affairs, education, training, occupational health and safety, industrial relations, immigration and law reform. Policy input within the ANF is through consultation with the branches and their members and representation of each branch on the national executive and the national council. National subcommittees cover professional issues, occupational health and safety, industrial issues, publishing, aged care, midwifery, and rural and remote area nursing. The ANF represents nurses internationally through links with other national and international nursing organisations, professional associations and the international labour organisations.

1.5 The ANF has taken a positive role and active leadership in many of the Commonwealth, State/Territory and local activities relating to aged care. ANF representatives are on many national committees including the Aged Care Workforce Committee; the review of the Resident Classification Scale; the National Accreditation Liaison Group; the Pricing Review of Aged Care Services; and the Australian Pharmaceutical Advisory Council's working group that developed the best practice guidelines for medication administration in residential aged care. The ANF has also taken a lead role in the National Aged Care Alliance which brings together many of the key stakeholders to develop consensus positions on matters of mutual interest and concern in relation to aged care[3].

1.6 Nursing is an ageing profession and this has profound implications for those requiring nursing care in the future and nurses themselves who it is likely will be working with reduced professional assistance and support. The average age of nurses was 40.4 years in 1997, which was an increase from 39.1 in 1994. In the ten years 1986 to 1996 the number of nurses aged 25 years and less decreased from 20.9% in 1986 to 5.9% in 1996. Conversely, during the same period, the number of nurses aged greater than 45 years increased from 18.9% in 1986 to 31.0% in 1996[4]. To compound the problem, students commencing nursing courses are older. Lawler *et al* reported on NSW applicants selecting nursing in 1997 and they found that nearly 25% were aged 23 years or older[5].

[3] see www.naca.asn.au

[4] AIHW 2001 Nursing Labour force 1999 AIHW Canberra

[5] Lawler J, Ahern M, Stanley A and West S 1997 *Who wants to be a nurse? A report on applicants selecting nursing as a university course in NSW in 1997*, University of Sydney

1.7 The nursing workforce is predominantly female - 92% of the registered nursing workforce and 93.7% of the enrolled nursing workforce. In the *geriatric/gerontology* clinical area in 1997, there were 20,662 registered nurses and 14,635 enrolled nurses. Of these only 1500 were male[6]. The major implication is that women are generally financially less prepared than men for retirement and that women are still living longer than men and have longer retirement periods. For example, the Australian Bureau of Statistics average weekly ordinary time earnings index states that in February 2001, women were earning $129.9 less than males ($728.4 and $858.3)[7].

1.8 The ANF has prepared a series of recommendations for consideration and would be happy to meet and discuss these further with Committee members.

2. RECOMMENDATIONS

2.1 That the Commonwealth Government provides additional funding to the aged care portfolio in order to achieve and maintain wage parity between nurses working in aged care and nurses working in the public sector.

2.2 That the Commonwealth Government's funding formula for residential aged care includes a transparent allocation for care including nursing care and allied health, indexed to accommodate future wage movements.

2.3 That the Commonwealth Government regulates staffing and skills mix in residential aged care facilities including the following requirements:

a) 4.5 hours of nursing care per resident per day;
b) 24 hour registered nurse cover where there is at least one high care resident; and
c) the employment of a full-time director of nursing (or classification equivalent)in each facility employing nurses must have a full-time director of nursing.

2.4 That a national approach to workforce planning for the aged care sector be taken with leadership from the Commonwealth Government, and that a working group of the Australian Health Workforce Advisory Committee be convened to investigate the workforce profile including registered and enrolled nurses required for aged care over the next 10-15 years.

[6] AIHW 2001 Nursing Labour Force 1999 AIHW Canberra
[7] NACA 2001 Residential aged care funding: second report NACA accessed Nov 2002 at www.naca.asn.au pp 15

2.5 That the working group of the Australian Health Workforce Advisory Committee be requested to determine the number of undergraduate places in nursing courses required to meet future workforce needs and develop strategies to address the expected additional shortages due to the retirement of 30% of the nursing workforce over the next 10-15 years.

2.6 That the AHWAC group prepares a plan in relation to the education and training needs of the aged care workforce to which the aged care industry can contribute eg training for unlicensed nursing and personal care assistants and enrolled nurses.

2.7 That the Commonwealth Government identifies a process for implementation of the recommendations of the two major reviews into nursing ie the National Review of Nursing Education and the Senate Inquiry into Nursing, particularly as they affect the deliver of services to older people.

2.8 That national, state and territory governments work with nursing professional and industrial groups to identify a valid system for managing nursing workloads, built around the clinical judgments made by nurses in the evaluation of workloads and staffing and skills mix decisions.

2.9 That the Commonwealth Government, in conjunction with State and Territory Governments, undertake a review of the superannuation entitlements for nurses to bring them in line other equivalent workers.

2.10 That the Commonwealth Government, in conjunction with State and Territory Governments, develop mechanisms so that nurses working in aged care are able to transfer their accrued long service leave entitlements between employers in the aged care sector and the public and private health care sectors.

2.11 That the Commonwealth Government reviews the Accreditation Standards to incorporate more stringent assessment guidelines for assessors, against which outcomes are measured.

2.12 That the Commonwealth Government works with the aged care industry to develop a plan for assessment of services between formal accreditation processes.

2.13 That the following occupational health and safety strategies are implemented in the aged care sector:

a) that the Commonwealth Government introduces 'no lift' programs across the aged care sector;

b) that the Commonwealth Government introduce a national reporting system for violence and aggression toward nurses and other health workers in order to understand the factors which give rise to violent incidents, the extent of the problem, and to inform the development of strategies to prevent violent incidents occurring;

c) that education and other support measures for managing violence are available to and routinely provided for nurse as continuing education in the workplace;

d) that employers be required to ensure that nurses do not work alone in areas of high risk or where the level of risk is unknown;

e) that the Commonwealth Government commission research into the long term effects of exposure to glutaraldehyde and that a process is put in place to eliminate the use of glutaraldehyde in health and aged care sectors within the next two years; and

f) that the Commonwealth Government in conjunction with State and Territory Governments develop a process to eliminate the use of latex products in health care delivery within the next two years.

2.14 That the Commonwealth Government works with State and Territory Governments to address transitional care issues for older Australians following admission to an acute care facility.

2.15 That older Australians have equitable access to health and aged care services in both the community and in the residential aged care sector (including access to respite services).

2.16 That the Commonwealth Government develops a plan to ensure that all unlicensed nursing and personal care assistants in the aged care sector achieve the minimum education level of Certificate III (AQF level) by 2005.

2.17 That the Commonwealth Government fund a national nursing scoping project in order to identify and make recommendations on articulation and recognition of prior learning pathways extending from Certificate III level education for unlicensed nursing and personal care assistants, pre and post enrolment education for enrolled nurses, to undergraduate and post graduate preparation for registered nurses.

2.18 That the Commonwealth Government continues to provide scholarships to nurses working in aged care to enable them to access gerontic specific education at a Graduate Certificate level.

3. CARE FOR OLDER PEOPLE

3.1 The ANF supports the view that many older Australians will generally have better health and well-being for longer periods as a result of illness prevention and health promotion initiatives. Improved socioeconomic conditions will also positively affect the lives of many (but not all) older people in Australia, and the ANF strongly advocates the development of strategies that will improve the health and wellbeing of socioeconomically disadvantaged older people, including Indigenous Australians. This investment in all sectors of society will have a major impact on the services required by older people in the future.

3.2 Despite the general improvements in health and well-being, many people in Australia, perhaps at an older age, will continue to require health or aged care support in the years prior to death. The demand for health and aged care will increase during the next 40 years, with an increase in the number of older people and an increase in the number of very old people. The ANF notes that health and/or aged care services may be offered increasingly in the community setting rather than in residential aged care facilities. The ANF position is that older people should be able to access high quality health and aged care services when they require them and where they need them. Australia is currently struggling to provide a quality service, including health and aged care, to older people in Australia.

3.3 Providing high quality systems for older people in Australia must include an investment in the workforce required to provide health and aged care services. Nurses are educated and clinically prepared to provide comprehensive care to older people who generally have health problems associated with the ageing process. Nursing involves a consumer centred approach to health care and is inclusive of the person's family and friends. Nursing takes a holistic rather than a task oriented approach and includes the physical, mental and emotional care of the person. Nurses are licensed in order to protect the public and this community focus is integral to nursing practice in all settings.

3.4 In relation to quality care in the residential aged care sector, the ANF has generally supported the accreditation process introduced by the Federal Government. It is necessary however that a system of quality control should be in place to evaluate the care that older

people receive, and to assess whether the significant Government funds provided to the aged care sector are being expended appropriately. Unfortunately, the current accreditation standards lack specificity leading to inconsistent application during the accreditation process. Assessors have inadequate guidelines against which to measure the provision of care resulting in inconsistent outcomes. The focus of accreditation must be on the outcomes of care. The ANF supports the use of a series of indicators from which facilities can choose to be assessed eg falls; use of drugs for chemical restraint purposes; rates of weight loss in residents; urinary tract infections; etc. The ANF also advocates for greater use of information such as staffing and skills mix to evaluate the service being provided.

3.5 It is also our opinion that more constructive and careful monitoring of facilities should take place in the period between accreditation visits. While the ANF supports the use of accreditors from the aged care industry, it is our position that more education is required and there should be an appropriate debriefing process for accreditors following accreditation visits.

3.6 The State/Territory public health system continues to complain about the impact on the acute care system of older people assessed as appropriate for a place in the residential aged care sector. While we are aware that not all the patients who are so classified by the Aged Care Assessment Teams require an immediate place, there is a significant number of older people who will not return home after an acute admission because of failing health or increasing frailty. We note the comments included in the recently released Myer Foundation report *2020 A vision for aged care in Australia*, that *(a) lack of rehabilitation and convalescent care triggers premature or inappropriate decisions to transfer people from acute hospitals to permanent residential care*[8]. The ANF calls on the Federal Government and the State/Territory Governments to work together so that older people receive care in the optimum environment to meet their needs ie when the older person is ready to move into a residential aged care facility then it should be a reasonably easy process in all regions. There should also be equitable access to appropriate other services that will assist older people in Australia to remain at home wherever possible eg appropriately resourced community nursing services.

3.7 The ANF fully supports the provision of care wherever the older person is living. Nurses provide complex care in the homes of people with complex needs and they are happy to continue to do so as long as the resources are available to provide high quality care. This

[8] Myer Foundation 2002 *2020 A vision for aged care in Australia*

includes additional support and resources for the family and carers of people receiving care at home and for their immediate environment. Homes must be safe for both the person receiving care, their families, and for those providing the care, including nurses.

3.8 Access to respite care remains an issue. Accommodating the needs of carers with the provision of appropriate respite care will prolong the time that older people in Australia are able to remain out of residential aged care facilities on a permanent basis (including the carers themselves who retain health and well-being for longer).

3.9 There must be effective coordination of care in the community. Nurses should be involved as many people requiring personal care services only, may have declining health that will require an intervention which can be pre-empted by a skilled professional working with other care providers.

3.10 Low care facilities previously known as aged care hostels have changed markedly with the introduction of the Federal Government policy, a*geing in place*. There has been a significant change in the resident profile in these facilities. The AIHW now reports that 23% of residents in low care facilities are classified as high care requiring significant health and aged care services. It was reported in the journal, *Hospital and Healthcare* that *while some were admitted as high care residents, two thirds have remained at the same facility, effectively being allowed to age in place*[9]. While it is obviously preferable to refrain from moving residents as they become more frail and/or ill wherever possible, this often results in a lower quality of health and aged care being available. High care facilities are required to have a registered nurse present at all times and low care facilities which are increasingly providing care to high care residents should be required to provide the same level of staffing for high care residents. Low care facilities are currently only required to be able to access a registered nurse when required and they do not always have nurses on staff. If facilities are unable to provide a high level of care then they should not participate in the ageing in place program.

3.11 Residential aged care is labour intensive. It is currently estimated that 78% of costs in the sector are wage costs. Aged care does not provide the same opportunities for improved productivity found in the acute health care sector eg access to technology; reducing length of stay; and access to allied health and specialist medical staff.[10] The capping of funding and inadequate adjustments for wage increases has, according to a National Aged Care Alliance report, led to the following: *costs are likely to be reduced either through lowering staff to*

[9] Anon 2002 Ageing in place increasing *Hospital and healthcare* August 2002 pp 8
[10] NACA 2001 Residential aged care funding: second report NACA accessed Nov 2002 at www.naca.asn.au pp 12

resident ratio, employing less expensive (less skilled) labour or reducing non labour costs with potential consequences for the quality of the services that are delivered[11].

3.12 Where older people or their family carers are unable to take responsibility then registered nurses must be available to assess, plan and evaluate the care required by the older person. The comprehensive educational preparation of registered nurses provides the necessary skills and knowledge to enable them to carry out assessment, planning, delivery, delegation, ongoing monitoring and evaluation of nursing care to clients.

3.13 Licensing of nurses occurs for public safety purposes. There are legislated systems in place to set the standards for nursing practice, assess the competency of licensed nurses, and receive and respond to complaints about nurses and the care that they provide. These important elements are not present for other workers and it is concerning that the most vulnerable in the community are not being protected in any way. The ANF does not hold the position however that only registered and enrolled nurses should be involved in the care of older people. Where healthy older people are responsible for their own care then the person themselves will make decisions about the most appropriate person to assist them where necessary. It is of course our position that older people must have the appropriate information in order to make informed decisions about assistance with care needs. Following assessment by registered nurses, enrolled nurses, assistants in nursing and other unlicensed workers may be delegated nursing or personal care activities to assist in the delivery of nursing care.

3.14 Registered nurses supervise, either directly or indirectly, aspects of care delegated to assistants in nursing and other unlicensed workers[12]. Supervision, direct or indirect, depends on the complexity of the delegated activities, the level of training and experience and the competence of the assistant in nursing or other unlicensed worker. The registered nurse delegating the care makes the decision on whether the supervision is direct or indirect. In some jurisdictions enrolled nurses may also supervise assistants in nursing and other unlicensed workers.

3.15 There are significant supervision and delegation dilemmas for registered nurses, many of whom do not find it professionally acceptable to delegate nursing care to workers who may be inappropriately qualified or unqualified. It is the view of the ANF that employers

[11] NACA 2001 Residential aged care funding: second report NACA accessed Nov 2002 at www.naca.asn.au pp 12

[12] Direct supervision: the registered nurse judges that a registered nurse should be present, observing, working with and directing the assistant in nursing or unlicensed personal care assistant during the provision of care.
Indirect supervision: the registered nurse is available **at all times on the premises** but may not **be required, in the judgment of the registered nurse, to** observe all activities.

are substituting nursing positions with unlicensed nursing and personal care assistants (however titled) citing current shortages as their rationale and yet they are doing little to reverse the exodus of registered nurses from the system or to increase the numbers of enrolled nurses being educated.

3.16 Enrolled nurses are an under-utilised resource in the aged care sector. The ANF has been concerned for some time about the reduction in enrolled nurse positions in the aged care sector. The AIHW Reports a decline in the number of enrolled nurses in aged care from 19,563 in 1993 to 13,930 in 1997 ie approximately a 30% reduction in numbers[13]. It appears that this reduction has occurred at the same time as an increase in the number of unlicensed nursing and personal care assistants. Enrolled nurses are well prepared to assist registered nurses in the provision of health and aged care. While there are challenges as a result of different educational frameworks for enrolled nurses across the country, there is consistency in that all enrolled nursing students applying for a license with the State/Territory nurse regulatory authority must meet the agreed minimum standards. The ANF recently joined with several partners to apply for funds to host a national consensus meeting on enrolled nurse education in order to move forward and achieve greater consistency in education for enrolled nurses.

3.17 The ANF supports expansion of the role of enrolled nurses to include the administration of medication. This expanded role would provide additional staffing and skills mix flexibility in, for example, aged care service provision. Any role expansion must be accompanied by appropriate education; be voluntary; and be appropriately remunerated.

3.18 Further work is required to expose under graduate students of nursing to clinical practice in the aged care sector and to prepare them to care for older people ie in the community, in residential aged care facilities and in the acute sector. Issues such as these were addressed in the National Review of Nursing Education and the Senate Inquiry into Nursing and we refer the Committee to these reports.

3.19 Access to aged care specific education is another issue of concern for nurses working in aged care. Aged care is a specialist area of nursing practice with its own discrete body of knowledge which is constantly growing. Nurses need to be actively involved in continuing education if quality care for older people using aged care services is to be the outcome. There is a shortage of gerontic specific education courses at Graduate Certificate

[13] AIHW 2001 Nursing Labour Force 1999 AIHW Canberra

level in external and distance modes offered at a price that nurses are able to afford. Such courses should include modules on dementia and the management of aggressive behaviour. Cost is also a barrier in that nurses themselves bear almost the entire cost of education and yet it is governments, employers and service recipients who reap the rewards with a higher quality of nursing care. Nurse receive marginal improvements in income and career opportunities as a result of a post graduate education investments of up to $10,000. A recent survey by the NSW Branch of the ANF found that only 56% of those surveyed said that their employer *encouraged and supported them in further education and professional activities*[14]*.* The recent Federal Government budgetary allocation towards scholarships and research funding is appreciated, particularly that targeting nurses working in aged care.

3.20 The industrial system in Australia fails to value nursing older people, in that many employers refuse to negotiate fairly over wages and conditions. This results in a significant wages gap between the public and private acute sectors and the aged care sector, and less favourable working conditions, making it difficult for aged care providers to recruit and retain nurses in a very competitive employment market. Employers have failed to support the intent of the May 2002 Commonwealth Budget announcement ie $211.1 million over 4 years which was designed to assist aged care providers meet the costs associated with the provision of services including nursing. In 2001, the wage differential nationally was $92.73. As at 30 September 2002 it wasthe current wage differential is $123.06. By comparison, the national wage differential in 2001 was $92.73[15].

3.21 A major study funded by the Commonwealth included the following recommendation,

> *Aged care employer groups and relevant industrial organisations together develop a strategy to move towards wage parity between aged care and acute care nurses in each State and Territory*[16]*.*

The ANF, being the main industrial organisation for nurses, is always willing to work with others to achieve wage parity for nurses. Unfortunately, we note that this willingness is rarely reciprocated by employers and that as a result there are major industrial campaigns for aged care in several jurisdictions. Unfortunately, the outcomes of the negotiations are unlikely to be wage parity with the public sector. For the aged care sector to be able to recruit and retain skilled and qualified nurses to work in the sector, mechanisms to achieve and maintain wage parity with other sectors in which nurses work is essential. The Federal Government, as the

[14] NSWNA 2001 What nurses think about aged care? A report on nurse perceptions about the aged care sector September 2001
[15] ANF 2002 Nurses PayCheck ANF Melbourne 1(4) pp33-42
[16] Commonwealth Department of Health and Ageing 2002 Recruitment and retention of nurses in residential aged care: Final report CDHA Canberra

major funder of aged care services, should ensure that part of that funding is quarantined to provide and maintain wage parity for nurses.

3.22 A consistent approach to nurses' wages, either nationally, or at a State and Territory level, promotes stability and certainty within the health and aged care sectors, facilitates the traditional mobility of nurses between sectors (public, private, and aged care), and is cost efficient. Prior to the introduction of the Workplace Relations Act 1996, this approach had the support of employers both in the public and private sectors because it allowed the nursing workforce, who is extremely mobile, to cross sectors without cumbersome industrial or legislative restrictions, and it enabled employers to attract and retain quality nursing staff. This approach also had a positive impact in terms of the public interest, ensuring that there were sufficient nurses across all sectors to meet health service needs. It is not healthy when there are labour market fluctuations that result in severe skill shortages, as is currently the case in nursing, especially in aged care. It is virtually impossible for aged care employers to recruit and retain nurses in a labour market where the remuneration for nurses in many states is between 5.1% and 24.9% below that in public and private hospitals.

3.23 In a regulated industry where approximately 75% of funding is received from the Federal Government, the working conditions are less than that found in most areas of the private sector. As previously noted, aged care nursing is a female dominated profession. All employment agreements in aged care should have as basic conditions clauses which meet the needs of the majority of the workforce, such as child care, paid maternity leave, care of older relatives, carers' leave, and conditions to assist with continuing to breast feed, etc. These conditions should be in addition to commonly negotiated conditions such as sick leave and annual leave.

3.24 Despite the Federal Government being the principal funder for residential aged care facilities, nurses employed in residential aged care facilities are unable to transfer their accrued entitlements between employers and this has been detrimental to the promotion of gerontic nursing and is at odds with a long standing industrial benefit available in the public health sector and most major private hospital groups. The accrual and transfer of entitlements is a feature of employment in a number of industries including:

- the contract cleaning industry in Victoria;
- the national building industry;
- ambulance employees; and
- hospitality workers employed by major employer groups.

3.25 The failure of the industry to offer this benefit not only detracts from a career in aged care but also acts against the employer's ability to recruit in a competitive labour market. The introduction of this benefit, properly managed on a national basis, would not be a significant cost burden on the industry. It is the view of the ANF that the majority of employers in the industry would support the introduction of a system allowing for the transfer of accrued long service leave entitlements. The ANF recommends that the Federal Government, in conjunction with State and Territory Governments, develop mechanisms so that nurses working in aged care are able to transfer their accrued long service leave entitlements between employers in the aged care sector and the public and private health care sectors.

3.26 Minimum staffing levels to promote safe care and safe practice, should be included in the aged care accreditation standards and in all industrial agreements in the aged care sector. The minimum standards are:

a) 4.5 hours of nursing care per resident per day;
b) 24 hour registered nurse cover where there is at least one high care resident; and
c) the employment of a full-time director of nursing (or classification equivalent)in each facility employing nurses.

3.27 There in increasing evidence in the acute health care sector that there is a link between the number of registered nurses and the hours of nursing care that they provide to patients, and health outcomes including reductions in morbidity and mortality[17]. This research has not been replicated either in Australia or in the aged care sector but we note the increasingly poor health status of residents in aged care facilities and suggest that comparisons are not impossible to make between these sectors. The ANF supports research in this area but we strongly recommend that some minimum standards (as outlined in 3.32 above) are implemented while the project is developed so that the quality of care in aged care facilities does not reduce any further.

3.28 The ANF is concerned that staffing and skills mix are not weighted highly enough in the aged care accreditation process. It is the position of the ANF that staffing and skills mix are key performance indicators in the care of older people. Providers should be required to demonstrate that they meet minimum staffing standards when the outcomes of care are being reviewed.

[17] For example Needleman *et al* 2002 Nurse staffing levels and the quality of care in hospitals *New England Journal of Medicine* 346(22) pp 1715-1722

3.29 The Commonwealth Government provided the majority of funding in the residential aged care sector and they should be able to create an effective and efficient system. It is the position of the ANF that the funding formula for aged care should include a transparent allocation for care including nursing care and allied health care. The funding must accommodate changes in wages for staff including nurses. Accommodation and other hotel-like services should be separately funded.

3.30 The ANF also supports regional indexation allowing for the different costs associated with aged care service delivery in different states and territories, and between metropolitan and rural areas. There should also be access to fund to provide for the cost of acute, rehabilitative and palliative care services in residential and community aged care settings, eg intravenous medications and major wound management.

3.31 Nurses working in the aged care sector are concerned that the amount of documentation that is currently required to justify funding is compromising quality care to residents because it takes time away from assessing, planning, and providing care, and to supporting and supervising other workers. This has been a consistent message since the introduction of the Aged Care Act 1997. Either the amount of documentation needs to be reduced, or additional funding provided to aged care providers to allow them to employ nurses specifically for the purpose of meeting documentation requirements.

4. NURSES AS OLDER MEMBERS OF THE COMMUNITY

4.1 Approximately 30% of the nursing profession will reach the traditional age of retirement within the next 10-15 years. Nursing is a physically and emotionally demanding profession and many nurses will be physically unable to work in the clinical setting beyond retirement age when they are able to access their superannuation. This decision may be made in the full knowledge that, for a variety of reasons, their income has been seriously truncated during their working lives and that their accrued benefits are insufficient for a financially comfortable retirement.

4.2 One of the reasons for this reduced income is the change in working patterns which is characteristic of contemporary nursing. Nurses are either demonstrating their dissatisfaction with the health and aged care systems generally by working less or they are having these changes forced upon them by employers looking for a more flexible and cheaper workforce. To control their excessive workloads, nurses are reducing their working hours, changing their status to casual or part-time, or resigning. In some sectors such as

aged care, despite the current nursing shortages, underemployment is common, with nurses often unable to gain or retain employment that is secure and provides adequate and stable remuneration. Nursing hours are being steadily reduced in many facilities as a cost saving measure. Permanent full time employment is progressively being replaced by periodic part time and casual employment often against the wishes of the nurse.

4.3 The ANF has taken a leading role in responding to the needs of nurses and negotiating, in all States and Territories, for both reasonable workloads and appropriate remuneration for the work that is being undertaken. The workload management strategies introduced for the public acute care sector in States such as Victoria, Western Australia, South Australia, Queensland and Tasmania, have had a positive effect on nurses in that they are choosing to return to work in the public hospital system and it appears that they may also be choosing to increase their hours of work.

4.4 The long term effects of reduced working hours will not only be felt by the health and aged care systems is a reduced quality of care, but there will also be an impact on individual nurses, for example, by reducing their future retirement benefits. A recent National Centre for Social and Economic Modeling report has again emphasised that women working part-time or taking extended breaks will struggle to achieve income levels in retirement equivalent to the current full age pension[18].

4.5 Nurses take their public advocacy role very seriously and experienced and specialist nurses are voicing concern that nothing is being done to prepare for future nursing shortages following their retirement over the next 10-15 years. Experienced nurses, many of whom will have specialist qualifications, will be exiting in large numbers but there is inadequate succession planning and no national planning to ensure that enough nurses are entering and staying in the health and aged care systems to replace either the numbers, the experience or the specialist qualifications. The ANF reiterates its recommendation to the Senate Inquiry into Nursing and the National Review of Nursing Education that a national approach to workforce planning be taken with leadership from the Federal Government and that a national working group be established to (a) provide advice on the required number of undergraduate places in nursing courses, and (b) develop strategies to address the expected additional shortages due to the retirement of 30% of the nursing workforce over the next 10-15 years.

[18] Horin A 2001 Women left behind in super stakes *Sydney Morning Herald* 5 July 2001 p 6.

4.6 The National Review of Nursing Education recommendation that an additional 400 places for two years only (total 800 places) be provided Australia-wide[19] is apparently a serious underestimation of the requirements. For example, the Victorian Department of Human Services' nurse policy unit advised the ANF that they require an additional 800 student places to accommodate workforce needs in the near future[20]. The ANF is very disappointed that the time frame suggested in the National Review, ie starting in 2003, is likely to be delayed and considered in conjunction with the broader Ministerial review of higher education. The ANF was recently notified that any changes to the allocation of places will be included in the Cabinet submission on higher education funding that is due at the end of 2003[21]. Any additional places for nursing students will therefore not be available until the 2004 academic year at the earliest. The ANF considers the issue of additional nursing places to be a matter of urgency and we are very disappointed that the outcomes of a major Federal Government review are not being implemented in a timely manner.

4.7 Nurses have access to less advantageous superannuation entitlements than those provided to public servants, teachers and police officers. Nurses do not belong to defined benefit funds where the superannuation entitlement is substantially superior. The majority of nurses in the health sector, whether it is public or private, only receive the superannuation guarantee contribution. The comparative disadvantage in the superannuation entitlement of nurses is further compounded by their historical pattern of part-time and casual employment - largely driven in a female dominated industry by child bearing and child rearing responsibilities - and their employment mobility. The effect of the differences in superannuation entitlements of nurses compared to other professionals is to reduce the overall incentive for people to choose nursing as a career, or for nurses to see their profession as providing a long term career path. It is recommended that the Federal Government, in conjunction with State and Territory Governments, undertake a review of the superannuation entitlements for nurses and other employees so that retirement income is able to provide a reasonable retirement lifestyle.

4.8 The consequences of occupational illnesses and injuries suffered by nurses are another factor adversely impacting on the quality of nurses' retirements. The ANF points to increasing levels of violence and aggression, manual handling injuries, latex sensitivity and

[19] DEST 2002 National Review of Nursing Education DEST Canberra pp 29
[20] Personal communication with B Moyes (assistant director)
[21] See the update on the National Review of Nursing Education on www.anf.org.au

the late effects of exposure to glutaraldehyde as occupational and safety issues that are seriously impacting on all nurses.[22]

4.9 Aged care is an area where there are high rates of occupational injury, particularly in relation to manual handling. An analysis of successful workers' compensation claims made under the Commonwealth and State and Territory Workers' Compensation Acts demonstrated that *nursing homes* (ie residential aged care facilities) experience higher claims rates than hospitals, including psychiatric hospitals. The rate for *nursing homes* was 72% higher than the all industries average. *Nursing homes* average workers' compensation cost per occurrence was $8330 per claim, which was 13% higher than for hospitals and 37% higher than for psychiatric hospitals. This is 13% higher than the average costs for all industries. The analysis found that sprains and strains accounted for the majority of occurrences (77%) in nursing homes. The mechanism of injury was predominantly manual handling related (58%) with the most common bodily locations being the back (45%) and shoulder (10%). Falls and slips also accounted for a significant proportion of incidents (15%)[23]. The ANF has long advocated the introduction of 'no lift' policies in residential aged care[24]. Where these policies have been introduced, considerable savings have resulted, both in terms of a reduction in staff workers' compensation and sick leave, and a reduction in workers' compensation premiums.

4.10 The ANF repeats its major OHS recommendations which were included in the ANF submission to the Senate Inquiry into Nursing and the National Review of Nursing Education:

a) That the Federal Government introduce 'no lift' programs across the aged care sector;

b) That the Federal Government introduce a national reporting system for violence and aggression toward nurses and other health workers in order to understand the factors which give rise to violent incidents, the extent of the problem, and to inform the development of strategies to prevent violent incidents occurring;

c) That education and other support measures for managing violence be available to and routinely provided for nurse as continuing education in the workplace;

d) That employers be required to ensure that nurses do not work alone in areas of high risk or where the level of risk is unknown;

[22] See the ANF submission to the Senate Inquiry into Nursing for further information

[23] Commonwealth Department of Health and Aged Care 1998 *Evaluation of the National OHS Strategy for Residential Aged Care* Aged and Community Care Services Development and Evaluation Reports No:39 Commonwealth of Australia Canberra

[24] This refers to eliminating the need for nurses and other care workers to manually handle people by introducing aids such as lifting devices when moving residents from chairs to beds etc.

e) That the Federal Government commission research into the long term effects of exposure to glutaraldehyde and that a process is put in place to eliminate the use of glutaraldehyde in health and aged care sectors within the next two years;

f) That the Federal Government in conjunction with State and Territory Governments develop a process to eliminate the use of latex products in health care delivery within the next two years.

5. CONCLUSION

5.1 The ANF is committed to the provision of quality heath and aged care services for older people in Australia. It is our view that there is a reluctance to invest in one of the primary determinants of a quality service, the nursing workforce. We therefore call on the Federal Government to commence preparations immediately so that the workforce is available when it is needed. The ANF strongly advocates for the implementation of the above recommendations and expresses its willingness to work with governments to achieve the required outcomes for older people in Australia.