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THE UNION FOR QNU NURSES AND MIDWIVES

QUEENSLAND NURSES' UNION

Submission to the

Joint Select Committee on Northern Australia

Inquiry into the Development of Northern Australia

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Introduction

The Queensland Nurses' Union (QNU) thanks the Joint Select Committee on Northern Australia (the Committee) for providing this opportunity to make a submission to the inquiry into the development of northern Australia.

The QNU - the union for nurses and midwives[1] - is the principal health union in Queensland. Nurses and midwives are the largest occupational group in Queensland Health and one of the largest across the Queensland government. The QNU covers all categories of workers that make up the nursing workforce in Queensland including registered nurses, registered midwives, enrolled nurses and assistants in nursing who are employed in the public, private and not-for-profit health sectors including aged care.

Our more than 50,000 members work across a variety of settings from single person operations to large health and non-health institutions, and in a full range of classifications from entry level trainees to senior management. The vast majority of nurses in Queensland are members of the QNU.

Nurses are the most geographically dispersed health professionals in Queensland and indeed Australia, working independently or collaboratively to provide professional and holistic care in a range of circumstances. They will play a vital role in ensuring quality health outcomes in the growth of Australia's north.

We contend that the development of this region's mineral, energy, agricultural, tourism, defence and other industries will depend on the provision of infrastructure and facilities. The nursing and midwifery workforce will provide critical services needed to support the long term progress of the area.

The Rural and Remote Nursing Workforce

The QNU draws the committee's attention to the actions of the state LNP government that has cut more than 1200 Full time Equivalent (FTE) nursing positions throughout Queensland in the two years since it was elected. By our estimation more than 100 FTE[2] of these positions were in rural and remote areas – a significant reduction given the size of the rural nursing workforce. At the same time, around 2,000 new nursing graduates have been unable to find employment, exacerbating an ongoing workforce problem.

[1] Throughout this submission the terms 'nurse' and 'nursing' are taken to include 'midwife' and 'midwifery' and refer to all levels of nursing and midwifery including Registered Nurses and Midwives, Enrolled Nurses and Assistants in Nursing.

[2] This is a conservative number based on data supplied to the QNU by Queensland Health. It includes the Torres Strait and Northern Peninsula, Cape York, North West and South West HHS, Edmonton, Innisfail, Cairns Hinterland, Dalby, Jandowae, Bowen, Ayr, Charters Towers, Ingham and Gayndah.

Health Workforce Australia (HWA) recently reported that by 2016 there will be a national shortage of 20,079 nurses and midwives and they project that by 2025 this shortage will be 109,490 (HWA, 2012, p. 11). In the face of such a significant dearth of nurses and midwives, the QNU continues to advocate for a co-operative industrial approach to solve this problem. It is our view that HWA's prediction could be worse than expected, especially when Queensland Health continues to deny new graduates employment. We need more, not less, nurses to support the growing demand for and expansion of health and aged care services in both the acute and non-acute sectors and in all areas.

It is hard to reconcile Queensland Health's cuts to nursing jobs and inability to employ new graduates with the obvious future need to recruit and retain nurses in rural and remote areas. The following table indicates that the rate of employed registered and enrolled nurses in 2007 was lower in Queensland (in proportion to its population) across all areas, particularly very remote areas, than the Australian average[3].

Employed registered and enrolled nurses: FTE (35 hour week) nurses per 100,000 population, by State and Territory and Remoteness Area, 2007

	Major cities	Inner Regional	Outer Regional	Remote	Very Remote	Total
NSW	1,039	1,126	935	1,006	1,603	1,093
Vic	1,197	1,423	1,523	2,221	..	1,331
Qld	1,031	1,128	1,093	1,107	1,137	1,121
SA	1,430	803	1,229	1,286	1,184	1,396
WA	1,045	841	1,073	1,073	1,138	1,057
Tas	..	1,577	800	731	1,780	1,362
NT	..	..	1,509	1,732	1,088	1,556
ACT	1,195	4,179	..	..	..	1,201
Australia	1,119	1,202	1,124	1,211	1,149	1,189

Source: Australian Institute of Health and Welfare (AIHW) (2009)

Queensland Health has long recognised the challenges in recruiting and retaining the nursing workforce in rural and remote areas of Queensland. Remote area nurses are subject to quite different stressors to their metropolitan and regional counterparts. According to HWA, (2013) nurses experience professional and geographic isolation, fatigue, problematic transport, exploitation, climate extremes, and personal safety and security. These communities report higher vacancy rates, higher locum use, and higher use of overseas trained professionals. In addition, the role of the nursing workforce broadens and expands

[3] Note: the source of this table is the AIHW (2009) *Nursing and Midwifery Labour Force Survey 2007*. The most recent AIHW publication *Nursing and Midwifery Labour Survey 2011* does not present data in this same format. However, the 2007 data may be reasonably indicative of the current labour force.

with increasing remoteness. In the most remote communities the only health workforce may well be nurses (HWA, 2013).

In 1995, the Queensland government endorsed the recommendations from a task force established to examine recruitment and retention issues for registered and enrolled nurses in remote areas. Queensland Health developed the Remote Area Nurse Incentive Program (RANIP) in consultation with the affected former regional health authorities and the QNU. Through subsequent enterprise bargaining agreements, Queensland Health and the QNU have continued to build on this program, though negotiations have been particularly difficult and protracted. Unfortunately it has not been possible to establish equity between the various Queensland Health clinical occupational groups regarding the incentives being paid to those in rural and remote areas, with the incentive package for nurses and midwives being far less favourable than their colleagues.

The QNU recognises that enterprise bargaining agreements are significant enablers of productivity enhancements and incentive arrangements. Since certification of the latest public sector nurses' agreement (EB8) in 2012, the only provision that Queensland Health has actually implemented is the inclusion of Cooktown within the RANIP scheme (See Attachment A). More generally, EB8 identified excessive nursing workloads and lack of career opportunities as reasons for the retention and attraction problems in rural and remote areas. However, there has been very limited progress in all other commitments to rural and remote nurses.

Further incentives

It is important to provide incentives for hard-to-staff positions, roles or locations – whether the nurses targeted are re-entrants, new entrants, transfers or nurses continuing in existing positions. Flexible working arrangements are the cornerstone to increase retention of nurses in the workforce. However, it is replenishing the total pool of qualified nurses that should be given priority as the large cohort aged around 50 moves into retirement. It should also be a priority to improve the general attractiveness of nursing as a career to ensure adequacy in quantity and quality of new recruits into the nursing workforce over the coming decade.

HWA (2013) noted that the most significant issue reported across rural areas is the ageing of the nursing workforce, indicating strategies are needed to strengthen attraction and recruitment. Anecdotally, members have reported that in some Hospital and Health Services 100% of the incumbents in senior nursing positions are aged over 65 years, presenting a significant succession planning risk.

The Senate Community Affairs Committee (2012) inquiry into the factors affecting the supply of health services and medical professionals in rural areas acknowledged that it is timely to

review incentives for rural and remote workers and recommended that a scheme to reimburse the Higher Education Contribution Scheme (HECS) available for doctors should be extended to nurses and allied health professionals relocating to rural and remote areas.

The QNU supports the idea of HECS refunds, but incentives need to be in place at the very start of the nursing career. Governments should provide funding for rural hospitals and Medicare Locals to sponsor the inherent costs of living away from home for local students to study nursing, perhaps in return for two or three years' work in their rural area. This of course means there will also need to be funded graduate programs in those areas.

Rural and remote training and competencies for nurses

It is the view of the QNU that nurses should work in a collaborative service model that allows independent decision-making and use of their knowledge within a multidisciplinary team that recognises and respects each professional domain. This requires proper measurement of nurses' input into collaborative models of care. The same applies to rural and remote areas, but multi-disciplinary teams need to incorporate all disciplines so that the rural or remote nurse has the necessary professional services and supports in place to be productive.

Employment of student nurses in rural and remote settings is a strategy that may also keep nurses in the profession longer. This arrangement aims to build a conduit so that there is fluid movement of students from commencement of the course to graduation. A workplace strategy that addresses the cross-generational issues in nursing will improve recruitment and retention of nurses in rural, remote and indeed all areas of Queensland Health. This would not be in lieu of clinical placement or clinical hours required to fulfil the requirements of the course but provide an opportunity for the student to experience the workplace to which he/she might be recruited on completion of their course.

Education providers have a financial incentive to retain students in tertiary study which means they do not necessarily give due consideration to whether the student is suited to the profession. With evidence suggesting a high proportion of nurses leave nursing early in their career (Beecroft, Dorey, Wenten, 2008) it is especially important to ensure that those beginning practitioners have already made a decision that they are personally suited to the profession. There is also a clear need for strong incentives to encourage prospective students to study nursing especially given the lack of job opportunities in Queensland at present.

The QNU advocates productivity strategies that measure service efficiency not solely in economic terms, but in the degree of optimisation of nurse-sensitive indicators, as these are a true and appropriate reflection of the productivity (and intrinsic value) of nursing and midwifery care (Armstrong, 2009). Studies on nurse-sensitive indicators (Wong & Cummings, 2007; Orrock & Lawler, 2006) illustrate the importance of nurses being given a

high degree of autonomy in their professional practice and the management of not only their own workload, but that of their nursing and multidisciplinary team colleagues as well.

We believe there needs to be an acknowledgment from the highest levels of state and federal government that the next generation of nurses in rural and remote settings will not be created without supported graduate programs or nursing internships. To this end, the Committee could explore incentives for undergraduate student placements in rural and remote areas. The undergraduate's experiences may also influence their future career decision, particularly in the specialty area they choose, so quality placements are necessary for effective preparation to practice. Any graduate program must be able to identify mentors and preceptors who are prepared (and remunerated) to undertake the important task of preparing graduates for independent practice.

The QNU asks the Committee to explore the capacity of the Commonwealth to provide federal funding models that enable graduate nursing programs in rural and remote settings. The Commonwealth already supports funding for internships for graduate medical practitioners and could extend this to nurses and midwives.

Substitution of roles

Although there are often calls for 'rural and remote generalist nursing', the QNU strongly opposes any moves towards dilution or substitution of registered and enrolled nurse positions. The QNU is concerned that the rapid increase in the number of unlicensed workers giving direct nursing care, particularly in aged care, will impact on the nursing workforce and the quality of care it is able to deliver[4]. While we accept that unlicensed nursing and personal carers may be competent at providing a basic range of services and are valued members of the team, however these staff may not be able to recognise more serious issues that require supervision and support from RNs.

The QNU has consistently argued that anyone undertaking nursing work should be designated as such and operate within a regulated framework. Where care and support includes nursing, then a nurse should undertake this work whether it is in the home or a facility. This will require consistent, transparent criteria on the nature of nursing in order to make a judgment.

[4] In Queensland, personal carers are referred to as Assistants in Nursing (AINs). The Nursing and Midwifery Board Australia does not currently licence AINs. Many AINs hold a Certificate III or IV qualification but this is not a mandatory requirement. The AIN assists with nursing care and works under the direction and supervision of a registered nurse.

The QNU contends that the Nursing and Midwifery Board Australia (NMBA) as the regulating body for registered nurses, enrolled nurses and midwives should also regulate AINs. Through a licensing regime, AINs will require a minimum level of formal education and accountability in their practice. Competency standards should be based on those currently governing the regulated nursing workforce.

As professional nursing activities become more evidence-based and more knowledge-intensive, there has been a corresponding rise in the requirements for formal qualifications and professional standardisation of nursing skills. Increased patient acuity and shortened lengths of stay in facilities as well as a renewed focus on primary and preventative health care, have changed the way in which individual nurses and midwives practice and the nursing profession. It is therefore likely that more acutely ill patients requiring more complex interventions and treatment regimens in shorter periods of time will have a significant impact on expected nursing workloads, and create the need for more rather than less skilled staff (Aiken et al., 2002; Duffield and O'Brien-Pallas, 2002).

In Queensland, there is continuing inadequate skill mix to meet the daily needs of patients/clients, particularly in the aged care sector. Lack of registered nurses, too few relief staff and funding shortfalls are the major contributing factors to an inappropriate skill mix resulting in a negative impact on nursing and midwifery workloads (Hegney et al., 2011). While the drivers for determining and adjusting skill mix come from a number of sources, the most prevalent influence to date has been financial constraints. The notion of expanded and extended practice for registered nurses ostensibly provides opportunities for less skilled workers to undertake the more routine aspects of nursing care so that the registered nurse or midwife is effectively employed in more complex practice activities.

There are significant risks to patients from understaffing and inadequate skill mix, including compromised safety and diminished quality of care; increasing morbidity (incidence of disease) and mortality (death rate); and an increased occurrence of adverse or sentinel events (injury or death resulting from a health care intervention, not the underlying condition of the patient) (Armstrong, 2009). Evidence confirms a direct relationship between the registered nurse and midwifery workforce and positive patient outcomes (Duffield et al., 2005; Duffield et al., 2007).

The QNU believes that creating an optimal minimum skill mix for each context of care relies primarily on the utilisation of nurses practicing to their full scope of practice, and secondly on economic constraints. Replacing registered/enrolled nurses with unregulated workers may yield immediate cost savings, but will have long term implications on the provision of safe, quality care, staff services and the effectiveness of our national health system. The optimisation of nurses' scope of practice and the increased use of the Nurse Practitioner are a priority for developing adequate strategies to address inequities in health outcomes suffered by residents in rural and remote communities.

Nurse Practitioners

Nurse practitioner-led models in primary care and Medicare Locals will be essential to minimise the burden on hospital services in rural areas. This is especially important given the national health and aged care reform agenda and the potential for nurses to play a pivotal role in primary health care service delivery and case coordination.

The total number of Nurse Practitioners in Australia is low (765 in September 2012) but growing steadily. The evidence-base continues to demonstrate that nurse prescribing increases patient access to medicines, is acceptable to patients and is appropriate and safe (Health Workforce Australia, 2013).

There are around 400 Rural and Isolated Practice Endorsed Registered Nurses (RIPERNs) in Queensland who may be eligible to become a nurse practitioner or advanced practice nurse in a rural or remote setting under the provisions of EB8.

The QNU recommends that in partnership with universities, the federal and state governments should develop a strategy to fast-track the requisite Masters level qualification by recognising prior learning and streamlining courses to meet the need for extended nursing and midwifery roles commencing with the RIPERN. We believe that the creation of at least 40 additional nurse practitioner scholarships would encourage experienced nurses into this role.

Maternity Services

For some time the QNU has been advocating for a 'continuity of care' model of midwifery in remote areas. Currently, many pregnant women in the far north and west of Queensland have to travel to a facility six weeks before their baby is due. This can create serious difficulties for women who have no family or connections in these towns.

The QNU supports a midwifery model that enables women to remain in their communities by providing access to a primary midwife during pregnancy. This results in less intervention during the birthing process and high quality antenatal and post natal care.

For many Aboriginal and Torres Strait Islander (ATSI) women, 'birthing on the land' is an important custom that is denied them when they have to travel elsewhere. The 'continuity of care' midwifery model provides cheaper, woman-centred care that enables women in these communities to remain with their families during an important life event.

We ask the Committee to consider how ATSI nurses will interact and collaborate with the newly regulated ATSI 'health workers' to improve outcomes for ATSI health care and thereby contribute to 'closing the gap'.

Health outcomes for rural and remote communities

According to the National Rural Health Alliance (2013a), rural and remote areas have the following characteristics:

- their people have lower incomes and fewer educational opportunities;
- their people are, on average, older;
- a greater proportion of them live with a disability;
- the more remote the area, the higher the proportion of Aboriginal and Torres Strait Islander people - a group whose members experience very particular health and lifestyle challenges;
- the health workforce is insufficient to meet need and is poorly distributed, with shortages becoming worse with increasing remoteness;
- health risk factors are higher: for instance people in rural and remote areas have higher rates of smoking, higher rates of risky drinking and higher rates of obesity; and
- remote areas are places where market systems do not work well: the number of people is lower, information poorer, communications less effective and doctors fewer, so Medicare doesn't work as well in the country as in the city.

Central to the provision of health services in rural and remote areas is access to universal health care through Medicare. However, this essential government program appears to be under threat. In a recent speech in Brisbane the federal health Minister, Peter Dutton, stated that he wants to 'start a national conversation about modernising and strengthening Medicare' because, he claims, 'the health system is 'riddled with inefficiency and waste' and warns that doing nothing to address the long-term budget burden is not an option. The Minister flagged a greater role for the private sector and private insurers in primary care as the government wanted to 'grow the opportunity for those Australians who can afford to do so to contribute to their own healthcare costs'.

The Minister described Australia's '1980s model' health system as 'tracking on an unsustainable path with no prospect of meeting the needs of the health of our nation in the 21st century'.

The QNU is concerned about these claims that Medicare is unsustainable and we are closely following the findings of the federal Commission of Audit. We have recently celebrated 30 years of universal health care. The Australian union movement helped to create Medicare through an accord with the Hawke government and it is one of our proudest achievements.

We note that although hospital expenditure is growing quickly[5], the private health insurance rebate is the fastest growing component of Australian government health expenditure, projected to grow from $192 real per capita in 2012–13 to $319 real per capita in 2022–23, an increase of over 50 per cent in real spending per person. This is notwithstanding changes to the private health insurance rebate that were expected to deliver net savings of $2 billion over five years (Commonwealth of Australia, 2010).

The QNU will continue to promote the role of government to provide health care for all Australians based on need not capacity to pay, regardless of where they live. The expansion of northern Australia must not become an opportunity for this federal government to abrogate its responsibilities in providing free health care for its citizens. The private sector cannot and will not provide fair access to health services where the market does not deliver a return on investment as is the case in many parts of rural and remote Australia.

eHealth

E-health refers to the health care components delivered, enabled or supported through the use of information and communications technology. It may involve clinical communications between healthcare providers such as online referrals, electronic prescribing and sharing of electronic health records. It can also provide access to information databases, knowledge resources and decision support tools to guide service delivery (Government of Western Australia, 2014).

E-health will allow consumers to receive safer, more accessible and better-coordinated care. This will be an important feature of health service provision in rural and remote areas. With better access to accurate consumer health information, providers will be able to make more informed decisions on treatment and coordination of care. E-health has potential to improve health outcomes at all levels from preventive health, specialist and acute care through to home monitoring of those living with disabilities.

The QNU welcomes a move towards providing Australian consumers and health professionals with up to date personal health information through Personally-Controlled Electronic Health Records (PCEHR) although we urge caution in relying on technology without proper control procedures around implementation. At its core, the PCEHR should maximise value for patients by achieving the best outcomes at the lowest cost. The PCEHR provides an opportunity to bring together the current fragmented system of record keeping into a cohesive means of monitoring and sustaining patient care.

[5] Hospital expenditure is also growing quickly, increasing from $594 real per capita in 2012–13 to $803 real per capita in 2022–23 and pharmaceutical spending remains a significant share of the health budget throughout the projection period, growing from $443 real per capita in 2012–13 to $534 real per capita in 2022–23 (Commonwealth of Australia, 2010).

Person-centred care motivates nurses. As such they require not only adequate training but also access to the hardware required to input information in the system. In our experience the cost of providing the required number of electronic devices for system users (especially nurses) presents a significant barrier to use of information technology and therefore is a critical success factor for implementation.

We recognise that the uptake of the PCEHR has been slow. We are still waiting on the release of the report of the review into the PCEHR that was finalised in Dec, 2013. In our view, implementation of the PCEHR will be greatly increased if there is more training and incentives to promote clinician engagement and public awareness campaigns.

The PCEHR initially targeted certain groups e.g. chronic and complex conditions, older Australians, Aboriginal and Torres Strait Islander (ATSI) people. We suggest that these groups may be more likely to experience difficulty accessing and using a complex system.

Telehealth

A high-speed National Broadband Network (NBN) will be of great benefit in the development of northern Australia and indeed the rest of the country through the provision of telehealth service such as video-conferencing to complement local health services.

Queensland has one of the largest managed telehealth networks in Australia in which over 1,000 systems deployed in over 200 hospitals and community facilities support more than 40 clinical specialties and sub-specialities to provide telehealth services across the state (Department of Health, 2013).

Telehealth will give remote communities timely access to services and specialists, assist with education, training and support for remote healthcare workers and provide support for people with chronic conditions to manage their health (National Rural Health Alliance, 2013b).

Fly in Fly out (FIFO) Workforce

Following release of the House of Representatives Standing Committee (the Standing Committee) on Regional Australia's report on fly-in, fly-out and drive-in, drive-out workforce practices in regional Australia (2013), the QNU believes that there is still a need for further discussion around the effects of this practice on health workforce planning, health services and communities in general. Adequate housing in rural, regional and remote areas and particularly in 'mining' towns is a major concern in attracting and retaining a health workforce.

As an example of the vagaries of the mining and resources sector, we draw the Committee's attention to the Mackay region in the Belyando Shire. As well as the resident population, the Belyando Shire accommodates a number of non-resident workers. The main population centre of Belyando is Moranbah, which is located about 180 km south-west of Mackay. Moranbah remains the administrative centre for the regional council, and is the centre for coal mining activity. In June 2010, Moranbah was estimated to have around 8,500 permanent residents and 2930 non-resident workers at any one time (Office of Economic and Statistical Reports, 2010). As non-resident workers typically rotate through a job, this implies that 3,000 – 5,000 non-resident workers were living elsewhere (largely in the Mackay region) and working/living in Moranbah during shift periods.

The increased workforce, particularly those associated with contractors, exceeded available housing levels in most towns in the Bowen Basin in general and the boom had a substantial impact on the cost of housing in Moranbah in particular. Between 2001 and 2006, average house sale prices in Moranbah increased approximately seven times, while median rent levels increased by approximately four times. In 2006, the cost of housing was rated as 95.5% higher than the cost in Brisbane. These price levels created pressures on households with lower incomes and non-mining sector businesses seeking labour supplies (Rolfe, Petkova, Lockie, Ivanova, 2007).

Research into the impacts of the coal mining expansion on Moranbah funded by the Queensland Department of Local Government, Planning, Sport and Recreation provides sound evidence of the impact of mining on this community (Rolfe et al., 2007). According to this research, residents and service providers were generally supportive of mining and the employment opportunities it had created. The boom was seen to have opened up a number of economic and employment opportunities (for coal miners, local businesses, house owners and apprentices/trainees) and to have had some positive impact on community development and vitality.

Mining also created some negative impacts on the local community. The majority of negative socio-economic impacts associated with mining were seen to flow directly or indirectly from three inter-related factors: the introduction of atypical work schedules throughout the mining industry, the shortage of locally available accommodation, and the dramatic expansion of a non-resident workforce. Such impacts were seen to include:

- Dramatic inflation in the cost of housing and accommodation. This led, in turn, to significant numbers of people living in sub-standard accommodation, commuting long distances to work, and/or spending an unusually large proportion of their income on accommodation;

- The separation of families who would prefer to live in Moranbah but who were forced to live elsewhere while one partner commuted to Moranbah for the duration of their shift block, placing significant pressure on family relationships;
- Social isolation among workers living in camp accommodation and/or spending large amounts of time commuting. This was believed to be exacerbated by the fatigue that all workers must manage when working 12 hour shifts;
- Increased demand for counselling and other services from men seeking help to cope with living away from their families and friends and to cope with problems such as depression, relationship breakdown, and social isolation;
- Increases in alcohol/substance abuse and in family violence;
- Declining capacity of local health, retail and other services to cope with demand (Rolfe et al., 2007).

However, within the last 12 months the situation in Moranbah has changed dramatically. When coal prices were booming towards the middle of 2011, so was the town's real estate, with some properties selling for record prices of $900,000, and others renting for up to $4,000 a week. With a drop in coal prices and BHP-Mitsubishi Alliance's (BMA) announcement it will operate with a 100% FIFO workforce, Moranbah is currently experiencing a dramatic downturn in real estate. Average house prices are now $340,000 to $360,000 for houses with average rentals around $400 a week (boom times $1800) or, for newer style houses, $1000 a week (boom $3000) (Property Observer, 2014).

Moranbah represents a stark example of the effect of the boom and bust cycle of the mining and resources industry. This industry has a significant financial incentive to provide high-level housing and as a result, an evolving national standard of accommodation. There is no national focus on the standards and needs of FIFO medical workers. The Standing Committee's (2013) investigation heard reports of doctors sleeping in clinic treatment rooms, nurses having to share apartments with strangers and other sub-standard accommodation arrangements. The Standing Committee made 21 recommendations which we ask this Committee to take into account during its inquiry into developing northern Australia.

Conclusion

Clearly, for those currently living in rural and remote areas access to health services is exacerbated by shortages of nearly all health professionals and infrastructure. In order to develop strong sustainable communities in northern Australia, the federal government will

need to ensure that those who live in these regions have access to all levels of education, high speed telecommunications, health, transport and other services.

The challenge for regional and rural development will be to optimise the advantages of the resources, tourism and other industries while minimising any adverse impacts on workers, families and communities. Taking up these opportunities will bring substantial benefits for the communities and Australia as a whole.

As the major professional and industrial organisation for nurses in Queensland, the QNU seeks to work co-operatively with the federal government in developing and maintaining the rural and remote health workforce.

The QNU would welcome an opportunity to discuss our submission further.

Recommendations

The QNU recommends that the federal government:

- **commissions multi-disciplinary research into the health, education, community, social, economic and other aspects of rural and remote development;**
- **consults further with all interested parties including unions in any future initiatives to develop northern Australia;**
- **explores the capacity of the Commonwealth to provide federal funding models that enable graduate nursing programs in rural and remote settings;**
- **considers the 21 recommendations arising from the House of Representatives Standing Committee's inquiry into the Fly-in Fly-out Drive-in Drive-out workforce;**
- **maintains Medicare as a single national insurer providing the most efficient and equitable means of sharing health care costs;**
- **develops a strategy to fast-track the requisite Masters level qualification in partnership with universities and state governments by recognising prior learning and streamlining courses to meet the need for extended nursing and midwifery roles commencing with the RIPERN.**

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Attachment A

Clause 23 – Rural and Remote - of the current enterprise bargaining agreement the *Nurses and Midwives (Queensland Health) Certified Agreement (EB8) 2012* states:

> The parties recognise that Queensland Health faces a number of challenges in relation to the recruitment and retention of nurses and midwives in rural and remote locations. This includes expanding demand for health services in these areas, the changing composition of health services as a result of the advent of new technology, non-alignment between the service location and where nurses and midwives are located, and competition with the resources sector. Queensland Health will work cooperatively with the QNU to develop ongoing strategies to address these challenges taking into account whole of government considerations. This will include examination of fatigue and overtime arrangements.
>
> From 1 April 2012, the RANIP annual isolation bonus as set out in HR Policy C2 will be increased as follows:
>
> At conclusion of one year of service - $3,500
>
> At conclusion of two years of service - $10,500
>
> At conclusion of three or more years - $7,000
>
> Cooktown will be incorporated as a designated RANIP site effective 1 April 2012.
>
> Within six months of certification of the agreement, the parties will evaluate and enhance the existing criteria for inclusion in RANIP. The aim is to assess the recruitment and retention performance of rural and remote locations, taking into consideration the local environment such as the expanding resources sector, in order to determine eligibility for inclusion in RANIP. Following this evaluation, a process will be jointly developed to consider the inclusion and/or removal of locations on an ongoing basis, subject to the workforce already engaged continuing to receive the package.
>
> HR Policy C2 will be varied to allow RANIP nurses and midwives the ability to cash out the air fare entitlement on a cost neutral basis. The cash equivalent must be directly related to travel being undertaken by the employee or for their spouse/dependants to travel to the centre.

Clause 36.10 - Advanced Practice - nursing and midwifery roles - also states:

Work being undertaken by DONMAC to map future priority needs, which is consistent with the jointly developed nursing and midwifery workforce strategic directions, will be the foundation for the establishment of targets and priority areas.

A formal pathway will be developed for Rural and Isolated Practice Health (Drugs & Poisons) Regulation 1996 Registered Nurses (RIPERNs) to become a nurse practitioner or advanced practice nurse/midwife in a rural and remote setting.