CHAPTER 2

NURSE SHORTAGES AND THE IMPACT ON HEALTH SERVICES

Workforce planning and education has been sporadic, poorly integrated and inadequate. Nurses today however continue to provide high quality care despite these issues. It is apparent however that the impact of nurses continually providing more health care with fewer resources and lesser recognition, is that we cannot retain the nurses we have and cannot attract potential recruits.[1]

2.1 The shortage of nurses is being experienced worldwide. The International Council of Nurses reported that the majority of states of the World Health Organisation experienced 'shortage, maldistribution and misutilisation of nurses'.[2] In Australia, difficulties in recruiting and retaining skilled experienced nurses are currently occurring in both the public and private sectors and it is anticipated that the situation will not improve in the foreseeable future. According to anecdotal evidence, 75 per cent of nurses in hospital wards are now talking about leaving. Some hospitals reported that they experience a 30 per cent turnover of nurses each year. Submissions indicated that the real shortage of nurses is hidden as nursing data is incomplete and inadequate, nurses are working greater amounts of overtime, there has been an increased use of agency nurses and hospital beds have closed.[3]

2.2 Many witnesses indicated that while there were shortages across the board, some specialist areas, notably critical care, midwifery, aged care and mental health, faced acute shortages of nursing staff.[4] Witnesses described the current situation as a 'crisis' which is having, and will continue to have, an adverse impact on the quality of care provided to patients. The School of Nursing, Queensland University of Technology, stated that if the crisis was not stopped and reversed, it 'will lead to a serious reduction in the Australian community's ability to access a range of hospital and residential aged care services. If healthcare agencies continue to treat the same number of patients, despite these shortages, patient care will be compromised'.[5]

2.3 This chapter looks at the current level of employment in the nurse workforce, the estimated shortage, even crisis, projected demands for nurses, nurse workforce planning needs and the impact on health service delivery of shortages. The data used is drawn from the Australian Institute of Health and Welfare (AIHW), State and

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1 *Submission* 814, p.4 (ACCCN).

2 *Submission* 887, p.8 (Queensland Nursing Council).

3 See for example *Submission* 835, p.15 (APHA); *Submission* 937, p. 3 (ACT Government).

4 See for example *Submission* 736, p.5 (QUT).

5 *Submission* 736, p.5 (QUT).

Territory sources and from the evidence provided during the inquiry. In this chapter, the use of the term 'nurse' refers to both registered nurses (RNs) and enrolled nurses (ENs). RN and EN are used when appropriate to differentiate between the two groups.

Nursing in context

2.4 In the past, discussions of the nurse workforce focused on nursing within the acute hospital sector, particularly acute public hospitals. However, as noted in the Committee's report on public hospital funding, while public hospitals play an important role in health care provision, 'their services form part of the continuum of care, an increasing amount of which is provided outside of hospitals'.[6] As a consequence of this trend, there has been a shift of nursing staff into the provision of care in the community. With the ageing population there is increasing demand for nursing in the aged care sector. This sector is now the next largest employer of nurses after the acute care sector. Nurses are also playing a critical role in health promotion and health prevention in the primary healthcare model. In rural and remote Australia, nurses form the basis of healthcare services and may, in more remote areas, provide the only health care to the communities in which they work.

2.5 At the same time, the working environment of nurses and the characteristics of those they care for, whether in the acute hospital sector, the aged care sector or the community, have changed particularly over the last decade. The following is a brief overview of major trends in healthcare in Australia, based on information contained in the National Review of Nursing Education (the Education Review) Discussion Paper.

- ageing population: in 1999, 12.3% of the population were aged 65 years and over. Age is a significant predictor of poor health and disability, with many chronic diseases and conditions highly prevalent in the older population;
- Indigenous population: life expectancy in the Indigenous population at 65 years is significantly lower than for the non-Indigenous population (68% of Indigenous males can expect to live beyond 65 years compared to 84% for all males and 80% of Indigenous females can expect to live beyond 65 years compared to 91% of all females). Less than one third of the Indigenous population live in capital cities with easy access to mainstream health services and one in five reside in remote settings;
- enhanced primary care: there is increased use of general practitioner services in metropolitan areas, however, in rural and remote areas there is a much lower provision of health professionals and a greater reliance on nurses for healthcare services;
- high tech short stays in acute hospitals: there has been a decrease in the number of acute hospital beds (from 5.2 beds per 1 000 population in 1987-88 to 4.0 beds in 1998-99) and in the average length of stays in hospitals (from 4.6 days in

6 Senate Community Affairs References Committee, *Healing our Hospitals, Report on Public Hospital Funding,* December 2000, p.6.

1993-94 to 3.7 days in 1998-99); acute hospital separations grew from 257 per 1 000 population in 1993-94 to 294 in 1998-99;

- de-institutionalisation and community care: there has been a move to the integration of services in the community and de-institutionalisation of mental health services. Between 1991 and 1996 there was a 47% decrease in the number of psychiatric hospitals and an 80% increase in the number of community healthcare centres;
- new technologies: scientific developments in relation to disease management and control, and technological advances in fields such as communications (for example, Telemedicine) impact on the education and the scope of practice for nurses;
- healthcare expenditure: there has been an average increase of 4.0% in healthcare expenditure for the ten years to 1999-00. Labour costs are the largest item, although, while significant, available information does not enable the proportion of health expenditure spent on nurses to be calculated;
- aged care: major restructuring of residential aged care occurred in 1997, with the move to 'ageing in place'. In 2000, there were 84 residential aged care places per 1 000 population aged 70 years and over (a decrease from 89.3 places per 1 000 in 1997) and 11 community aged care packages per 1 000 population aged 70 years and over (an increase from 3.9 packages per 1 000 in 1994); and
- consumer input: consumers of health services have become more knowledgeable and have higher expectations of health services, both qualitatively and quantitatively.[7]

2.6 These changes have impacted on the skill level and expertise required of all nurses. In the acute sector, changes to care and improvements in technology has led to the increasing need for a highly specialised workforce. Indeed, some specialties would not be able to function efficiently without an appropriate specialist nurse workforce. Changes in the aged care sector has seen a move away from what has been described as 'custodial care' to the provision of more complex and intensive levels of care, such as palliative and post-operative care.

2.7 In the community sector, nurses are dealing with much sicker clients due to shorter hospital stays. The care of those suffering from drug problems, increased incidence of mental illness and depression and the emergence of social problems such as child and elder abuse and violence, have added to the complexity of the community sector working environment. As a result, a more highly skilled generalist workforce is emerging in the community sector. This trend is exemplified in rural and remote areas where the nurse workforce is the major provider of health services.

2.8 Changes to the healthcare system, the way in which services are delivered and changes to the skills required of those working within the system, are significantly

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7 National Review of Nursing Education, *Discussion Paper*, December 2001, pp.60-65; see also *Submission* 937, p.2 (ACT Government).

affecting the nurse workforce at a time when there is a severe shortage of experienced nurses and there are acute problems in retaining those still in the nurse workforce.

The nursing workforce

2.9 Queensland Health's submission stated that no one knows exactly how many nurses there are in Australia.[8] Data on the nursing workforce is available from a number of sources: statistics on registration and enrolments are available from nursing boards in each State and Territory and data on the nurse workforce is available from the Census, the AIHW's annual nursing labour force survey (conducted in conjunction with renewals of registration) and the Australian Bureau of Statistics quarterly labour force sample survey.

2.10 A major problem with the data arises from variations between the data sets. Variations arise as a result of double counting of nurses with registration in more than one jurisdiction, differences in nomenclature and differences in the purpose for which the data is collected. There are also delays in the processing of data and reporting the findings. The limitations of the data on the nurse workforce are discussed later in the chapter. The following information provides an overview of the latest available data.

Nursing Labour Force 1999

2.11 The AIHW's *Nursing Labour Force 1999* presents statistics from the 1997 Nursing Workforce Survey. The results of the 1999 survey will be available later this year. The AIHW's findings were cited in many submissions as evidence of the change to the nursing environment. *Nursing Labour Force 1999* showed the following:

- after allowing for multiple registrations, nursing registrations and enrolments fell from 270 720 in 1993 to 257 662 in 1999, a decrease of 4.8%; for the period 1994 to 1997, there was a decrease of 5.6%;[9]
- in 1999 it was estimated that there were 233 096 in the nursing labour force with 221 988 nurses employed mainly in nursing; in 1994 the numbers were 242 225 and 225 110 respectively;[10]
- in 1999, an estimated 24 571 registered and enrolled nurses were not in the nursing labour force (that is, they were not looking for work in nursing as they were either employed elsewhere or not employed, or were overseas) an increase from 23 659 in 1997;
- from 1994 to 1997, the number of employed enrolled nurses decreased by 12.2% from 52 676 to 46 276, mainly on account of a 22.0% decrease in those employed in nursing homes; and

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8 *Submission* 942, p.5 (Queensland Health).

9 Figures for 1999 estimated, based on applying the average of 1996 and 1997 data to total registrations and enrolments for 1998 and 1999.

10 Nursing labour force figures include total employed in nursing, those on extended leave and those looking for work in nursing. AIHW, *Nursing Labour Force 1999*, p.34.

- nurse employment per 100 000 population fell from 1 171.1 in 1989 to 1 032.7 in 1999.[11]

2.12 The AIHW noted that raw counts of the number of people in an occupation do not, by themselves, give an accurate indication of the labour supply, particularly in occupations where there are large numbers of part-time workers. Nursing numbers adjusted to full-time equivalent (FTE) nurses take account of hours worked. The AIHW also provided indicators of changes in the workload of nurses in hospitals which is related to the number of occupied beds, patient throughput (ie separations) and the average length of stay in hospital for both the public and private sectors.

2.13 The trends identified included that between 1995-96 and 1998-99 there was a marginal increase of 0.5% in the number of FTE nursing staff in hospitals (public and private acute and psychiatric and private free-standing day hospitals). Between 1995-96 and 1998-99 in public hospitals there was an increase of separations per FTE nurse – from 44.6 to 49.3. This reflects the 4.9% decline of FTE staffing (a decline of 2.8% in nursing staff and a 53.3% decline in other personal care staff) and the 7.4% increase in patient separations (to 20.3 FTE per 1 000 separations). There was also an 8.5% decrease in patient average stay day. This means that patient numbers per FTE nurse increased.

2.14 In private hospitals (acute and psychiatric hospitals) between 1995-96 and 1998-99, there was an increase of 10.1% in overall FTE staffing (an increase of 11.0% in FTE nursing staff and an increase of 8.9% for other staff). At the same time there was an increase of 4.5% in separations per FTE nurse (to 15.2 FTE per 1 000 separations) and 6.8% decline in patient days per FTE nurse. In private free-standing day hospitals, FTE nurses and other staff increased 50.1% and 45.8% respectively between 1995-96 and 1998-99 although the numbers of staff remain small. AIHW noted that the difference between public and private hospitals FTE per 1 000 separations is largely associated with wide differences in the nursing care requirements of the patients treated in each sector.[12]

National Review of Nursing Education published information

2.15 The National Review of Nursing Education provides a further source of information on the nursing workforce in its published material, including the December 2001 Discussion Paper and a commissioned research study that investigated job growth and turnover in nursing occupations in the period 1987-2001.[13] The trends identified in the research study included:

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11 AIHW, *Nursing Labour Force 1999*, p.31.

12 *Nursing Labour Force 1999*, pp.18-19; pp.80-82.

13 Shah, C & G Burke, *Job Growth and Replacement Needs in Nursing Occupations,* Report 01/18 to the Evaluations and Investigations Programme, Higher Education Division, Department of Education, Science and Training, Canberra, 2001. http://www.dest.gov.au/highered/eippubs/eip01_18/2.htm

- employment of nursing workers (personal care assistants; assistants in nursing; directors of nursing; nursing professionals; and enrolled nurses) grew at an average annual rate of 0.8%, half the rate of all occupations; employment contracted in some States (South Australia and Tasmania) while in Queensland the growth rate was 2.7 per cent per year;
- between 1987 and 2001, employment of nursing professionals (nurse managers, nurse educators and researchers; registered nurses; registered midwives; registered mental health nurses; registered developmental disability nurses) increased by 30% to 183 900 in 2001, an annual growth rate of 1.4%;
- registered nurses numbers grew between 1987 and 2001 to 163 500, an increase of 29.3% during the period;
- the employment of enrolled nurses declined 20.6% between 1987 and 2001 to 22 500 (partly due to restructuring of the nursing workforce in the early 1990s);
- projected annual growth of employment in nursing occupations is expected to be 0.4% (compared to 1.5% for all occupations) over the next five years with large growth in managerial positions and registered midwives and contraction in employment for enrolled nurses and registered mental health nurses; and
- projected net job openings for new entrants to the nursing profession (RNs and ENs) are expected to be about 27 000 over the next five years, with 80% due to replacement and 20% due to growth with the highest rate of job openings in managerial positions and for registered midwives.[14]

2.16 The Education Review noted that caution should be used in interpreting the numbers provided as, for example, changes in classification categories can impact on trend data; data is collected from different sources which may not ask the same questions; and, much of the data relies on self reporting which requires individual interpretation of categories and labels. The Education Review concluded 'however, it is possible to gain a picture of the trends from the information supplied'.[15]

State and Territory nursing data

2.17 The Committee also received statistics on nurse registrations and enrolments in States and Territories. In South Australia in 2000, there were 16 742 RNs (a decrease of 5.8% from 17 779 in 1992) and an estimated 5 000 ENs (a decrease of 26% from 6 774 in 1992) with active registration with the Nurses Board of South Australia. Of these, an estimated 1 846 RNs and 353 ENs were not in the workforce.[16]

2.18 In Victoria, from 1996 to 2000 there was a 2.4% decline in the total number of nurses registered from 71 813 to 70 075. In 1998, some 13 461 nurses were registered but not employed as nurses. In 2001, 71 079 nurses were registered in

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14 Education Review, pp.75-79, 96-101; see also Shah & Burke, sections 2.5.3, 2.6.

15 Education Review, p.75.

16 *Submission* 940, p.14 (SA Department of Human Services); *Nurse Labourforce*, Feb 2002.

Victoria, an increase of 1.5% over the previous year.[17] Significant growth is also expected in 2002, however, the number of graduates becoming registered accounted for less than half the growth in registrations in 2000 and 2001. The growth was attributed to an extensive recruitment campaign, including advertising and cost-free refresher/re-entry courses, conducted by the Victorian Government. As a result, the public sector workforce increased by over 2 300 FTE nurses (an increase of 10%) with 1 300 of these introduced into the public health system to improve nurse-patient ratios, while 1 000 were recruited to meet growth in demand. It was suggested in evidence that some of these nurses had been attracted from the aged care sector.[18]

2.19 In NSW in 2000, there were 76 188 RNs and 16 136 ENs. Since 1996 there has been a 2.8% increase in the number of RNs and a 2.7% decline in ENs.[19] In January 2002, the Nursing Re-Connect campaign was launched to attract nurses who have been out of the nursing workforce for some time back into nursing. By March 2002, some 300 nurses had re-entered nursing or were about to do so.[20]

2.20 In Queensland, in 2001 there were 36 817 RNs, an increase of 5.4% since 1996 and 7 095 ENs, a decrease of 11.7%.[21] Queensland's total public sector nursing workforce FTE increased approximately 9% between 1995 and 1999, with the registered nurse workforce increasing about 12% and the assistant in nursing and enrolled nurse workforces both decreasing about 2%.[22]

2.21 In Tasmania, the number of nurses holding current annual practicing certificates (inclusive of ENs and RNs) has declined by 11% since 1997. Tasmania has advertised nurse vacancies extensively – locally, nationally and internationally – but with only limited success.[23]

2.22 In the ACT, separation rates of nurses in the public sector have exceeded commencement rates by nearly 25% over the past three years. During this time the largest reductions have been in enrolled nurses and level 1 registered nurses. At present there are approximately 4 000 nurses registered and about 2 100 practicing.[24]

2.23 The Northern Territory has experienced a decline in nursing staff. There are now about 1 700 nurses employed in the public health sector, comprising 36% of the

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17 Nurse Recruitment and Retention Committee (Victoria), *Final Report*, May 2001, p.34; Nurses Board of Victoria*, Annual Report 2001*, p.7.

18 *Committee Hansard* 28.2.02, pp.179,182 (Department of Human Services Victoria).

19 *Submission* 296, p.2 (Nurses Registration Board of NSW).

20 *Committee Hansard* 22.3.02, p.500 (NSW Health Department).

21 Queensland Nursing Council, *Annual Report 2001*, p.61.

22 *Submission* 942, Supplementary Information, 17.4.02, Queensland Health, *Towards a sustainable supply for Queensland Health's nursing workforce: Recruitment and planning issues,* Sept 2000, pp.4,8; Queensland Nursing Council, *Annual Report 2001*, p.61.

23 *Submission* 923, p.4 (Department of Health and Human Services Tas).

24 *Committee Hansard* 21.3.02, pp.375, 378 (ACT Department of Health and Community Care).

total workforce.[25] Turnover in many areas is also significant and the Australian Nursing Federation (ANF) (NT Branch) stated 'these turnover rates are considerably more excessive than the eastern seaboard statistics'.[26]

Factors impacting on demand for nurses

2.24 There are many factors impacting on the demand for nurses. Two main areas are employment trends in the nursing workforce including ageing of the workforce and the move to part-time work; and changes in the healthcare sector.

2.25 The nursing workforce has a large number of part-time employees and this is increasing. The proportion in part-time work (that is, less than 35 hours per week) increased from 41.2% to 44.1% between 1990 and 1999, and in 1999 enrolled nurses were much more likely to work part-time (60%) than registered nurses (52.5%).[27]

2.26 With the shift to part-time work, greater numbers of nurses are needed to provide the same level of services. The impact of this shift is illustrated by information from Queensland. In 1995 the average FTE per registered nurse was 0.86, which fell to 0.84 in 1999. It was noted that 'although the changes in average FTE appear to be subtle, they do have an important impact on the number of nurses Queensland Health employs'. The number of registered nurses employed by Queensland Health increased by 16% between 1995 and 1999 as compared with an increase of 12% in FTE.[28]

2.27 The AIHW reported that since the mid 1980s, the age structure of the nurse workforce has undergone a major change. At the 1986 census, 23.3% of nurses were aged under 25 years with 17.5% aged over 45 years. By the 1996 census, 7.7% of nurses were under 25 years and 30.3% were over 45 years. This reflects the move to university-based training as well as the decline in the number of students undertaking nursing education. The average age of nurses increased from 39.1 years to 40.4 years between 1994 and 1997.[29] In some areas the average age is higher, for example, on the Tasmanian North-West Coast and in the Swan Health Service WA, the average age in 2000 was 51 years.[30] In some specialist areas the average age is also greater, for example, in South Australia the average age of midwives is 44 years while in Tasmania the average age of midwives is 54 years.[31]

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25 Territory Health Services, *Annual Report 2000-2001*, p.19.

26 *Submission* 919, p.3 (ANF, NT Branch).

27 *Nursing Labour Force 1999*, p.13.

28 *Submission* 942, Supplementary Information, 17.4.02, p.6.

29 *Nursing Labour Force 1999*, p.12.

30 *Submission* 923, p.4 (Department of Health and Human Services Tasmania); *Committee Hansard* 27.2.02, p.66 (Swan Health Service).

31 *Submission* 940, p.12 (SA Department of Human Services); *Committee Hansard* 15.3.02, p.265 (Nursing Board of Tasmania).

2.28 The Australian Nursing Council Inc (ANCI) noted that the ageing workforce reflected the expansion of the nursing workforce which had occurred during the 1970s and 1980s. Those nurses are now in their 40s and 50s. Over the next 10 to 15 years, 30% of the workforce will be contemplating retirement. Nurses approaching retirement may also switch to part-time work, further exacerbating the nurse shortage. At the same time, the average age of nursing students has increased. In 1997 it was found that 25% of NSW entrants to nursing study were aged 23 years or older. The consequences are a reduced working life for up to 25% of all new graduates.[32]

2.29 Some witnesses did not see the ageing of the workforce as the main problem, rather the concern is the failure to graduate sufficient nurses to replace older nurses as they reach retirement. (This is discussed further below.) Older, experienced nurses are also essential to provide mentoring for inexperienced nurses coming into the workforce.[33]

2.30 Nursing remains a predominantly female profession. There has been little change in the number of males employed in nursing – enrolled male nurses increased from 6.2% to 6.3% of total ENs from 1994 to 1997 and in the same period the number of employed male registered nurses increased from 7.6% to 8.0% of total RNs.[34]

2.31 The nursing workforce is also highly mobile with nurses readily able to move between employment settings, be that intrastate, interstate or overseas. For example, in the Northern Territory, many nurses are attracted to short-term contracts during the peak tourist season from approximately April to September. In the Northern Territory, the ANF also indicated that the overall turnover of junior registered nurses is around 100%. In Central Australia, at Alice Springs Hospital the rate of turnover is higher at 137% per annum.[35] The Tasmanian Government noted that since 1991 approximately 10% of the Tasmanian School of Nursing graduates have gone overseas, the majority to the United Kingdom.[36] Womens and Childrens Health, Victoria stated 'Nursing Agencies in the UK are recruiting Australian nurses with offers of free return flights to the UK, onsite accommodation, 7 weeks annual leave, full orientation and support on arrival, and an excellent salary package; all this is difficult to compete against!'.[37]

2.32 An overview of changes in healthcare was outlined above. These changes have impacted on the demand for nursing staff, particularly experienced staff. Changes in patient acuity and shorter hospital stays were cited most often in evidence as impacting on the demand for experienced nursing staff.

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32 *Submission* 926, p.6 (ANCI); ANF, 2002-2003, Federal Government Pre Budget Submission, February 2002, p.4; *Submission* 962, p.19 (ANF).

33 *Committee Hansard* 28.2.02, p.188 (Department Human Services, Vic); see also *Submission* 919, p.6 (ANF NT Branch).

34 *Nursing Labour Force 1999*, Table 37, p.66 and Table 38, p.67.

35 *Submission* 919, pp.2,3 (ANF NT Branch).

36 *Submission* 923, p.4 (Department of Health and Human Services Tasmania).

37 *Submission* 780, p.11 (WCH Vic).

2.33 Patient acuity in both the hospital and the community health sectors has been rising. This is due, in part, to the ageing population and with it, an increase in chronic illnesses and disabilities. Demand for health services has grown and advances in technology mean that more complex interventions are available. It was argued that hospitals are increasingly becoming large intensive care units, with cardiac monitoring and respiratory assistance and treatment a growing part of the average patient's plan of care.

2.34 New technology allows rapid assessment, treatment and discharge from hospitals. For example, there has been an increase of day surgery procedures. Shorter hospital stays have resulted in patients moving back into the community with more complex healthcare needs. Thus, the community sector is also experiencing an increase in patient acuity and an increase in the number of treatments provided to patients in the home. This has led to an increased demand for nursing staff outside hospital facilities. The shortage of other health professionals, such as occupational therapists, increases the burden on nursing staff in both hospitals and the community.

2.35 Over the last decade there has been a particular government focus on reducing hospital budgets. As the nursing workforce constitutes the largest group in the healthcare system – over 55% of the entire health workforce – it has often been the most affected by fiscal constraint. Women's Hospitals Australasia & Children's Hospitals Australasia (WHA&CHA) argued that this is reflected in the comparison of percentage growth rates across health professions: the nursing workforce between 1986 and 1991 increased 3.2% (medical practitioners increased 18.3%) while in 1991-96 the increase was 0.5% (medical practitioners increased 13.4%).[38]

The shortage of nurses

2.36 The Committee received evidence of critical shortages of nurses in all areas of healthcare services. However, establishing the numerical extent of the shortage is problematic. The ACT Government stated 'with no clear, rigorous and nationally agreed methodology available, there is widespread concern that it is not possible to accurately determine and report on the actual number of nursing vacancies either locally and nationally'.[39] It was argued that the task has been made more difficult as nursing staff have taken on extra duties and are working more overtime in response to staff shortages, services have closed hospital beds and data is incomplete and/or inadequate. In addition, shortages may be more prevalent in a specialist area or locality such as remote and regional areas. As a consequence, 'only few studies have attempted to quantify shortages and fewer have done it rigorously'.[40]

2.37 The Commonwealth Department of Employment and Workplace Relations (DEWR) maintains the National Skills Shortage (NSS) List which indicates the

38 *Submission* 936, p.10 (WHA & CHA).

39 *Submission* 937, p.1 (ACT Government).

40 Shah & Burke, Executive Summary, p.5.

occupations experiencing shortages nationally and by State and Territory.[41] These lists are based on market intelligence undertaken by DEWR and only indicate the areas of shortage and not a numerical measure of the extent of the shortage. The NSS for February 2002, which is based on data for the second half of 2001, identified a national shortage of registered nurses as well as shortages in 16 specialist areas.

Table 2.1: National Skills Shortage List – February 2002

	AUST	NSW	VIC	QLD	SA	WA	TAS	NT	ACT
Registered nurse (general)	**N**	**S**	**S**	**S**	**S**	**S**	**S**	**S**	**S**
Accident/ Emergency	**N**	S	S	S	S	S	S		
Aged Care	**N**	S	S	S	S	S	S		S
Cardiothoracic	**N**	S	S	S	S	S	S		
Community	**N**	S		S	S	S	S	S	
Critical/ Intensive Care	**N**	S	S	S	S	S	S		S
Indigenous Health	**N**			R	S	S		S	
Neo-Natal Intensive Care	**N**	S	S	S	S	S	S		
Neurology	**N**	S	S	S	S	S			
Oncology	**N**	S	S	S	S	S	S		S
Operating theatre	**N**	S	S	S	S	S	S	S	S
Orthopaedics	**N**	S		S	S	S	S		
Paediatric	**N**	S	S	S	S	S	S		
Palliative Care	**N**	D	S	S	S	S			
Perioperative	**N**	S	S	S	S	S			
Rehabilitation	**N**	S		S	S	S	S		
Renal/Dialysis	**N**	D	S	S	S	S	S	S	
Respiratory	**N**	S		S	S	S	S		
RegisteredMidwife	**N**	S	S	S	S	S	S		
Registered Mental Health	**N**	S	S	S	R	S	S		S
Enrolled Nurse	**N**	S	S	S	S	S	S		

N = National shortage *R = Shortage in regional areas*
S = State-wide shortage *D = Recruitment difficulties*

Source: Department of Employment and Workplace Relations

2.38 The Department of Immigration and Multicultural Affairs maintains the Migration Occupations in Demand List (MODL).[42] As at May 2001, the list contained six nursing categories: nurse managers; nurse educators and researchers; registered

41 Shortages exist where employers are unable to fill or have considerable difficulty in filling vacancies for an occupation or specialised skill needs within that occupation at current levels of remuneration and conditions of employment, and reasonably accessible location. See www.workplace.gov.au

42 People seeking to migrate to Australia on the basis of their work skills receive points if their nominated occupation is on the Migration Occupations in Demand List.

nurses; registered midwives; registered mental health nurses; and registered developmental disability nurses. Queensland Nurses Union (QNU) stated:

> This list is significant given that employers are exempt from local labour market testing if the occupation appears on the MODL and they are therefore able to recruit suitably qualified overseas workers to fill vacancies. Inclusion of an occupation on the MODL is therefore recognition by the government that a significant skills shortage exists in that particular occupation.[43]

2.39 In evidence, some specific examples of shortages were provided to the Committee:

- the NSW Department of Health Reporting System indicate that in May 2001 the public sector was 'actively recruiting' approximately 1 486 FTE positions. At the same time it was using approximately 2 775 FTE casual staff including 692 agency nursing staff;[44]
- in Victoria, public hospitals estimated vacancies of 600 to 800 in early 2002;[45]
- a survey of Directors of Nursing in Victoria in 1999 found that almost 60% of hospitals and nursing homes needed more nurses;[46]
- the ANF (SA Branch) indicated that South Australia was between 500 and 700 registered nurses short of nursing requirements;[47] and
- in the ACT there are vacant funded positions in both public hospitals (a vacancy rate of 4% at Canberra Hospital and 6% at Calvary) and the community care sector with the number of vacancies increasing over time.[48]

2.40 In addition, some States have published nurse labour force projections:

- South Australia: To maintain the RN workforce in South Australia at its current size, between 650 and 1 350 new graduates per year are required. In 2000, 389 nursing students graduated and 430 were predicted to do so at the end of 2001. There needs to be 226 to 468 ENs graduating to maintain the EN workforce with 239 graduating in 2000. The SA Department of Human Services is carrying out a full review of the labour force model, as there are some concerns about the projections made.[49]

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43 *Submission* 457, p.8 (QNU).

44 *Submission* 867, Attachment 3, p.3 (NSW Health); see also *Submission* 962, p.4 (ANF).

45 *Committee Hansard* 28.2.02, p.183 (Department of Human Services Victoria).

46 *Submission* 379, Appendix 5, *The Hidden Costs of Understaffing*, p.2 (ANF Vic Branch).

47 *Committee Hansard* 27.3.02, p.709 (ANF SA Branch).

48 *Submission* 375, Supplementary Information, 22.4.02 (ACT Government).

49 *Submission* 940, pp.16-17 (Department of Human Services SA); *Committee Hansard* 27.3.02, p.776.

- Victoria: Labour force projections in 1999 estimated that with the current level of demand, Victoria would face a shortfall of 5 500 registered nurses by 2008. Preliminary findings of a study into the aged care workforce anticipates a shortfall of 7 000 nurses by 2004 in residential and sub acute services.[50]
- Queensland Health indicated that based on current service delivery models, the demand for nursing services in the public sector will increase by at least 30% over the next ten years. However, this estimation is subject to the influence of factors such as the take up of private health insurance etc.[51]
- Tasmania: to maintain the RN workforce at its current level, preliminary estimates indicate the need to recruit a minimum of 260 nurses annually to account for attrition. Currently the Tasmanian School of Nursing graduates 130-140 students annually.[52]

2.41 Projections of nurse labour force needs are discussed in more detail later in this chapter. Issues related to the specialist areas of nursing, including aged care, Indigenous nursing, midwifery, mental health nursing and critical care are discussed in chapters 7 and 8 of this report.

Supply of nurses

2.42 A broad range of factors influence the supply of both registered and enrolled nurses. These factors including the number of new nurse graduates; the number of overseas nurses entering the Australian workforce; retention and workplace issues; and recruitment and the image of nursing.

Nurse education

2.43 The Commonwealth Department of Education, Training and Youth Affairs (DETYA) and the National Review of Nursing Education provided statistics on nurse students and graduates. The Education Review stated that the data on supply was not easy to interpret, with differences in the pattern of commencements and completions in Bachelor of Nursing courses across the States and Territories. The following general trends were identified:

- commencements of domestic students in all nursing courses (undergraduate, post graduate and research students) decreased over the period 1994 to 2000;
- commencements of domestic students in bachelor courses decreased from 11 653 in 1994 to 8 423 in 2000;
- total enrolments of domestic nursing students declined between 1994 and 2000 by 5 893;

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50 *Submission* 960, p.9 (Victorian Government).

51 *Submission* 942, Supplementary Information, 17.4.02, p.12 (Queensland Health).

52 Department of Health and Human Services, *Final report of the Tasmanian Nurse Workforce Planning Project*, November 2001, Report 1, pp.29, 58.

- the decline in domestic nursing students in bachelor courses declined between 1994 and 2000 but the decline has been less marked since 1997;
- there has been a steady decrease in the number of domestic undergraduate students completing nursing courses, from a high of 9 525 in 1994 to 5 844 in 1999; and
- completions of domestic higher degree research have remained at about 30 per year, while course work degree completions and other postgraduate completions (postgraduate diplomas and certificates) have risen.

The Education Review indicated that some 2000 and 2001 data showed increases in completions for all States and Territories accept Tasmania and the ACT.[53]

2.44 The funding of student places is determined at the unit level and is converted to equivalent full-time student units (EFTSU). The allocation of total EFTSU allocated to universities for domestic nursing students has dropped by about 2 000 between 1994 and 2000. The number of EFTSUs attracting HECS has declined from 23 121 in 1994 to 19 494 in 2000. Fee-paying courses are largely in postgraduate certificates and diplomas areas with about 20% in the higher degree category.[54]

2.45 In evidence the number of students dropping out of nursing studies was discussed. Attrition rates in the first year of nursing studies ranged from 15% to 20% with smaller attrition rates in subsequent years. Research has indicated that the nursing student retention rate in university courses of 78% is the third highest of all courses. It was noted that in hospital-based courses the attrition rate had been 50% in some States.[55] Issues contributing to withdrawal from courses included:

- wrong choice of course;
- students using nursing as an entry point to university and then switching to the course that they initially wished to pursue; and
- pressure from other commitments outside study, such as the demands of full-time or part-time employment, and health and family issues.[56]

2.46 The problem of retaining new graduates when they first enter the nursing workforce was highlighted with witnesses noting the high rate of attrition in the first years following graduation.[57] New graduates leave because of problems with transition from study to work. Those who leave following completion of their graduate year may do so for personal reasons or to travel overseas although it was argued that many leave because they are disillusioned and the remuneration is

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53 Education Review, pp.87-89; see also *Submission* 928, pp.13-15 (DETYA).

54 *Submission* 928, p.16 (DETYA).

55 *Committee Hansard* 28.2.02, p.136 (Australian Council of Deans of Nursing).

56 See for example, *Committee Hansard* 27.2.02, p.82 (ANZCMHN WA Branch); *Submission* 940, p.23 (Department of Human Services SA).

57 *Committee Hansard* 28.2.02, p.187 (Department of Human Services Victoria).

inadequate leading them to seek a career change.[58] The issues of transition to practice are discussed further in chapters 3 and 6.

2.47 Attrition rates both during study and in the years immediately following completion of study are important for workforce planning. Research is this area has been commissioned by the Australian Council of Deans of Nursing and will be available later in 2002.[59]

Overseas nurses

2.48 Australia has always attracted many overseas nurses, particularly those from the United Kingdom. Nurses migrate permanently to Australia and large numbers come to Australia on working holidays. Nurses have been actively recruited from overseas and this is undertaken primarily on an individual health service or hospital basis and with varying levels of intensity.[60] Government bodies are reticent to become directly responsible for overseas recruiting campaigns.

2.49 The Department of Immigration and Multicultural Affairs (DIMA) indicated that in 2000-01, 580 nurses permanently entered Australia and 4 830 nurses entered on a temporary basis. There was a net gain in nursing professionals in Australia over the period 1997-98 to 1999-2000 of 1 200 nurses.[61]

2.50 Balancing the intake of nurses is the loss to Australia of qualified nurses who travel overseas. The enticement of travel is a positive for attracting people to nursing as a career. Nursing qualifications gained in Australia are favourably regarded in overseas countries meaning that Australian nurses wishing to travel can easily gain employment whilst on a working holiday.

2.51 The Department's submission provides an overview of the arrangements to allow overseas qualified nurses to enter Australia:

- permanent entry: nurses entering permanently may do so under a range of schemes including the Employer Nomination Scheme, Labour Agreements, the Regional Sponsored Migration Scheme and General Skilled Migration. Nurses doing so have been assessed by ANCI as being at the required Australian standard and are immediately eligible for registration in this country.

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58 *Committee Hansard* 27.2.02, p.75 (Peak Nursing Council of WA); see also *Committee Hansard* 22.2.02, p.473 (UTS).

59 *Committee Hansard* 28.2.02 p.137 (Australian Council of Deans of Nursing).

60 As an example, the Sir Charles Gairdner Hospital advised that overseas recruitment in 2001 was 26.63FTE through formal programs and 49.71FTE through informal programs, *Submission* 730, Additional Information 12.3.02. In Victoria there was 1105 overseas additions to the Victorian Nursing Register in 2000-01 (21% of the total). Of these 819 (74%) were from the UK/Ireland and New Zealand - *Submission* 960, Additional Information 8.5.02 (Vic DHS).

61 *Submission* 952, p.1 (DIMA).

- temporary entry: temporary entry may occur through Business (Long Stay), Occupational Trainee, Labour Agreements or Working Holiday Maker visas. Some nurses whose qualifications do not meet Australian standards are able to enter under Student, Occupational Trainee or Short Stay Business visas to undertake migrant nurse bridging programs in order to gain registration for work purposes. Some 3 200 Working Holiday Maker visas and 1 110 Business (Long Stay) visas were granted to nurses in 2000-01.

2.52 The Department concluded that 'in recent years, the Government has sponsored legislative and policy changes which have increased opportunities for various employers in the Australian health industry to recruit highly skilled overseas nurses. The Department will continue to work closely with the Australian Nursing Council Incorporated and, through them, the various State and Territory nurse registration bodies to assist them to address the shortage of nurses in Australia.'[62]

2.53 Some submissions argued that the processes for nurses entering Australia are complex and could be simplified. Women's and Children's Health Victoria (WCH) stated that 'by networking with our international colleagues, we know that nurses are travelling to Australia, but that the visa restrictions in place at present prevent them from working as nurses, and many are barmaids or fruit pickers'. WCH commented that 'the process of gaining registration with the Australian nursing registration authorities needs to be streamlined' and that 'due to the bureaucratic processes surrounding visa applications for entry into Australia, nurses are pursuing other avenues, such as UK-based Nursing Agencies'.[63] A Victorian nursing review indicated that the costs of business sponsorship and migration agents have led many healthcare facilities to view overseas recruitment as an option of last resort.[64]

2.54 The majority of overseas nurses enter Australia on the Working Holiday Maker visa. However, the conditions of the Working Holiday Maker visa require that the working holiday maker must not be employed in Australia by any one employer for more than three months without the written permission of the Secretary of DIMIA. NSW Health argued that a three-month period was too short a time in nursing as nurses are only just becoming familiar with the service and environment by the end of this time. It was suggested that the employment period be extended to six months.[65] An extension of time would not only assist with the nursing shortage, but would also enhance the skilled migration program as many of these nurses may apply to return to Australia as migrants at a later date.

2.55 However, not all witnesses supported more extensive immigration. Local, national and international health agencies are each competing worldwide for a limited number of qualified nurses. RMIT described the situation:

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62 *Submission* 952, 6 (DIMA).

63 *Submission* 780, pp.11-12 (WCH Vic).

64 Nurse Recruitment and Retention Committee, p.33.

65 *Submission* 867, p.5 (NSW Health Department). See also *Committee Hansard* 22.3.02 p.505.

> Countries are "stealing" from each other and it is not really addressing the problem of getting new nurses or nurses who have left the profession into the system. It is a redistribution of nurses throughout the world not an answer to the nursing shortage.[66]

2.56 The ANF did not support mechanisms to overcome Australian workforce shortages that may adversely affect health care in another country, especially that of a developing country. The ANF stated that 'an advanced country such as Australia should not use strategies that negatively affect other countries to solve local problems'. The ANF did support the voluntary flow of nurses between countries.[67] The Victorian Government indicated its support for the recently-signed protocol which discourages Australian public institutions from, in particular, recruiting nurses from English-speaking less developed countries, such as India and Pakistan.[68]

2.57 The Commonwealth has recently announced that it will introduce incentives to fast-track applications of nursing staff from abroad, particularly those who will work in regional areas. Overseas nurses will be able to participate in bridging courses held in Australia so that they meet Australian standards and then make an application for a long-term temporary resident visa while already in the country. There is also capacity to change visa arrangements, such as move to a Business Long Stay visa.

2.58 The Committee supports the fast-tracking of applications for overseas nurses. Onerous visa application processes should not hamper overseas nurses who wish to work in Australia. However, the Committee does not consider that the employment of overseas nurses is an appropriate mechanism to overcome the long-term shortage of nurses in Australia. While overseas nurses are currently employed in our hospitals and health services they are in the large part merely replacing Australians who have travelled overseas to work. Addressing the shortage of nurses will only be achieved through workforce planning and implementation of appropriate domestic recruitment and retention measures.

Recommendation 2: That the Commonwealth Department of Immigration and Multicultural and Indigenous Affairs streamline visa arrangements and simplify the process of recognising overseas qualifications for nurses wishing to migrate to Australia on a permanent or temporary basis, and to publicise the capacity to extend and to change visa arrangements.

Retention and workplace issues

2.59 There have been numerous studies on the issue of the retention of nurses and why nurses leave the profession. These studies, as well as evidence to the Committee, pointed to working conditions as a fundamental reason for nurses leaving. These included conditions of pay, particularly in the aged care sector, safety issues,

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66 *Submission* 914, p.17 (RMIT).

67 *Submission* 962, pp.6-7 (ANF).

68 *Submission* 960, Supplementary Information 8.5.02 (Department of Human Services Victoria).

increased workload leading to stress and burnout, inappropriate and insufficient nursing skills mix, lack of recognition of individual skills and knowledge, occupational health hazards, and lack of accommodation and childcare. Issues of recruitment and retention noted in this section are also considered in chapter 6.

2.60 Information about the number of nurses leaving the workforce is difficult to obtain. However, some indication of the trends may be gained by looking at the number of persons with nursing qualifications not employed as nurses. The AIHW's *Nursing Labour Force 1999*, indicated that in 1999 there were 15 056 registered and enrolled nurses looking for work in nursing (both employed elsewhere or not employed) and 24 571 nurses not in the nursing labour force (not looking for work in nursing or overseas).[69]

2.61 Evidence was also received that in New South Wales in 1998, it was estimated some 16 000 registered nurses were not in the nursing workforce.[70] In South Australia in 2000, 1 846 registered nurses and 353 enrolled nurses were not in the workforce.[71] In Queensland, it was estimated that the number of qualified nurses not working in nursing could exceed 9 000.[72] In Victoria, it was estimated that some 13 000 were registered but not employed in nursing.[73] In the ACT there are nearly 4 000 nurses registered but only approximately 2 000 practicing.[74]

2.62 The estimates above are indicative only. The pool of qualified nurses not in the workforce is difficult to establish. For example, the QNU argued that the AIHW's data was an under-estimation of the number, as it did not include those who had allowed their registrations or enrolment to lapse. Changes in registration requirements in some States, such as currency of practice requirements, and increases in costs of registration may have influenced some not to maintain their registration when working in non-nursing occupations. However, it does appear that there are significant numbers of qualified nurses not in the nursing workforce, which the Nurses Board of Victoria noted 'underscores a substantial problem, not in actual number of nurses, but those willing to work under current conditions'.[75] In such a case, mechanisms to encourage re-entry are important.

2.63 It has been argued that retention is a key issue in ensuring that there are adequate numbers in the nursing workforce to meet demand in the future. As noted by the National Review of Nursing Education 'the small proportion of the workforce in

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69 *Nursing Labour Force 1999,* Table 13, p.34. See footnote 9 concerning 1999 labour force data.

70 *Submission* 867, Attachment, *NSW Nursing Workforce Research Project*, Sept 2000, pp.9,45 (NSW Health).

71 *Submission* 940, p.14 (Department of Human Services SA).

72 *Submission* 457, p.6 (QNU).

73 Nurse Recruitment and Retention Committee, *Final Report*, p.34.

74 *Submission* 444, p.2 (Nurses Board of the ACT).

75 *Submission* 765, p.2 (Nurses Board of Victoria).

the less than 30 years of age category means that those who might be interested in a long term career will be sourced from fewer nurses than in the past'.[76]

Recruitment and the image of nursing

2.64 Nursing was, in the past, seen as a traditional employment option for young women. Nursing has lost some of its attractiveness as greater career options have become available for young women and they become more aware of appropriate remuneration, conditions and career opportunities.[77] Many nurses would not recommend nursing as a career choice.

2.65 Nursing has also suffered from a poor image, particularly in the media. This exacerbates problems in recruiting school-leavers to enter nursing studies. The need to improve the image of nursing is discussed further in chapter 6.

Implications of the nurse shortage

> We must not slip into a minimalist agenda where a person's entitlement to essential care is comprised of basic services stretched by inadequate funding and overworked staff. If quality is to mean anything, it must be the driving force not just of service delivery but of basic funding allocation decisions, in the first instance, adopted by government budget making levels.[78]

Use of agency nurses and casualisation of nursing workforce

2.66 Many witnesses noted that there was an increase in the use of agency and casual nurses across all sectors of healthcare. Two factors have contributed to this increase: the shortage of nurses resulting in dependence on agency staff to fill gaps; and a perception that by working through an agency, nursing staff can obtain more attractive working conditions including pay and 'family friendliness'. Young nurses are also attracted to agency and casual employment because of the increased flexibility, increased leisure time and a decreased need for job security.

2.67 The Royal College of Nursing (RCN) noted that employment through agencies had become prevalent in the 1980s in metropolitan acute hospitals. This had continued and 'intensified' in recent years. The RCN indicated that critical care nurses and others are currently able to demand high salary rates and this has exacerbated utilisation rates of agency nurses. The Victorian Government also stated that competition between agencies for specialist staff has led to above-award wages, bonus payments and loyalty programs being offered as inducements, with the costs being passed on to hospitals in both the private and public sectors.[79]

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76 Education Review, p.86.

77 *Submission* 927, p.4 (RCN).

78 *Committee Hansard*, 21.3.02, p.396 (CHA).

79 *Submission* 960, p.15 (Victorian Government).

2.68 The ANF (NT Branch) stated that in the Northern Territory, 'health and aged care facilities are forced to rely heavily on agency staff to fill the void'. However, unlike other States a large proportion of agency staff were permanent staff who sought extra work to cover the increased costs of living in the Northern Territory.[80]

2.69 Witnesses noted that concerns have been expressed about the impact on quality of care through the use of agency staff.[81] It was noted that it is not always possible to know the calibre and skills of agency staff members until they have started work. There were also problems with continuity of care and the maintenance of clinical competency. Use of agency nurses also increased the administrative workload of permanent staff, adding to staff stress:

> It is also very stressful for nurses who work in an area–whether full-time or part-time–to have people walking in and out from an agency or from somewhere else. These nurses have to orientate those people, get them up to speed and supervise them. This happens quite a bit, and it is a significant stressor.[82]

2.70 The financial impact of the use of agency nurses may be great, with agencies charging a premium to place staff in specialist areas. Evidence was received that hospitals were paying as much as $265 per hour for staff. In some instances the agency retains more than 30% of the amount charged to the hospital.[83] It was reported that nursing staff from Western Australia were flying to Victoria for four or five days work with an agency.[84] One rural aged care facility indicated that its agency staff are paid casual rates, are provided with free accommodation and free flights from and to Brisbane.[85] UnitingCare advised that one of its facilities in Western Sydney spends $45 000 each month on agency nurses.[86]

2.71 In the private sector, the Australian Private Hospitals Association (APHA) also indicated that the inflated prices charged, agency practices and the onerous contractual conditions of agency staff 'further restrict the ability of the hospital to recruit permanent staff'. APHA estimated that the increasing reliance on agency staff added about 11% to total private hospital costs and indicated that agencies are enticing staff with pay and conditions which cannot be matched in the private sector. Agencies also levy a recruitment fee on hospitals offering a permanent position to an agency nurse who may have worked a shift at the hospital in the previous three months. The

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80 *Submission* 191, p.2 (ANF NT Branch).

81 See for example, *Committee Hansard* 15.3.02, p.267 (Nursing Board of Tasmania); *Submission* 960, p.15 (Victorian Government).

82 *Committee Hansard* 28.2.02, p.186 (Department of Human Services, Vic).

83 *Submission* 835, Supplementary Information, p.3 (APHA).

84 *Committee Hansard* 27.2.02, p.81 (ANZCMHN WA Branch).

85 *Submission* 746, p.2 (Pioneer Homes).

86 *Submission* 871, Supplementary Information 21.3.02 and *Committee Hansard* 21.3.02, p.397 (UnitingCare).

fee is payable even if the hospital recruited the nurse through its own recruitment processes such as a newspaper advertisement. APHA also argued that unlike genuine recruitment agencies, nursing agencies do not generally focus on finding permanent employment for their clients. APHA stated, 'on the contrary it is in the interests of nursing agencies for their clients to continue indefinitely as casual workers'.

2.72 APHA indicated that it had forwarded submissions to the Australian Competition and Consumer Commission providing details of charges and practices by nursing agencies that in its view 'amount to an abuse of market power'. APHA has also written to the Minister for Health and Ageing proposing a national inquiry into nursing agencies.[87]

2.73 In April 2002, the Victorian Government banned the use of agency staff in public hospitals because of the high costs involved. It was estimated that approximately 7% of FTE nurses were agency staff and that reducing reliance on agency nurses could result in savings of up to $20 million per year. At the same time, increased use of the Government's public nurse banks by hospitals is being encouraged. Almost 5 000 nurses are registered with the public nurse banks which operate across a couple of hospitals or a network of hospitals. The Victorian Department of Health Services indicated that nurse banks offered flexible work to nurses in the public sector. There are also better outcomes for quality care because the nurses listed in the banks are loyal to that organisation and they understand the process and protocol of the organisation.[88]

2.74 The Committee considers that the increase in the use of agency nursing staff has ramifications for the efficient delivery of quality healthcare. The Committee considers that at the present time nursing agencies are acting in a largely unregulated manner and that the charges they impose and the practices they engage in are a matter of concern.

Recommendation 3: The Committee recommends that the Minister for Health and Ageing undertake an urgent national review of the charges and practices of nursing agencies, including their impact on costs to public and private providers of health services and their impact on the shortage of nurses in Australia.

Recommendation 4: The Committee recommends that the Australian Competition and Consumer Commission conduct a review of the practices of nursing agencies in the healthcare sector.

87 *Submission* 835, Supplementary Information, p.5, (APHA).

88 *Submission* 960, p.15 (Victorian Government); *Committee Hansard* 28.2.02, p.186 (Department of Human Services Victoria).

Quality of care

> There is very little to feel happy about when you have been responsible for up to twenty patients on the ward and thus have not been able to care for any of them in a manner you feel is adequate.[89]

2.75 Many witnesses indicated that the shortage of nurses in the workforce was impacting adversely on the quality of patient care provided by the nurse workforce. Coupled with shortages, changes in service delivery have also acted to exacerbate workplace concerns. In-patients are now being cared for in their most acute and vulnerable periods and the nurse workforce must meet the challenges of high need, high technology and rapid admission and discharge flow of patients. In the community, nurses are also facing increased numbers and acuity of patients and the coordination problems of sharing care with family and other support people.

2.76 It was argued that if the ratio of appropriately qualified nurses to patients is not adequate, patient care is at risk. This may result from longer waiting periods before patients are attended by a nurse, a greater risk from clinical errors and nurses being asked to undertake duties beyond their skill level or knowledge. It was stated that employers are responding to shortfalls in specialties by allocating more duties to unqualified or non-nurses especially in the acute, renal, aged and peri-operative fields. There are also some concerns that in both the specialist and general nursing workforce, there are shortages of nurses with practical experience who can work without the need for ongoing supervision.[90]

2.77 Nursing staff also indicated that quality of care is affected adversely as time pressures do not allow nurses to undertake regular and on-going training and professional development.

Professional development of new nurses

2.78 The shortage of experienced nurses affects not only quality of care provided but also the development of new and inexperienced nurses in the workforce. The Nurses Board of Victoria noted:

> A vicious cycle has been established whereby, with heavy workloads and inflexible working conditions, more experienced nurses leave the profession. Those who are left have to carry heavier loads and do not have the time to work with the new and inexperienced nurses. They too leave the workforce, as they become frustrated with the lack of support for their development; hence those that remain have to work harder.[91]

2.79 Evidence also pointed to situations where newly graduated nurses may be the only permanent staff employed in a particular area. The new graduate may find

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89 *Submission* No 448, p.2 (Wollongong Hospital ICU Nursing Staff).

90 See for example, *Submission* 937, p. 4 (ACT Government); *Rethinking Nursing,* p.7.

91 *Submission* 765, p.4 (Nurses Board of Victoria).

themselves in the position of supervising agency or casual staff who may be better qualified and have more experience. This adds to the stress of new graduates.

Skills mix

2.80 The increased use of unqualified workers in nursing has raised issues about the overall state of health provision and public safety. The NSW College of Nursing noted that studies have shown a direct correlation between adequate numbers of registered nurses and quality of patient outcomes. Where the nursing workforce is either reduced in numbers or skills mix (that is, there is an increase in the use of unqualified workers), the quality of care is reduced, patients and nurses are dissatisfied and nurses leave the workforce.[92] There are also diminished opportunities for experienced nurses to provide direct, expert patient care as the role of the registered nurse becomes more managerial. This leads to decreasing job satisfaction, alienation from their nursing work and burnout.

2.81 The Nurses Board of the ACT commented that unsafe practices due to lack of qualified staff are a major issue for the Nurses Board. If nurses are unable to meet the practice standards established by the Nurses Board because of the low number of nurses rostered on duty, the legislation only permits action against the nurse who has not met the standards rather than the employing agency that cannot or does not adequately staff the facility. Nurses become embroiled in a dilemma between maintaining professional standards of care and fulfilling their obligations to employers with a significant risk to safe patient care. The Nurses Board viewed this situation with great concern.[93]

2.82 The ANCI stated that there is potential for unregulated workers to be used to support nursing practice, however it argued that they should not be used as substitutes for qualified nurses and their contribution to care should be carefully evaluated. The ANCI noted that research has indicated that care by skilled nurses rather than unskilled and unregulated workers, results in a significant reduction of adverse events. Furthermore, debate and consultation about which settings are appropriate for suitably educated care workers to work in and their role is needed.[94]

Workforce planning

> Australia has no mechanisms in place for assessing future nursing labour force needs, and subsequently, there is no nursing workforce planning occurring at a national level.[95]

2.83 Shortages in the nursing workforce are not new and some witnesses stated that in the nursing workforce, under and over supply was cyclical. However, the present

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92 *Submission* 480, p.3 (NSW College of Nursing).

93 *Submission* 444, p.2 (Nurses Board of the ACT).

94 *Submission* 926, p.7 (ANCI).

95 *Submission* 962, p.18 (ANF).

situation was described by many witnesses as reaching crisis point and if it were to continue would seriously undermine the quality of care provided to users of the Australian healthcare system.

2.84 Mechanisms which will decrease the rate of attrition from the current workforce and encourage the re-entry to nursing of those qualified nurses who are no longer working in the healthcare sector provide possible solutions to the current shortage. Evidence from Victoria and NSW suggests that programs which make nursing more attractive and support re-entry have a positive impact on the number of nurses returning to the system.

2.85 However, drawing on the pool of nurses not currently working is only a short-term solution: the pool of qualified nurses is not limitless and that pool appears to be shrinking and is ageing.[96] Increasing the number of graduates is a medium to long term solution given the lead time for nursing students to come into the workplace. There is also a need to ensure that there is an appropriate skills mix in graduates so that long term needs of specialist areas are met. In addition, there is a need to ensure an adequate supply of suitably qualified nurses by locality, for example, in rural and remote Australia. In order to address these issues, adequate workforce planning is essential.

2.86 As noted in chapter 1, many reviews and research projects have been undertaken on nursing issues in recent years. The report on recruitment and retention of nurses in residential aged care presents reviews of current Australian nursing workforce studies.[97] A review commissioned by the Department of Education, Training and Youth Affairs (DETYA) provides a more detailed source of information on nursing labour force studies.[98]

2.87 Workforce planning is undertaken by States and Territories. The ANF commented that current strategies are 'based on the *ad hoc* responses of the States and Territories and these rarely involve the primary inputs to the equation needed to produce an accurate or meaningful result'. The ANF also added that it is apparent that 'some States and Territory Government decisions are made without reference to other jurisdictions'.[99] Commentators and witnesses argued that workforce planning is hampered by a lack of success in influencing policy issues identified in reports, lack of a national approach, lack of coordination with the tertiary education sector, inconsistencies of approach and inadequacies of the data and often does not take into account the needs of the private sector and aged care sector.

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96 *Submission* 942, p.6 (Queensland Health).

97 DHA, *Recruitment and Retention of Nurses in Residential Aged Care, Final Report,* 2001, pp.17-21.

98 Johnson, D & B Preston, *An Overview of Issues in Nursing Education*, October 2001, Sec 1.6, http://www.detya.gov.au/highered/eippubs/eip01_12/fullreport.htm

99 *Submission* 962, p.18 (ANF).

2.88 The review of labour force studies indicated that the lack of success in influencing policy may arise as there was often a range of options provided in the studies with no clear indications of which one is preferred for practical policy. The conclusions and recommendations of the studies may also be very different from current practice or the common sense judgement of the stakeholders. In addition, there may not be a strong strategic policy connection between those responsible for commissioning and receiving the report (for example, State departments of health) and those who are responsible for implementing the recommendations (universities).[100]

2.89 The lack of mechanisms to ensure workforce needs are taken up by the tertiary sector and the need for a more coordinated approach were raised. One commentator, while noting that university decisions have 'critical consequences for the health and community service sectors in terms of registered nurses', stated that 'there are no mechanisms at national level and few mechanisms at state level to ensure that these university decisions impact positively on future workforce requirements'.[101] In evidence it was also noted that the tertiary education sector is Commonwealth funded while the planning and responsibility of the public health sector, the largest employer of nurses, is a State matter. (See also chapter 5.) The Commonwealth funding of the aged care sector, a very large employer of nurses, adds to the complex division of responsibilities.

2.90 The fragmented nature of the health system and the split roles and responsibilities between various levels of government has led to calls for greater coordination in workforce planning. Many stakeholders, including nursing unions, APHA and State Governments supported a national approach. For example, Queensland Health recommended a national nursing supply management strategy to address shortages and to maintain an adequate long-term supply of nurses.[102]

2.91 The need for a national approach to nurse workforce planning was addressed by the National Nursing Workforce Forum which recommended the establishment of a national nursing workforce advisory committee; the development of a national nursing workforce strategy; and the establishment of the position of Commonwealth chief nursing officer.[103]

2.92 The Department of Health and Aged Care indicated that the Commonwealth reported the Forum's outcomes and recommendations to the Australian Health Ministers' Advisory Council (AHMAC), 'with recommendations for national approaches to broader health workforce planning with emphasis on nursing issues'.[104]

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100 Johnson & Preston, Sec. 1.6.

101 Duckett, S, 'The Australian health workforce: facts and futures', *Australian Health Review,* Vol 23, No 4, 2000, p.67.

102 *Submission* 942, p.6 (Queensland Health); see also *Submission* 937, p.1 (ACT Government); *Submission* 960, p.10 (Victorian Government); *Committee Hansard* 27.2.02, p.778 (Department of Human Services SA); *Committee Hansard* 22.2.02, p.500 (NSW Health).

103 *Rethinking Nursing*, p.3.

104 *Submission* 944 p.2 (DHAC).

In response, the Australian Health Workforce Advisory Committee (AHWAC) was established in December 2000 to provide advice to AHMAC on national health workforce planning and analysis of information and identification of data needs.

2.93 AHMAC requested that AHWAC examine the specialised nursing workforce as a first priority and in particular the areas of critical care, midwifery, mental health, aged care and emergency medicine. AHWAC is currently undertaking reviews of midwifery and critical care nursing. These reviews are expected to be completed by late 2002.

2.94 Witnesses conceded that AHWAC had been established in response to the recommendations from the National Nursing Workforce Forum, however they maintained that its program falls far short of what was envisaged by the Forum's recommendations. The ANF stated:

> The nursing workforce in the postgraduate areas of midwifery and critical care are currently under review. The model to be used will provide recommendations for the number of nurses required in these specialty areas but the essential context will be missing. The recommendations will be made in isolation from the broader labour force issues that affect entry to nursing practice and exit from the profession. And there is little point in considering postgraduate areas of nursing specialisation without first considering whether there will be a sufficient intake of undergraduate students to meet future specialist nursing needs.[105]

2.95 The ANF concluded 'our current shortage is the result of piecemeal and shortsighted approaches to health workforce planning and change is urgently required'.[106]

2.96 Many witnesses supported the need for a long-term view of nursing requirements and the development of a national, intersectorial approach.[107] WHA & CHA argued that all aspects of the health workforce – medical, nursing, midwifery, allied health and healthcare providers – must be considered together and not in isolation.[108] The Department of Human Services Victoria expressed similar concerns that the review being undertaken was focussing on component parts of the nursing workforce rather than the overall picture.[109]

2.97 Other evidence echoed these points. The NSW College of Nursing stated:

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105 *Submission* 962, p.20 (ANF).

106 *Submission* 962, p.18 (ANF); see also *Committee Hansard,* 27.3.02, p.696 (University of Adelaide).

107 See for example, *Submission* 962, p.18 (ANF); *Committee Hansard* 27.3.02, p.778 (Department of Human Services, SA); *Submission* 888, p.2 (Australian College of Health Service Executives).

108 *Submission* 936, p.11 (WHA & CHA).

109 *Committee Hansard* 28.2.02, pp.181-2 (Department of Human Services Victoria).

> Future labour force needs can only be effectively predicted by utilising a national approach with a multidisciplinary focus. Nurses do not work in isolation in the majority of health care contexts but with teams of doctors and allied health personnel. Patients are important partners in such teams. As in the UK, labour force needs in health require scoping through a multi focal lens encompassing all contexts and all workers.[110]

2.98 The ACT Department of Health and Community Care added that it:

> …believes strongly that a strategic intersectorial solution must be implemented if a way forward is to be found and recommends the following. The first of these recommendations includes that the Commonwealth undertakes extensive strategic planning related to the nursing work force and its unique characteristics based on solid ongoing research.[111]

2.99 APHA argued for the inclusion of the private sector in workforce planning because there is a need for 'strategic workforce planning responsive to demands of the health system as a whole'. APHA stated that the private sector needs to be engaged at a State and Commonwealth level in the planning for and creation of training places.[112] APHA also urged improved reporting on workforce targets:

> We also believe that monitoring of performance and accountabilities of each of the stakeholders – that is, government, training authorities and professions – in meeting the work force planning recommendations of AHWAC could be strengthened.[113]

2.100 At its hearing in August 2001, the Department of Health and Aged Care informed the Committee that health ministers had recently discussed the need for a mechanism to provide broad long-term advice regarding health workforce strategies to meet future health system needs. An expanded role for AHWAC was considered, however, 'discussion has now focused on setting up a new body to undertake long-term broad strategic advice'. The Department went on to state:

> The States are the major employers of nurses and the ones that can do most to deal with the problem. But it is a national problem and it needs a national approach. We believe that is best done through those intergovernmental mechanisms that I have described, the various committees. The new, if you like, overarching strategic committee which health ministers are in the process of setting up will assist us to take a more strategic view of the work force as a whole. It will look not just at doctors or nurses or physiotherapists

110 *Submission* 480, p.3 (NSW College of Nursing).

111 *Committee Hansard* 21.3.02, p.370 (ACT Department of Health and Community Care).

112 *Submission* 835, p.16 (APHA).

113 *Committee Hansard* 21.3.02, p.394 (APHA).

> or whatever but at what are the overall work force needs to deliver health care as we perceive it.[114]

2.101 The health ministers agreed that the new body would be established as an officials committee to be known as the Australian Health Workforce Officials Committee (AHWOC). Its purpose is to provide a forum for reaching agreement on key health workforce issues requiring collaborative action and to advise on health workforce requirements, as a basis for assisting AHMAC to fulfil its roles. Details of the role of AHWOC are provided in the glossary to this report.

Adequacy of existing nurse workforce data

2.102 In addition to calls for a national approach to workforce planning, concerns were raised about the adequacy of data currently available on the nurse workforce and the models used for workforce planning.

2.103 At the present time, State and Territory Governments conduct their own analyses of needs. The ANF noted that the quality of the projections is variable.[115] The review commissioned by DETYA concluded that the studies were hampered by inconsistencies of approach and inadequacies in the data. For example, some major methodological and data problems identified with some workforce studies include:

- a range of problems related to estimating or projecting future values for attrition (or separation) rates, including: not taking account of age profiles; and not consistently determining values for both separations and re-entry;
- problems of not adequately accounting for graduates' availability or suitability; and not accounting adequately in subsequent periods for graduates unable to gain desired positions in an initial period; and
- projected future workforce size is very difficult to estimate, and judgements must be made regarding appropriate (or likely) mixes of staff with different qualifications and work roles, work intensity, industry structure and work organisation, and other matters.[116]

2.104 Witnesses also noted shortcomings in labour force analyses. For example, among factors not routinely considered in the models are: the number of students enrolled in nursing courses in the tertiary education sector; changes in healthcare delivery such as case payments; the latest Commonwealth initiatives in health and aged care, for example ageing in place, or health service changes being proposed by State and Territory Governments for example, multipurpose centres, hospital in the home or the deinstitutionalisation of mental health services.[117]

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114 *Committee Hansard* 28.8.01, p.9 (DHAC).

115 *Submission* 962, p.18 (ANF).

116 Johnson & Preston, Sec 1.6.

117 *Submission* 960, p.9 (Victorian Government) *Submission* 962, p.18 (ANF).

2.105 Reviews of some of the models are being conducted, for example, South Australia is conducting a full review of its labour force model.[118] Queensland Health stated that it 'is committed to the development of a work force planning methodology that, rather than addressing professional groups in isolation, plans workforce requirements around streams of care…it is a new approach to planning which has the potential to take into account things like shifting professional boundaries and changing roles'.[119] The Victorian Government recommended that research into workforce predictors and planning models be encouraged.[120]

2.106 The major source of nursing data currently is from the AIHW's biennial survey of the nursing labour force. The survey is sent to all nurses renewing their registration with the registration board of each State and Territory. The survey seeks information on a range of demographic, work setting and educational information relating to the registered nurse labour force. The response rate to the survey varies between States and, as noted by the ANF, each jurisdiction modifies the data collection tool to meet local needs. Data is not collected over a consistent period (some jurisdictions collect data on an annual basis, some biennially) or at a consistent point in time as some jurisdictions undertake the collection over a twelve month period and others on a particular date.[121] The interpretation of the information is hampered by the fact that the survey is self-reported which requires assumptions to be made for the non-responding cohort.[122]

2.107 There have been significant delays in the publication of AIHW data, in part due to delays in obtaining data from some States. While the AIHW is to shortly publish data based on the 1999 survey, the most current data available is from 1997. The data is out of date for workforce planning purposes.

2.108 Many submissions noted that the lack of data limited the ability of stakeholders to undertake adequate workforce planning and other research into the nursing workforce.[123] The Victorian Department of Human Services noted 'there is concern in Victoria that [AIHW] data alone is insufficient for workforce planning both locally and nationally' and 'workforce planning is limited by the paucity of available data on forecasted nursing demand, vacancies, bed closures and workforce attrition.'[124] In the Western Australian report, *New Vision, New Directions,* it was stated that 'in the absence of comprehensive and reliable data, accurate projection models cannot be developed'. In response to these problems, the WA Department of Health has redesigned its labour force survey form to enhance data collection and

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118 *Committee Hansard* 27.3.02, p.776 (Department of Human Services SA).

119 *Committee Hansard* 26.3.02, p.574 (Queensland Health).

120 *Submission* 960, p.10 (Victorian Government).

121 *Submission* 962, p.21 (ANF).

122 Nurse Recruitment and Retention Committee*,* p.34.

123 See for example, *Submission* 962, p.4 (ANF); *Submission* 926, p.8 (ANCI).

124 *Submission* 960, pp.9-10 (Department of Human Services Victoria).

management.[125] Queensland Health also stated 'one of the key issues for us is having a national data set on the nursing work force that will enable us to actually plan for the future'.[126]

2.109 The Australian Midwifery Action Project (AMAP) stated that 'the availability of data on the midwifery labour force is one of the most pressing issues. The capacity to draw meaningful conclusions is compromised because of the use of non-standardised terminology and the incompatibility of databases and data domains'.[127]

2.110 In the private sector, the lack of data is also impacting adversely on planning. APHA noted that private hospitals were unable to plan for the increase in patient numbers, and were not able to assess the market availability of nursing staff because published nursing workforce data for the private sector was inaccurate, spasmodic or out of date. APHA also noted that the state-based system of workforce data collection is also variable and open to interpretation.[128]

2.111 Stakeholders called for improved data collection and dissemination. The ACT Department of Health and Community Care stated that research should also include the determination of a national information management system that will allow for accurate monitoring of the nursing work force.[129]

2.112 AHWAC has identified the need to improve existing nursing workforce data collection and has indicated that this is being pursued as a priority. AHWAC stated that the initial work in this area would focus on improvements to the AIHW's national nursing registration survey including increasing the response rate to the survey and improving the timeliness of data processing.[130]

Conclusion

2.113 Evidence received by the Committee clearly indicates that the need for national coordination of nursing workforce issues has been well established. Many reviews and reports have also identified this need, however little progress has been made to implement a national approach.

2.114 The Committee considers that many of the problems in nurse workforce planning can only be addressed on a national basis encompassing all sectors where nurses are employed. There has been a tendency for workforce planning to address

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125 West Australian Study of Nursing and Midwifery, Steering Committee, *New Vision, New Direction: report of the West Australian Study of Nursing and Midwifery,* WA Department of Health, 2001*,* p.18.

126 *Committee Hansard* 26.3.02, p.577 (Queensland Health).

127 *Submission* 912, p.3 (AMAP).

128 *Submission* 835, p.4 (APHA).

129 *Committee Hansard* 21.3.02, p.370 (ACT Department of Health and Community Care); see also *Submission* 960, p.10 (Victorian Government).

130 *Submission* 822, p.2 (AHWAC).

different groups of health professionals in isolation. The health workforces do not operate in isolation and there are interdependencies and pressures on professional boundaries as a result of organisational change which must be recognised.

2.115 A national approach is also needed to develop an improved workforce planning model to better predict future needs. There is an urgent need to improve the quality of the data available on the nurse workforce and its timeliness.

2.116 The Committee considers that the leadership role to advance work on these matters belongs to the Commonwealth. The Commonwealth already has direct responsibilities for the nurse workforce through its funding of the tertiary education sector and thereby funding for nurse training. The Commonwealth also directly funds the aged care sector which is a large employer of nurses. The Commonwealth also has a national perspective on health policy and funds specific programs such as Indigenous health and rural and remote health.

2.117 The Committee recognises that workforce matters are already being considered by AHWAC and further consideration will be given to workforce matters 'requiring collaborative action' by the newly formed AHWOC. However, the Committee considers that little progress will be made without strong leadership by the Commonwealth and without significant, direct involvement by all stakeholders. The Committee is not suggesting that the Commonwealth should take over the sole responsibility for nursing workforce issues. Rather, there is a need for a collaborative effort between all levels of government and stakeholders in the nursing system.

Recommendation 5: That the Commonwealth in cooperation with the States and Territories facilitate and expedite the development of a national nursing workforce planning strategy.

Recommendation 6: That the Commonwealth provide the Australian Institute of Health and Welfare with the resources required to establish a consistent, national approach to current data collection on the nursing workforce in Australia.

Recommendation 7: That research be undertaken to examine the relationship between health care needs, nursing workforce skill mix and patient outcomes in various general and specialist areas of care, with a view to providing "best practice" guidelines for allocating staff and for reviewing quality of care and awarding accreditation to institutions.

Chief Nursing Officer

2.118 Many witnesses called for the establishment of a position of principal nursing adviser at the Commonwealth level and pointed to the National Nursing Forum's

recommendation that nursing units and chief nursing officers should operate at Commonwealth and State levels.[131] The ANCI considered that:

> …the contribution of a national nursing perspective to the health policy process is integral to effective health outcomes for the community. Nursing leadership advice and contribution to Commonwealth government policy and initiatives would not only enhance policy decision making in areas such as health work force and education but also assist in and coordinate implementation of relevant policy.[132]

2.119 The ANF and other witnesses noted that the Commonwealth has a major responsibility for the nursing workforce as it sets national health priorities; it funds service provision, including nurses, through its funding agreements with the States and Territories; it has primary responsibility for Indigenous health and the aged care sector; and it sets the standards for service provision in other sectors such as home and community care and care for veterans. The Commonwealth is also responsible for the tertiary education sector in which nurses are educated and for the aged care sector in which the Commonwealth pays for the employment of nurses.[133]

2.120 The ANF saw the role of the principal nursing adviser as providing the Commonwealth with advice on general nursing issues; contributing to decisions affecting the nursing workforce; liaising with State and Territory chief nursing officers and the nursing profession generally; representing the Government at national and international forums; coordinating national activities that impact on nursing; and tracking nursing initiatives initiated by other government departments (for example, mental health, aged care, general practice, veterans' affairs, education).[134]

2.121 The Queensland Nursing Council considered that a principal nursing adviser would act as a focal point for existing bodies and informal networks and provide a significant resource to provide for a timely and effective advisory and policy role. It would also provide greater cohesion in a sector which is fragmented between specialist groups and where there are differing perceptions of an 'employee' model compared with a 'professional' model.[135]

2.122 The ACT Government went further than recommending a single position and stated that the Commonwealth should make 'a dedicated investment in addressing long-term planning by the funding of a chief nurse directorate – and by this we mean a directorate, a group of people, not a single individual – who will have responsibility

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131 See for example, *Submission* 867, Attachment 1, p.10 (NSW Health Department); *Submission* 962, p.20 (ANF); *Submission* 480, p.4 (NSW College of Nursing); *Submission* 942, p.17 (Queensland Health).

132 *Committee Hansard* 26.3.02, p.617 (ANCI), see also ANCI Position on the Establishment of a Nursing Directorate headed by a Chief Nurse in the Commonwealth Government, Feb 2002.

133 *Submission* 962, pp.21-22 (ANF).

134 ANF, 2002-2003 Federal Government Pre-Budget Submission, February 2002, p.10.

135 *Submission* 887, p.13 (QNC).

for workforce, education and other professional issues and will work in collaboration with State and Territory branches'.[136]

2.123 The Commonwealth Department of Health and Ageing currently has the full-time equivalent of 12.15 staff working on nursing workforce issues. Five of these staff are in the Aged Care Division.[137]

Conclusion

2.124 The Committee considers that much is to be gained through the establishment of a position of Chief Nursing Officer. The gains include greater coordination of national programs and policy impacting on nursing such as the education, supply and role of nurses; improved liaison with State and Territory Governments, overseas nursing counterparts and other sectors including the private and aged care sectors; and greater recognition that improved healthcare can only come through a nationally coordinated health workforce.

Recommendation 8: That the Commonwealth, as a matter of urgency, establish the position of Chief Nursing Officer within the Department of Health and Ageing.

National Registration

2.125 At the present time, nurses working in each State and Territory are registered or enrolled by the relevant regulatory authority. Under Mutual Recognition requirements, regulatory authorities are obligated to register or enrol applicants under conditions that are not more onerous than those imposed by the regulatory authority in the State or Territory of origin of the applicant.

2.126 Many witnesses recommended the introduction of a national registration scheme for nurses. The WHA, for example, argued that differences in nursing practice, curriculum development and quality that exist across Australia are due to the lack of one registration board, standard registration processes and commonality with educational curriculum development. This is hampering workforce planning and the provision of an appropriately educated and flexible nursing and midwifery workforce.[138] Catholic Health Australia also supported the notion of a national registration process and stated 'when it comes to aged care in particular, there needs to be nationally consistent approaches to medication, distribution and the interface with state governments' poisons legislation'.[139]

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136 *Committee Hansard* 21.3.02, p.370 (ACT Department of Health and Community Care).

137 *Submission* 944, Supplementary Information, 24.9.01, p.5 (DHAC).

138 *Submission* 936, p.12 (WHA).

139 *Committee Hansard* 21.3.02, p.397 (CHA).

2.127 National registration is supported by many nurses, in part due to the mobility of the nurse workforce and the problems of obtaining registration in different jurisdictions.[140] One nurse outlined concerns nurses have with separate registration:

> In Queensland, registration for a mental health nurse is not separate from registration as a general nurse but in other states…they are separated. My concern is: how come some nurses are able to practise in one field in one state without the same qualification as in another state or recognition that it is a separate field?
>
> …we need to have professional standards that go across all of the states as well. In my own mind, I cannot come to a conclusion about why it should be that nursing in different states within Australia means different things to different people.
>
> Also, the process of registering in different states is really quite difficult for nurses. Each state asks for a different set of documents and they are large and voluminous. Also, the registration fees for nurses within each state are vastly different. Victorian nurses pay…a small amount. In South Australia it is almost double that amount. In Queensland it is somewhere in between.[141]

2.128 Other witnesses pointed to time delays in acquiring registration in another State or Territory, with delays of six to eight weeks reported.[142]

2.129 National registration was not supported by all witnesses. Some pointed to the lack of problems with the present system. The Nurses Board of South Australia stated:

> There is very little inconvenience, if I could put it that way, for people to move from state to state. The Mutual Recognition Act supports health professionals crossing state and territory borders. We ask for a fee to be paid; we ask for identification of the licence where they were practising in the previous state and also that they identify their competency within the particular area. It is a very streamlined process. Once that is undertaken, the person is free to practise within the state. I think that the mutual recognition certainly supports that free movement.[143]

2.130 The New South Wales Nurses Registration Board stated:

> Essentially, regulation requirements for becoming a registered nurse in New South Wales are very similar across Australia. We have cross-accreditation, so somebody registered in New South Wales will be registered in Queensland should they simply apply for that, with mutual recognition. That

140 See for example, *Committee Hansard* 26.3.02, p.565 (QNU).

141 *Committee Hansard* 26.3.02, p.660 (Mater Hospital).

142 *Committee Hansard* 28.2.02, p.161 (Mercy Hospital for Women).

143 *Committee Hansard* 27.3.02, p.782 (Nurses Board of South Australia).

> works very effectively. We are unaware of delays in people gaining registration. We do not have a waiting list.[144]

2.131 A number of potential problems with national registration were outlined. The ANCI noted that people supporting national registration argued that Nursing Acts vary significantly between jurisdictions and that the barriers are the authorities which administer the Acts. ANCI countered that currently, there are more commonalities than differences between each of the Nursing Acts and what is not often taken into consideration by those pointing to differences are the objectives of the Acts and the policies that can be developed from the powers of the Acts.

2.132 The ANCI went on to note that, more importantly, there are significant differences between jurisdictions in other relevant legislation for example, legislation related to drugs and poisons. ANCI stated that:

> Any attempt to establish a national system of regulation requires that all legislation which impacts on nurses' practice be considered. In addition, any differences in legislation or policies have not generated difficulties in moving between jurisdictions under mutual recognition legislation. The processes involved provide for an almost instant recognition of nurses moving from one jurisdiction to another.[145]

2.133 The ANCI also indicated that issues involved in cross-border practice had been addressed. While mutual recognition provided for nurses registered in one State or Territory to be registered in other States or Territories, registration fees still had to be paid in all the jurisdictions where the nurse was working. In order to reduce the financial burden on those nurses who are required to register in more than one jurisdiction, all nurse regulatory authorities in Australia now have the ability in certain circumstances to consider waiving the fees or to exempt an individual from the requirement to pay a fee.[146]

2.134 The Victorian Department of Human Services also commented that nursing boards investigate complaints against nurses and that a single board would be required to do this task under national registration. It was suggested that there may be problems of a single board being able to do this across the nation. In addition, problems with State legislation may arise. The Department concluded 'we do not have a strong view on it, but would it really address any of the issues that are of importance to the system? We say not really.'[147]

2.135 Some witnesses did not support national registration because of problems experienced with mutual recognition requirements. The Nurses Board of the ACT stated that under mutual recognition, jurisdictions must register nurses that they may

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144 *Committee Hansard* 22.3.02, p.512 (NSW Nurses Registration Board).

145 *Committee Hansard* 26.3.02, p.617 (ANCI).

146 ANCI, *Position Statement Cross Border Nursing Practice: Waiver of Fees*, May 2000.

147 *Committee Hansard* 28.2.02, p.191 (Department of Human Services, Vic).

not have otherwise accepted, for example, the nurse may be required to retrain in one jurisdiction and not the other. The Board concluded that 'the mutual recognition is enough of a problem without national registration, if we go for the lowest common denominator, and not for the public safety aspect, just to address a shortage'.[148] The Nursing Board of Tasmania also pointed to difference in currency of practice requirements for registration that are standard in some States and not in others, for example, New South Wales.[149]

Conclusion

2.136 The Committee supports the need for national registration of nurses. The Committee considers that major advantages accrue from such as proposal. National registration would assist in the development of national consistency of registration requirements.

2.137 The Committee has noted the comments by those with concerns about mutual recognition and its implication for automatic registration notwithstanding that standards vary across jurisdictions. In the Committee's view this is a strong argument for national registration so that there is alignment of registration requirements acceptable across all jurisdictions. However, national registration should be implemented though each State and Territory regulatory agency. This would enable State and Territory regulatory bodies to maintain their State and Territory functions including the investigation of complaints related to unprofessional conduct and incompetence.

2.138 The Committee considers that national registration should be developed under the auspices of the ANCI as it already develops and maintains national competency standards for both registered nurses and enrolled nurses. National registration would also provide an improved mechanism for data collection for workforce planning. As has already been stated, the inadequacy of nursing workforce data is a major impediment to improving workforce planning. Through national registration there would be increased mobility opportunities for nurses to move between States and Territories. This would be welcomed by nurses.

Recommendation 9: That national registration be implemented for registered and enrolled nurses.

148 *Committee Hansard* 21.3.02, p.389 (Nurses Board of the ACT).

149 *Committee Hansard* 15.3.02, pp.269-70 (Nursing Board of Tasmania).