

CHAPTER 8

NEEDS IN SPECIALIST NURSING

8.1 In recent years there has been an expansion in the demand for specialist services, for example, intensive care units and mental health services. An important component of specialist service delivery is the availability of appropriately qualified nursing staff. Indeed, many areas of specialist medicine could not be maintained without specialist nurses. However, evidence indicated that there are nursing shortages in many specialist areas. This chapter provides an overview of the needs of some of these specialist areas including mental health nursing, rural and regional nursing, Indigenous nursing, midwifery, and community, neonatal, paediatric, critical care, operating theatre, emergency and oncology nursing.

Mental Health

The future crisis that everyone speaks of is here now. Mental Health Nursing is in the grips of a national human resource crisis. Short term solutions need to be created along with more considered approaches that are medium and long term.¹

8.2 In the last decade there have been significant changes to the delivery of mental health care and to the education of the mental health workforce. The national mental health reform process resulted in the deinstitutionalisation and mainstreaming of mental health services into general health services. Mental health management is focused on care in the community with support from acute care and short stay units in general hospitals:

There has been a move away from the institutional care, particularly in the up to 70s age group, with a devolution of institutions into an explosion of community based services, to the point now where the acuity of patients now being managed in the community is far higher than it has ever been at any time in the past.²

8.3 Changes to mental health education have resulted in a move from direct entry psychiatric nursing courses to programs within undergraduate courses, combined with post registration specialist mental health courses from Graduate Certificate to Masters level.

1 *Submission 777*, p.3 (ACT Mental Health Service).

2 *Committee Hansard 27.2.02*, p.67 (ANZCMHN (WA Branch)).

8.4 The shortage of mental health nurses is being felt in all States and Territories.³ Submissions noted that this shortage is occurring at a time when there is increasing demand for mental health services by a larger proportion of the population.⁴

8.5 In 1997, there were 2 181 enrolled nurses employed in mental health areas and 10 113 registered nurses. 33.9 per cent of mental health nurses are males and 66.1 per cent female. In 1997, more than 55.7 per cent of mental health nurses were aged 40 years or older, an increase from 46.6 per cent in 1994. Only 12.7 per cent of mental health nurses are less than 30 years of age.⁵ As a result many mental health nurses are approaching retirement. For example, in the ACT an estimated quarter of mental health nurses will retire by the year 2006 and half by the year 2011. However, there have been less than 400 mental health nurse graduates in the past three years across Australia to replace those retiring.⁶

8.6 Submissions pointed to the move to generic undergraduate nursing programs as a major reason for the decline in new entrants to mental health nursing. It was argued that student nurses in general undergraduate courses have inadequate exposure to mental health nursing during their studies and therefore do not consider a career in mental health nursing. The Health and Community Services Union (HACSU) (Victorian Branch) reported that the mental health content in Victorian undergraduate degrees varies from zero to 17.4 per cent.⁷ The Australian and New Zealand College of Mental Health Nurses (ANZCMHN) (Victorian Branch) added that 'the quality and quantity of specialist content has been eroded to such an extent that clinical agencies sometimes question the relevance of nursing education to clinical practice'.⁸ The Centre for Psychiatric Nursing Research and Practice (CPNRP) stated that the Victorian Department of Human Services had attempted to increase the mental health content of undergraduate nursing courses. It had convened a working party which reported in 1998. However, it 'failed to have any significant impact'.⁹

8.7 Although there is little emphasis on mental health nursing in undergraduate courses, witnesses pointed to the importance of these skills in the general nursing environment. The ANF stated 'most clinical nurses identify mental health education as a requirement for practice, as patients/clients with a mental illness are increasingly accessing other services such as acute care (particularly in emergency departments),

3 A comprehensive review of workforce shortages in each State and Territory is provided in the *Scoping study of the Australian mental health nursing workforce 1999, Final report*, Canberra, 2001, pp.19-27.

4 See for example, *Submission 960*, p.17 (Victorian Government); *Committee Hansard 27.2.02*, p.70 (ANZCMHN WA Branch).

5 AIHW, *Nursing Labour Force 1999*, Table 61, p.94.

6 *Submission 741*, p.2 (ANZCMHN (Vic Branch)).

7 *Submission 967*, p.3 (HACSU (Vic No 2 Branch)).

8 *Submission 741*, p.3 (ANZCMHN); see also *Committee Hansard 28.2.02*, p.164 (Austin & Repatriation Medical Centre).

9 *Submission 766*, p.2 (CPNRP); see also *Scoping Study*, p.3.

community health and aged care'.¹⁰ CPNRP also argued that generic mental health skills should be essential for nurses irrespective of the area in which they chose to practice.¹¹ The Department of Health and Aged Care (DHAC) similarly stated 'the expansive role of the primary care sector is an issue for the general nursing workforce and adequate mental health training needs to be included in the general nursing training at the undergraduate level'.¹²

8.8 Witnesses also voiced concern about the quality of clinical placements for students. Some health service providers are reluctant to host mental health placements for nursing students and prefer placements for allied health students such as psychologists and occupational therapists.¹³

8.9 Many nursing students have a negative view of the mental health sector, particularly concerning violence and danger and the stigma related to mental illness. The ANZCMHN also noted that the image of mental health nursing is not improved when graduates 'come into a culture in which there is a large degree of burnout...they will see insensitivity and indifference' and choose not to work in mental health.¹⁴

8.10 A lack of postgraduate education programs was also identified, for example, in Western Australia the last postgraduate program for community mental health nurses was offered several years ago and has not been continued. In addition, the majority of mental health nurses do not have university qualifications and so access to university, post basic education or graduate education is not easily available.¹⁵ As with many other specialist nursing areas, the cost of postgraduate education is seen to be prohibitive for some of those wishing to specialise.

8.11 Submissions identified the main areas impacting on retention of mental health nurses. Working conditions are often poor, with heavy workloads and lack of resources which adds to the stress of nursing staff. There is a lack of pay parity with other health professions. There is a high level of workcover claims in the mental health sector. There is a lack of career pathways which has resulted in low morale, lack of job satisfaction, and poor status. Mental health nurses, as with other specialist nursing groups, lack professional development opportunities and employer educational assistance schemes. All of these issues undermine the attractiveness of mental health nursing for new graduates and encourage professional stagnation of those already practicing.

10 *Submission 962*, p.34 (ANF).

11 *Submission 766*, p.3 (CPNRP).

12 *Submission 944*, p.4 (DHAC).

13 ANZCMHN, *Scoping study of the Australian mental health nursing workforce 1999, Final report*, National Mental Health Strategy, Canberra, 2001, p.3.

14 *Committee Hansard 27.2.02*, pp.42, 68 (ANZCMHN).

15 *Committee Hansard 27.2.02*, p.37 (ANZCMHN).

8.12 The shortage of mental health nurses is impacting adversely on patient care as well as the nurse workforce. Lack of staff has been reported as contributing to increased violence in the workplace.

8.13 The present crisis in staffing in the mental health sector has not had a sudden onset. Workforce matters were covered in the evaluation of the *National Mental Health Strategy, Final Report*, 1997 and again in 1999 in *Learning Together: Education and Training Partnerships in Mental Health - Final Report*. The latter report proposed guidelines and information for universities, professional associations and employers to implement so as to update mental health education and training. The report also recommended that it be considered as a source document informing the development of a national education and training framework under the Second Mental Health Plan; and proposed a number of detailed actions for a national education and training network.¹⁶

8.14 In 2000, the National Mental Health Education and Training Advisory Group was established to follow up on the education and training of the mental health workforce.¹⁷ The Advisory Group has developed National Practice Standards for the Mental Health Workforce in consultation with five mental health disciplines of nursing, social work, occupational therapy, psychology and psychiatry. The Standards offer a strategic national framework for the education and training of the future mental health workforce. Draft Standards were circulated in late 2001.

8.15 In May 2001, a scoping study prepared by ANZCMHN, was published. The study had been initiated in 1998 by the Australian Health Ministers' Advisory Council (AHMAC) National Mental Health Working Group following concerns over the decline in numbers of suitably qualified and experienced mental health nurses. It focused on the problems of recruiting and retaining mental health nurses and the current challenges facing mental health education. The findings of the study included that the take-up rate of postgraduate places in mental health nursing courses is inadequate to meet the future needs of specialist mental health services; postgraduate education in mental health nursing is in need of rationalisation and reform; there is inadequate planning and development of the mental health nursing workforce to meet needs of mental health services; and mental health nurses are increasingly working under stress which is impacting adversely on recruitment and retention. The Scoping Study identified six areas for immediate action including the promotion and development of the mental health nursing workforce; and the urgent reform of undergraduate and postgraduate education in mental health nursing.¹⁸

16 Deakin Human Services Australia, *Learning Together: Education and Training Partnerships in Mental Health Service, Final Report*, February 1999. Prepared by Deakin Human Services Australia with funding from the Commonwealth Department of Health and Aged Care under the National Mental Health Strategy.

17 *Submission 944*, p.4 (DHAC).

18 ANZCMHN, *Scoping study of the Australian mental health nursing workforce 1999, Final report*, National Mental Health Strategy, Canberra, 2001, pp.3-4.

8.16 The November 2001 mid-term review of the Second National Mental Health Strategy also raised concerns about the mental health workforce. It stated that ‘the overall *nursing complement* is too limited to fill even current posts. The future is even more daunting as nursing is an ageing work force without sufficient new recruits’, and further, ‘the situation is serious with a high risk of insufficient numbers of trained nurses being available in the foreseeable future to sustain a viable mental health service’.¹⁹ Ways forward for the mental health workforce were outlined in the review and those relating to nurses included:

- addressing the immediate and serious workforce issues at both Commonwealth and State and Territory levels including the extent of current and likely shortages of mental health professionals especially nurses; introducing measures to retain current staff; and making mental health career choices increasingly attractive in the future; and
- addressing educational needs and the content of training for mental health professionals, and standardising all new training models for mental health professionals with a set standard for core competencies for the mental health disciplines.²⁰

Conclusion

8.17 The Committee notes the conclusions of the Mental Health Nursing Scoping Study: that mental health services are changing and becoming more complex; that the demands made on mental health nurses by clients in acute in-patient facilities are becoming increasingly challenging; and that experienced mental health nurses are required in community mental health services. At the same time, the Scoping Study found that there were major concerns about the future viability of the mental health nursing workforce.

8.18 The reports already completed into the needs of mental health nursing and the evidence received by the Committee provide ample indication of the underlying workforce problems facing the sector. These are not projections of potential problems, but problems which mental health services across the country are dealing with today.

8.19 The situation requires urgent action: action to ensure that those already working in the sector are supported and provided with opportunities for further education, career pathways and recognition of their contribution to the health sector generally; action to ensure that adequate take-up rates of postgraduate places in mental health nursing courses occurs; and action to rationalise and reform postgraduate education for mental health nurses. The Committee notes that the Scoping Study identified areas for immediate action. The Committee considers that work should be undertaken in these areas to improve recruitment and retention of mental health nurses so as to ensure the viability of mental health services in the future.

19 Betts, V & G Thornicroft, *International Mid-Term Review of the Second National Mental Health Plan for Australia*, National Mental Health Strategy, November 2001, p.11.

20 Betts & Thornicroft, pp. 5-6.

8.20 The Committee received many suggestions for improving the educational opportunities for those wishing to enter mental health nursing and to retain those already in the sector and makes the following recommendations:

Recommendation 76: That the Commonwealth fund scholarships for psychiatric/mental health nursing for graduate year students wanting to specialise in the area, and for already qualified nurses wishing to undertake a mental health nursing course.

Recommendation 77: That a targeted campaign be undertaken to improve the status and image of psychiatric/mental health nursing.

Recommendation 78: That funding be provided for the development of advanced practice courses in mental health nursing.

Rural and remote nursing

It is very serious and it is most serious in rural and remote areas. Nurses, as you well know, in some more remote areas are the highest trained and, perhaps with the exception of Aboriginal health workers, the only trained health professionals in more remote areas. So if we are short of them, we are short of the only people who can provide hands...health services.²¹

8.21 Nursing services constitute the largest group in the rural and remote health workforce and in most areas are the first line contact in healthcare services. Nurses provide a wide range of services, which in many smaller towns and communities, are only supported by on-call or part-time medical officers and allied health staff. In the more remote centres, nurses often are the sole primary healthcare provider and are frequently called upon to provide other health services due to community demand and lack of any other form of health personnel support.

8.22 Services are experiencing recruitment difficulties and shortages of appropriately skilled registered nurses and specialist nursing staff. There are particular difficulties in aged care services and midwifery. The Royal Flying Doctor Service indicated that it was experiencing difficulties recruiting midwives and nurses with other post basic/graduate nursing qualifications. This situation is becoming so critical that the RFDS Queensland Section has established a position where the nurse only undertakes the emergency component of her duties while completing an external course in early childhood.²² In many small rural hospitals the Director of Nursing may be the only qualified midwife and is on call 24 hours a day to provide midwifery services. In 1999, around 30 per cent of nurses employed in small rural centres and other rural and remote areas (except for large centres) were enrolled nurses. In cities only 17.1 per cent are enrolled nurses.

21 *Committee Hansard* 21.3.02, p.423 (NRHA).

22 *Submission* 455, p.3 (RFDS).

8.23 As with the general nursing workforce, the rural and remote workforce is ageing with an average age of 38 years and with 35 per cent of remote and rural nurses aged over 45 years. The turnover of nurses in rural and remote areas is high – the National Rural Health Alliance (NRHA) stated that in some areas it was 450 per cent.²³ The Rural Health Stocktake found that nurses in the small towns were either young and generally transient; or older, and mostly trained in the era before university training was available. The Stocktake stated that ‘the consequence of the transfer of training of nursing to university is the transfer of training away from the local hospital, and hence from the rural environment. Therefore, there is an imminent nursing workforce problem which some predict will dwarf the lack of doctors in the bush’.²⁴

8.24 The healthcare needs of rural and remote Australia have come under scrutiny in a number of reviews, inquiries and research projects. The Commonwealth has responded to the healthcare needs of rural and remote communities through mainstream programs²⁵ and through a number of targeted programs, including those aimed at the nursing workforce.

8.25 The Federal Budget 2001-02 provided \$104.3 million over four years for general practices to employ more nurses in areas where patient access to medical services is limited, including rural and remote areas, and was aimed at providing general practices with nursing staff to assist in the management of chronic diseases, conduct health assessments and provide clinical support. Under this measure, \$5.2 million over four years was allocated for re-entry training programs for rural nurses including approximately 400 scholarships each year, worth up to \$3 000 each. The scholarships will benefit former rural nurses by removing some of the financial barriers to re-entry into the workforce. The scholarships are available to rural nurses who wish to update their skills or re-enter the workforce in non-acute settings such as aged care, general practice or community health centres. The Royal College of Nursing administers the program.²⁶

8.26 The Department of Health and Ageing reported that soon after the Government announced this program, several State Governments announced very generous upskilling programs which affected the number of people who applied for the program. In light of the lower than expected uptake, it was decided to increase the scholarships from \$3 000 to \$6 000, aiming for half the number of participants but optimising the use of funds.²⁷

23 NRHA, *Action on Nursing in Rural and Remote Areas: Draft Issues Paper*, p.6.

24 Best, J, *Rural Health Stocktake Advisory Paper to the Commonwealth Department of Health and Aged Care*, March 2000, p.93.

25 Such as the Australian Health Care Agreements, Medicare Benefits Scheme, Pharmaceutical Benefits Scheme, Aged and Community Care, Private Health Insurance Incentives, Public Health Outcome Funding Agreements and other Specific Purpose Payments.

26 DHA, *Budget 2001-02, Health Fact Sheet 3*.

27 Senate Community Affairs Legislation Committee, *Committee Hansard 5.6.02*, p.202 (DHA).

8.27 The 2001-02 Budget also provided \$13 million over four years to improve access to undergraduate nursing education for rural and regional nursing students. 100 scholarships were provided for rural students and ten scholarships were provided for Aboriginal and Torres Strait Islander nursing students or health workers who want to upgrade their qualifications at a cost of \$10.9 million. Provision was made for 30 additional scholarships in December 2001.²⁸ Funding of \$2.1 million was provided for support measures associated with the scholarships with a particular emphasis placed on Indigenous nursing students. Funding was also provided for culturally appropriate training for rural nurses to assist them in providing care for Indigenous Australians.

8.28 The Commonwealth also funds nursing scholarships for relevant postgraduate courses, short courses and programs and for attendance at conferences to improve the knowledge base and skills of rural and remote nurses and further their professional development.

8.29 The National Rural and Remote Midwifery Upskilling Program provides funding to the States and Territories for upskilling of midwives in rural and remote areas. The program is expected to provide for at least 1 575 midwives over the four years from 1999-2000 to 2003-2004 and is based on a payment of \$3 000 per midwife to enable them to undertake a two-week upskilling or refresher course. The Department indicated that at June 2002, a total of 1 999 midwives had participated in the program.²⁹

8.30 In the 2002-03 Budget, the Commonwealth provided an additional \$26.3 million over four years to fund up to 250 scholarships for aged care nursing, valued at up to \$10 000 per year, for students from regional areas to undertake undergraduate, postgraduate or re-entry nursing studies at rural and regional university campuses.

8.31 The Commonwealth also provides funding for University Departments of Rural Health. These Departments are designed to provide educational opportunities and professional support for rural health professionals and students, including nurses. In the future, all Departments will provide further education, training and upskilling courses for rural nurses and health care professionals. Some of these Departments are, or will be, providing placements and, or, components of courses for undergraduate nurses.³⁰

8.32 In addition, State and Territory initiatives include Nurse Practitioners in NSW, South Australia and Victoria. Other initiatives include Isolated Practice endorsement in Queensland; Rural Health Policy Cadetships in Western Australia; and rural nursing scholarships available through some State Governments, universities and

28 Minister for Health and Ageing, *Media Release*, 13.12.01.

29 Senate Community Affairs Legislation Committee, *Committee Hansard* 5.6.02, p.201 (DHA).

30 *Submission* 944, p.6 (DHAC).

nursing organisations.³¹ For example, NSW provides scholarships to first year undergraduate nursing students with a rural background, rural placement grants and postgraduate scholarships.³²

8.33 While these positive initiatives were welcomed, it was noted that:

- there has been a large number of nursing inquiries in which specific recommendations have been made about rural and remote nursing which have not been implemented;
- there has been a piecemeal approach to dealing with health issues in rural and remote areas without an overall ‘blueprint’ for rural and regional development;
- there is a tendency for the Commonwealth to fund initiatives for rural and remote nurses (and allied health practitioners) mainly through General Practice;
- there is a lack of an integrated, cohesive strategy for dealing with nursing (and allied health) workforce issues affecting remote and rural Australia;
- there is little prospect of attracting substantial numbers of practising nurses away from urban areas while there remain significant shortages of nurses overall; and
- the number of undergraduate nursing scholarships being funded by the Commonwealth represents a much smaller proportion of rural nursing students than the scholarships available to rural medical undergraduates relative to their overall numbers.³³

8.34 NRHA provided the Committee with an overview of a range of inquiries and research projects which made recommendations in relation to rural and remote nursing. While these recommendations covered many key issues facing rural and remote nurses including education opportunities, the role of distance education, advanced nursing practice, and retention issues, NRHA stated that ‘little has changed’. NRHA suggested that there were ‘substantial barriers yet to be addressed hindering progress on nursing workforce issues in rural and remote Australia’. These barriers include:

- the lack of national leadership;
- the lack of clarity about which level of government is responsible for specific aspects of nursing workforce issues;
- the relatively low status and high numbers of nurses (and thus perceived overall costs of policy actions) compared with doctors where much greater efforts have gone in educating, attracting and retaining them in rural areas;
- resourcing issues;

31 *Submission* 800, p.5 (NRHA).

32 *Submission* 921, p.2 (NSW Farmers’ Association).

33 *Submission* 800, pp.5-6 (NRHA); *Submission* 962, p.52 (ANF).

- opposition from some influential medical organisations to some innovative approaches to nursing in rural and remote areas;
- the lack of effective structures for interaction and agreement and associated poor coordination between the key players in workforce planning and nurse education; and
- fragmentation of developments in education, training and new nursing models of practice.³⁴

8.35 The Committee received many recommendations for the improvement in recruitment and retention rates for rural and remote nurses.

Attracting people to nursing who will practice in rural and remote areas

8.36 NRHA indicated that a high proportion of nurses working in rural and remote areas have strong rural backgrounds or connections. However, overall participation rates for students from rural and remote backgrounds in higher education are low. Leeton Shire Council noted that once students moved away from home to attend university, they often did not wish to return to rural areas to work. There have been moves to provide postgraduate courses through distance education, but the University of South Australia is the only university offering a full undergraduate course by distance education, supplemented by a short block of on-campus workshops every semester.³⁵

8.37 In evidence a number of strategies for improving rural participation rates in nursing were suggested, these included:

- marketing campaigns in secondary schools;
- reducing the cost of courses or introducing a system to enable ‘pay as you go’;
- reducing HECS fees for every year worked in a designated rural community;
- waiving HECS fees for nursing students from remote and rural backgrounds;
- increasing scholarship or sponsorship arrangements through area health services in rural areas;
- introducing bonded scholarships;
- introducing a rural nursing certificate; and
- increasing educational opportunities in rural areas.³⁶

The marketing of nursing in primary and secondary schools was seen as being essential if students from rural and remote areas are to be attracted into nursing.

34 *Submission* 800, pp.11-12 (NRHA).

35 *Submission* 445, p.2 (Leeton Shire Council).

36 *Submission* 445, p.3 (Leeton Shire Council); *Submission* 921, p.8 (NSW Farmers’ Association).

Improving education of rural and remote nurses

8.38 The importance of education and training for rural and remote practice was emphasised. Frontier Services stated that universities were ‘failing to provide staff with the confidence they need to work with minimal supervision in remote areas, whether in aged care or in remote clinics. Younger staff appointed to these positions simply do not stay.’³⁷

8.39 The NRHA considered that there was considerable room for improvement in undergraduate programs to prepare students for rural and remote practice. Issues of concern included limited or no rural or remote experience on the part of teaching staff; insufficient content on Indigenous health and rural and remote cultural sensitivity and cultural safety; inadequate funding for rural and remote placements; and lack of recognition of the extra load on rural and remote health services from accepting student nurses. Insufficient clinical experience was a particular concern as nurses in rural and remote areas have less support and back-up than their urban counterparts. NRHA recommended that universities urgently address problems in their courses to ensure that undergraduate nursing programs are suitable for those wishing to enter rural and remote practice.

8.40 Nursing students wishing to undertake clinical placements in rural and remote services often face problems in accessing places including high costs of travel and accommodation. The Victorian Government has implemented a program to provide financial assistance to both metropolitan and undergraduate nursing students taking up rural placements where accommodation and travel costs are incurred.³⁸ NRHA recommended that the Commonwealth establish a scholarship scheme for student nurses similar to the John Flynn Scholarship Scheme for medical students to allow for two-week placements each year while studying.

Further education and re-entry education

8.41 Witnesses pointed to the difficulties experienced by rural and remote nurses in accessing educational opportunities. Release for education may be difficult because of: lack of appropriate staff to fill vacant positions; the reduced funding to area health services; the reduced number of doctors in some areas leaving the nurse as the only professional available 24 hours a day; and the high level of experience and skill of these nurses who are often working as the primary provider in an area making them indispensable to a community. The ANF noted that further education costs significantly more for nurses based in rural and remote areas than it does for their metropolitan counterparts as travel and accommodation costs and living expenses away from home may be high. This acts as a disincentive to further education. The ANF argued that an extension of the current Federal Government scholarship scheme

37 *Submission 826*, p.2 (Frontier Services); see also *Submission 445*, p.2 (Leeton Shire Council).

38 State Government Victoria, *Nurse Recruitment and Retention Committee, Government Response*, June 2001, p.xv.

for rural and remote nurses would enhance their practice and contribute to high quality nursing outcomes.

8.42 Maintaining skill levels for skills infrequently used, for example managing a major burn injury or delivering a premature baby, is also an issue for nurses working in rural and remote areas. The ANF recommended that a mechanism needs to be developed to allow nurses working in rural and remote areas to have access to appropriately funded and supported skills maintenance programs. These could be developed through partnership arrangements between metropolitan and rural facilities.³⁹

8.43 Other factors acting as barriers to further education include time pressures, as many nurses work part-time, the dispersion and remoteness of the nursing workforce; the relatively high proportions of nurses whose qualification is a hospital Registered Nurse Certificate (that is, not university nursing courses); and, the age structure of the workforce.

8.44 Recommendations in this area made in evidence included the need for more flexible modes of learning. For example, NSW Farmers' Association noted the need for improved access to information technology and tele-health facilities for nurses to allow greater education and training opportunities.⁴⁰ It was also suggested that more training needs to be available in regional and rural centres, including the development of regional study centres located at regional hospitals. This would enable staff to undertake refresher and other courses at a facility close to home and thereby decrease costs and time taken. There was a need for paid study leave or scholarships. Currently, many nurses use long service leave and holiday entitlements to attend courses and greater financial support and scholarships were recommended.⁴¹ However, the NSW College of Nursing noted that evidence suggested that where nurses are removed from their day-to-day responsibilities to attend education programs, both outcomes and retention rates of the programs are higher.⁴²

8.45 The idea of a circuit nurse to provide relief for rural and remote nurses wishing to undertake educational opportunities was raised in evidence. The NSW College of Nursing noted that 'the majority of barriers may be overcome if there was an appropriate individual available to replace staff during release times'. A circuit nurse would travel from town to town to give care during times when the nurse needs to travel for educational purposes. While the College noted that many circuit nurses would be required, there would be advantages through increased retention rates in rural and remote areas, it would boost morale in areas where nurses feel ignored, undervalued and exhausted and provide opportunities for nurses who want to

39 *Submission 962*, p.51 (ANF).

40 *Submission 921*, p.7 (NSW Farmers' Association).

41 *Submission 355*, p.1 (Network 9 Health Council).

42 *Submission 480*, Supplementary Information, 22.4.02, p.2 (NSW College of Nursing).

experience working in rural and remote areas but who are not willing to commit to moving and resettling.⁴³

8.46 Queensland Health is also establishing a statewide system of rural and remote nursing relief. The program will provide a pool of relief nursing (registered and enrolled) staff for Queensland Health's rural and remote facilities. Relief nurses will be available for planned relief periods of up to four months duration.⁴⁴

8.47 NRHA noted the importance of the role of ENs in rural and remote health services. Rural and remote ENs have less access to continuing education and they are often placed in positions where they are working outside their scope of practice. NRHA recommended that bridging programs be more widely available to ENs in rural and remote areas to achieve advanced standing in Bachelor of Nursing programs.

Improving retention rates

8.48 Retention rates in rural and remote areas vary with turnover rates in Central Australia being 110 per cent for nurses. Factors most commonly identified by rural nurses as essential in influencing their decision to take up and remain in rural nursing are both personal (lifestyle and family related) and job-related (experience, career development and diversity).⁴⁵

8.49 In remote areas limited resources mean that nurses are often on call for extended periods of time or are involved in extended call-outs in demanding circumstances. In these circumstances, burnout becomes a problem and nurses leave the workforce. Rural nurses also suffer from lack of resources, particularly lack of additional staff in times of shortage or heavy workloads. Often this leads to excessive amounts of overtime being worked and adds to stress. These situations are difficult for experienced nurses and extremely unfavourable for new graduates. Many witnesses noted that new rural and remote nurses were not retained because of inadequate preparation and orientation and they were unprepared for the complexity of the task, the isolation and responsibility.

8.50 A further concern raised was the scope of practice of remote area nurses. Remote area nurses often work outside of their scope of practice because they are isolated from other healthcare providers and have to respond as best that they can to the health needs of the community. NRHA stated that this places nurses in an unacceptable position. NRHA also argued that more effective action is required by States and Territories to provide protection for nurses working outside their scope of practice in situations where more appropriate health care providers are not available.⁴⁶

43 *Submission 480*, Supplementary Information (NSW College of Nursing).

44 *Submission 942*, Supplementary Information (Queensland Health).

45 *Submission 800*, pp. 34-35 (NRHA).

46 *Submission 800*, p.55 (NRHA); see also *Submission 867*, Attachment 1, p.8 (NSW Health).

8.51 Remuneration of rural and remote nurses was raised by witnesses. While income is not seen as the major factor in influencing rural and remote area nurses' decisions to stay, NRHA stated that it is unlikely that major increases in recruitment of nurses can be achieved in rural and remote areas without an improvement in salaries.⁴⁷

8.52 Employment conditions and the working environment were also important in decisions to remain in nursing. For example, there is a lack of funding for relief while staff are attending in-service training or on other leave. Centres with only one nurse are often forced to close down when that nurse is on annual or sick leave. This causes stress to both the nurse and the community. Even in larger centres such as Mt Isa, there is limited choice as to when leave can be taken as services must be adequately staffed at all times. It was suggested that single nurse posts should be converted to two person positions or to implement a locum system. NRHA stated that improved relief arrangements for rural and remote nurses would make a substantial contribution to improving the recruitment and retention of nurses as well as enhance quality of care.

8.53 Incentive packages are offered in some jurisdictions,⁴⁸ though many witnesses pointed to the differences in incentives offered to other health professionals and other occupations in rural and remote areas. For example, the QNF Mt Isa Branch reported that in Mt Isa, doctors are housed in flats or houses provided by Queensland Health, whereas the nurses quarters at the hospital contain cell-type rooms, have holes in the walls, communal toilets and showers, and leaking ceiling.⁴⁹

8.54 Strategies suggested in evidence for increasing retention rates centred on conditions of service, remuneration and recognition of the unique nature of rural and remote nursing:

- remuneration commensurate with training and responsibility, to reflect that often nursing staff work alone and are the first point of contact with very little support;
- a rural component be factored into Nurses Awards;
- remuneration and allowances equal to other health workers employed in rural and remote areas;
- expansion of the Nurse Practitioner model to better reward expert skills and improve the level of health care to local communities;
- development of a rural incentive scheme including relocation expenses, housing subsidies and bonuses for length of service etc;
- provision of adequate and safe accommodation;

47 NRHA, *Draft Issues Paper*, p.15.

48 For example Queensland Health provides a Remote Area Incentive Package for RNs and Accommodation Assistance as part of Rural and Remote Incentive, IRM 2.7-17 and IRM 2.2-12, *Submission 942*, Supplementary Information 26.3.02 Attachments.

49 *Submission 704*, p.1 (QNF (Mt Isa Branch)).

- provision of mobile phones in all work vehicles (an occupational health and safety issue);
- provision of relief staff for education and holiday entitlements;
- child minding; and
- opportunities for partners to be gainfully employed/occupied eg a package be available to families which includes job creation type funding for a spouse.⁵⁰

8.55 Some initiatives have been developed to address the working conditions of rural and remote nurses. In Western Australia, the Department of Health is developing an implementation plan for the recommendations of the 2001 study of nursing and midwifery. Recommendations on rural and remote nursing included that accommodation facilities be reviewed; that accommodation be provided to attract nurses and midwives with families to practice in rural and remote settings and that there be a review of the use of and access to information technology.⁵¹

Conclusion

8.56 There are many issues facing the nursing workforce in rural and remote Australia. Some of the issues are similar to nursing as a whole, though exacerbated by distance and isolation. In rural and remote areas the situation is particularly challenging as the nursing workforce provides the backbone of skilled healthcare and in some areas the only healthcare.

8.57 Attracting and retaining nurses in rural and remote areas is increasingly difficult. New graduates may not have the experience or appropriate level of knowledge to meet and understand the challenges of nursing in rural and remote areas.

8.58 Experienced nurses find moving to non-metropolitan areas unattractive due to the expense of moving, inadequate accommodation, lack of remuneration commensurate to qualifications and the degree of isolation or remoteness. Nursing staff already employed in rural and remote areas are leaving because of workload, lack of recognition of their skills, poor educational opportunities and pressures of providing care that may be outside their scope of practice.

8.59 The Committee considers that urgent action is required if there is to be a nursing workforce of sufficient numbers and appropriate skill to meet the challenges of providing healthcare in rural and remote Australia.

50 See for example, *Submission 197*, p.2 (Institute of Nursing Executives NSW & ACT); *Submission 355*, p.1 (Network 9 Health Council); *Submission 445*, p.3 (Leeton Shire Council); *Submission 455*, p.4 (RFDS); *Submission 708*, p.3 (Greater Murray Area Health Service); *Submission 737*, p.8 (Eyre Region Health Service); *Submission 921*, (NSW Farmers' Association).

51 Pinch, C & Della, P, *The West Australian study of nursing and midwifery: New Vision, New Direction*, Perth, Department of Health, 2001, p.54.

Recommendation 79: The Commonwealth provide additional funds to universities to extend clinical education in rural and remote regional hospitals.

Recommendation 80: That the Commonwealth increase the amount of funding of rural and remote nursing programs, including scholarship programs, in line with funding of medical programs.

Recommendation 81: That the Commonwealth and States provide funding for nursing relief programs such as ‘circuit nurse’ programs in rural and remote Australia.

Recommendation 82: That all rural and remote area health services with the assistance of State governments offer additional incentives to nursing staff through employment packages including accommodation assistance, additional recreation and professional development leave, and appointment and transfer expenses to encourage nurse recruitment.

The Indigenous nursing workforce

8.60 Indigenous nurses and Aboriginal Health Care Workers play an important part in the provision of healthcare services in rural and remote areas. Indigenous nurses account for 0.8 per cent of the nursing workforce, with a high proportion being enrolled nurses. In 1996, there were 693 Indigenous registered nurses and 564 Indigenous enrolled nurses.⁵² In South Australia in 1999 it was estimated that there were approximately 64 registered and enrolled nurses of Aboriginal and Torres Strait Islander origin with active status.⁵³

8.61 Increasing the number of Indigenous people entering the health workforce is ‘essential to produce an effective health workforce capable of meeting the health needs of Australia’s Indigenous people’. In addition to producing an effective health workforce, other benefits will be gained: improving the health and welfare of the individual student will have flow-on effects to their family and communities; Indigenous nurses will become role models for young Indigenous people; improved employment opportunities for people from Aboriginal and Torres Strait Islander communities; and increased understanding of Aboriginal and Torres Strait Islander cultural and health issues in the nursing workforce.⁵⁴ Increasing the number of Indigenous nurses will help to overcome shortages in the nursing workforce not only in rural and remote areas but also across Australia.

52 *Indigenous health in core nursing curricula and the development of recruitment and retention strategies for Indigenous Australians in Nursing Education, Consultation Draft*, Nov 2001, p.15.

53 *Submission 940*, p.12 (Department of Human Services, SA).

54 *Consultation Draft*, Nov 2001, p.27.

8.62 Increasing the number of registered nurses can be achieved through attracting Indigenous young people into nursing careers and facilitating enrolled nurses and Aboriginal Health Workers to undertake education to upgrade to registered nurses.

8.63 A number of major issues have been identified as barriers to the success of Aboriginal and Torres Strait Islander nursing students. These included:

- cultural issues generally and in relation to curricula;
- lack of suitable bridging courses and acknowledgment of prior learning;
- inadequate educational preparation, particularly in the sciences;
- inappropriate selection criteria and interview processes;
- lack of acknowledgment of experience and knowledge in Indigenous health in career structures;
- insufficient support within universities for Aboriginal and Torres Strait Islander nursing students;
- lack of articulation between nursing and Aboriginal Health Worker qualifications; and
- lack of distance learning opportunities to enable students to remain in their communities while undertaking nursing programs.⁵⁵

8.64 Inadequate educational preparation was raised in evidence. The Aboriginal Medical Services Alliance Northern Territory (AMSANT) noted the difficulties of Indigenous students attaining education levels sufficient to undertake nursing studies.⁵⁶ The Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN) stated:

You may or may not be aware of how many indigenous people complete grade 12. It is a very low number. Certainly some people who come in and undertake the undergraduate nursing program are from school...Many are mature age entry students, and they do not have the science background that is required. Many have literacy and numeracy skills that are not as advanced as they ought to be and so they are behind the eight ball right from the start. Even though the support may be there for them, it is extremely difficult.⁵⁷

8.65 CATSIN provided the Committee with details of recommendations it has adopted to develop strategies for the recruitment and retention of Indigenous nurses. The recommendations cover cultural heritage and identity; professional nursing issues; recruitment and retention of Aboriginal and Torres Strait Islander nursing

55 *Submission 800*, p.33 (NRHA); *Consultation Draft*, p.14.

56 *Submission 958*, p.5 (AMSANT).

57 *Committee Hansard 26.3.02*, p.644 (CATSIN).

students; nursing education; and the relationship between the roles of Aboriginal Health Workers and the Aboriginal and Torres Strait Islander Registered Nurse.⁵⁸

8.66 CATSIN provided the Committee with the consultation draft of the report for Indigenous health in nursing curricula.⁵⁹ The draft provides a detailed list of strategies to increase recruitment, retention and graduation of Indigenous students of nursing; to promote the integration of Indigenous health issues into core nursing curricula; and to improve nurses' health service delivery to Indigenous Australians. CATSIN reported that there had been a very good response from the Deans of Nursing and that they had accepted the recommendations contained in the consultation draft.

8.67 In January 2002, the Indigenous Nursing Education Workshop was held to discuss the future of Indigenous Nursing Education. Those taking part in the workshop included Deans and staff of schools of nursing, representatives of nursing associations, Commonwealth and State and Territory health department staff, representatives of Indigenous and rural health bodies, and staff of Indigenous student support bodies. Strategies identified to improve recruitment and retention included:

- promotion of nursing as a career to primary and secondary school students;
- employment of flexible learning strategies and multiple entry points into nursing;
- provide financial assistance through scholarships;
- educate teachers and clinical staff and recruit Indigenous staff;
- develop mentors and role models to provide support for students;
- work actively with Indigenous communities;
- address difficulties Indigenous nurses experience in the workplace; and
- deal with broader issues including racism.

Strategies were also identified to make Indigenous health and culture a part of the core curricula for all nursing students.⁶⁰

8.68 AHMAC has endorsed the Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework.⁶¹ It has been drafted as a framework for workforce reform and consolidation, requiring collaboration between Commonwealth, State and Territory Governments and the Aboriginal and Torres Strait Islander community controlled health sector.

58 CATSIN, *Recommendations to Develop Strategies for the Recruitment and Retention of Indigenous Peoples in Nursing*, August 1998.

59 *Indigenous health in core nursing curricula and the development of recruitment and retention strategies for Indigenous Australians in Nursing Education, Consultation Draft*, Nov 2001.

60 *Submission 31*, Supplementary Information 26.3.02 (CATSIN).

61 Standing Committee on Aboriginal and Torres Strait Islander Health, *Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework*, AHMAC, May 2002; see also Senate Community Affairs Legislation Committee, *Committee Hansard* 5.6.02, p.CA221.

8.69 The Workforce Strategic Framework sets out a range of strategies to achieve a competent health workforce for the broad Australian health system (all of which must be responsive to needs of Indigenous people and be culturally appropriate and accessible) and for the delivery of comprehensive primary healthcare services for Aboriginal and Torres Strait Islander people. Five objectives, including increasing the number of Aboriginal and Torres Strait Islander people working across all the health professions, were identified. These are supported by detailed strategies to achieve the objectives.

8.70 It is intended that the objectives and strategies in the framework will be incorporated in the broader National Strategic Framework for Aboriginal and Torres Strait Islander Health which is being drafted by the National Aboriginal and Torres Strait Islander Health Council for signature by all Health Ministers.

8.71 The Commonwealth provides funding for Indigenous nurse education. As noted above funding for ten nursing scholarships for Aboriginal and Torres Strait Islander nursing students or health workers who want to upgrade their qualifications was provided in the 2001-02 Budget. Funding of \$2.1 million was provided for support measures associated with the scholarships with a particular emphasis placed on Indigenous nursing students. Funding was also provided for culturally appropriate training for rural nurses to assist them in providing care for Indigenous Australians.

Conclusion

8.72 The Committee strongly believes that it is important to encourage more Indigenous nurses into the general nursing workforce. Increasing Indigenous people's participation in nursing will improve the accessibility, quality and cultural appropriateness of healthcare for Indigenous communities. There needs to be a concerted effort by all stakeholders for this to occur. The Committee recognises the importance of Indigenous nurses in all health settings – Indigenous nurses should not be restricted to providing healthcare only for Indigenous communities.

8.73 The Committee considers that the recommendations made by CATSIN and the strategies proposed under the Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework provide a sound basis for improving the recruitment and retention of Indigenous nurses. The Committee considers that they must be implemented as soon as possible, particularly those strategies aimed at the education and training sectors. As a first step, the Committee considers that the Commonwealth should increase the number of scholarships provided to Aboriginal and Torres Strait Islander nursing students and health workers who wish to upgrade their qualifications. The present number of ten scholarships provided by the Commonwealth is insufficient.

Recommendation 83: That the Commonwealth increase the number of scholarships for Aboriginal and Torres Strait Islander nursing students and health workers to increase their numbers and upgrade their qualifications.

Recommendation 84: The strategies for the Aboriginal and Torres Strait Islander nursing workforce proposed in the Health Workforce National Strategic Framework be implemented as a matter of urgency.

Midwifery

8.74 To practice as a midwife in Australia, a postgraduate course must be completed following initial registration as a nurse. In evidence, comments were made regarding the position of midwifery within the nursing profession. Midwives supported the view that midwifery should be recognised as an independent profession distinct from nursing.⁶² The ANF held the position that midwifery is a specialist area of nursing practice. However, the ANF just as strongly supported the position that all nurses providing midwifery care should have midwifery qualifications.⁶³

8.75 Witnesses pointed to a shortage of midwives, with the Australian College of Midwives stating that ‘consumers are now being exposed to non-midwifery care and this must be addressed as a matter of urgency’.⁶⁴ Two specific areas of acute shortages were identified: rural and remote areas; and midwives attending to the needs of Indigenous women.

8.76 The midwifery workforce is also ageing. The average age of midwives ranged from 44 years in South Australia to 54 years in Tasmania. In 1995, 25 per cent of midwives were aged between 35 and 39 and over 65 per cent of midwives are aged over 35 years.

8.77 The Australian Midwifery Action Project (AMAP) provided the Committee with a rudimentary analysis of midwifery needs and concluded that some 940 student midwives were required to maintain the midwifery workforce. Current new graduates were estimated at 550 so that less than two-thirds of the numbers required are being educated. AMAP noted that NSW Health had stated that ‘the pool of new graduate midwives supplying the midwifery workforce is considerably less than the predicted numbers required to adequately sustain the workforce’. In addition, NSW Health had found that 30 per cent of newly qualified midwives did not seek midwifery related employment on graduation.⁶⁵

8.78 The NSW Midwives Association indicated that overseas trained midwives were unlikely to provide a source of midwives to overcome the shortage as current maternity care trends in Australia are incongruent with contemporary midwifery practices internationally. In addition, qualified midwives from overseas programs with

62 *Submission 891*, p.4 (NSW Midwives Association).

63 *Submission 962*, p.31 (ANF).

64 *Submission 886*, p.4 (ACM).

65 *Submission 912*, p.6 (AMAP).

a Bachelor of Midwifery qualification may have difficulties obtaining registration to practice midwifery in Australia.⁶⁶

8.79 Evidence suggested that the lack of adequate graduates in midwifery is due to:

- costs of midwifery education as midwifery is classified as a postgraduate qualification and thus attracts full course fees;
- the requirement to be a registered nurse before entering midwifery studies, that is five to six years of study before qualifying to practice as a midwife;
- many women and students from Indigenous and/or rural and isolated backgrounds are already either not entering postgraduate study or facing financial hardship following further education; and
- high attrition rates with anecdotal reports suggesting rates as high as 50 per cent in some midwifery programs.⁶⁷

8.80 It was also asserted that midwifery education lacks overall consistency in design, duration or level of award both nationally and within each State. At present there is no national monitoring system to guarantee comparability or an adequate baseline of competence. There is also inconsistency in the nature of clinical placements in hospitals.⁶⁸

8.81 The introduction of three-year Bachelor of Midwifery or undergraduate midwifery degree programs without the pre-requisite three-year nursing registration was supported by midwives. Midwives commented that requirements for midwives to go through general undergraduate training was both a waste of scarce educational resources and acted as a disincentive to those who consider a career in midwifery. Midwifery education is discussed in more detail in chapter 4.

8.82 The Committee received suggestions to improve retention rates for midwives including:

- improved recognition of the skills of midwives;
- introduction of family friendly, flexible work practices;
- provision of opportunities for skill maintenance and development;
- provision of satisfying working experiences with new models of care;
- improved access to ongoing educational opportunities; and
- provision of access to refresher programs.

8.83 Evidence was received about programs to improve retention and recruitment of midwives. In Victoria, the Midwifery Re-entry Program is funded by the Victorian

66 *Submission* 891, pp.3-4 (NSW Midwives Association).

67 *Submission* 912, pp.7-8 (AMAP); *Submission* 718, p.2 (Midwives, St George Hospital).

68 *Submission* 718, pp.3-4 (Midwives, St George Hospital).

Government and provides a 14 week program to encourage non-practising midwives to return to the midwifery workforce.⁶⁹ The Commonwealth provides funding for the National Rural and Remote Midwifery Upskilling Program. Under the program funding is provided to the States and Territories for upskilling of midwives in rural and remote areas.

8.84 Evidence was also received about the development of enhanced role midwives. In 1999, two recommendations of the National Health and Medical Research Council report on services provided by midwives were reviewed in Western Australia. The recommendations related to the initiation and administration of medications and the ordering and interpretation of routine tests by midwives. The review determined an operational framework for the implementation of the enhanced role midwife. The recommendations of the review covered the areas of employment, certification, education, legislative changes, Clinical Protocols, and future development of the enhanced role midwife.⁷⁰

8.85 The Western Australian Department of Health indicated that the Department and the Minister had approved this project and tenders were being sought for an academic institution to write the curriculum to allow midwives to act in the enhanced role. Enhanced role midwives will be recognised as such on the register of nurses. The Department noted that one of the reasons for advancing the project was to provide protection to midwives, especially those working in country areas:

...who are ordering tests, interpreting the results and giving medications without the legal protection of either the Nurses Act or the Poisons Act. What happens is that the doctor will actually write a pathology form and just leave it for the nurse to do what he or she wants to with it. The doctor will leave a whole stack there for them. So technically they are working outside the guidelines but, if they did not work outside the guidelines, their client base would not be getting the service that they require.⁷¹

8.86 The shortage of midwives in rural and remote areas was also highlighted in evidence. Women in rural and remote areas are more likely to have a higher rate of maternal and infant morbidity and mortality. Women are also being airlifted or transported many miles from their homes to seek care during the birth of their baby because of the lack of locally available midwifery care. The Australian College of Midwives stated that recruitment and retention of midwives in the rural and remote areas of Australia is problematic. Travel, geographical separation from family,

69 *Submission 886*, p.4 (Australian College of Midwives).

70 Chief Nursing Officer's Office (WA), *Interim Report of Reference Committee to Recommendations from NHMRC 1998 Report 'Review of Services Offered by Midwives': Enhanced Role Midwife Project*, Nov 2001, p.3.

71 *Committee Hansard 27.2.02*, p.90 (Department of Health, WA).

absence of ongoing education or professional development results in midwives leaving these areas.⁷²

8.87 There is also an acute shortage of midwives and inadequate numbers of Indigenous people training to become health workers and health professionals. The need for Indigenous workers in midwifery was particularly important as the differential in birth outcomes between Indigenous women and other Australians has not been eliminated. The number of low birth weight babies being born to Indigenous women is still two to three times the number of those born to non-Indigenous women. Stillbirths and the death rate for babies in the first 28 days are also higher for Indigenous babies. As well, nearly 30 per cent of Indigenous mothers from remote communities have to travel away from their home location to give birth. If cultural needs are not met, women feel the loneliness at being separated from their families, and find the strange surroundings overwhelming. Many Aboriginal people fear that if they give birth somewhere other than on their homeland they may relinquish rights of traditional ownership.⁷³ CATSIN indicated that it had been provided with funding for bursaries for Indigenous nurses to undertake postgraduate midwifery studies.⁷⁴

8.88 The Australian Health Workforce Advisory Committee (AHWAC) is presently undertaking a review of midwifery. A workforce working party has been established to report to AHWAC on the number, composition, distribution and workforce characteristics of the current midwifery workforce and the optimal supply of midwives across Australia including projections of future requirements. It is expected to report to AHWAC later this year.⁷⁵

Conclusion

8.89 The Committee has reviewed the education and regulation of midwifery in chapter 4 and recommended the development of a national curriculum framework to overcome inconsistencies in midwifery education. The Committee believes that a variety of midwifery educational models be available.

8.90 The Committee notes the evidence provided on the issue of insurance for midwives and recognises that independent midwives are primarily covered by professional indemnity insurance. However, the Committee understands that with professional indemnity insurance being withdrawn or becoming prohibitively expensive, many midwives have stopped practicing. The Committee is aware that negotiations are currently taking place between government and industry on insurance issues.

72 *Submission* 886, p.5 (Australian College of Midwives)

73 *Submission* 912, p.6 (AMAP). See also Senate Community Affairs References Committee, *Rocking the Cradle: A Report into Childbirth Procedures*, December 1999, pp.75-7.

74 *Committee Hansard* 26.3.02, p.639 (CATSIN).

75 *Submission* 822, Attachment 2 (AHWAC).

Recommendation 85: That the Commonwealth while examining medical insurance issues also consider the issue of professional indemnity insurance for nurses, including midwives and allied health workers.

Community nurses

8.91 The role of the community health sector has expanded over the last decade. Community nurses play a major role in prevention and/or self-management of many chronic illnesses and disabilities. In addition, there has been an increasing emphasis on post acute care in the community as a result of early discharge of patients from hospital. With increasingly complex care requirements comes increased workloads and the need to maintain appropriate skill levels. Other factors leading to increased workloads include emerging social issues, for example, elder abuse, child abuse and violence. The Australian Council of Community Nursing Services stated:

If we look at early discharge from hospitals, there are now far more people in the community with very high needs that we did not see before. I am the director of education within RDNS and I look at the skills our community nurses have to have and at what level; certainly, with people choosing to die at home under palliative care and the set-up in some homes...it is like running a mini hospital. It is getting more and more complex, and this is where education for registered nurses is essential to keep up to date – just with the equipment and so on that they have to deal with.⁷⁶

8.92 Evidence pointed to three main areas of concern: lack of resources; lack of planning; and lack of recognition of community nursing as a speciality.

8.93 Witnesses noted that community nurses are at the forefront of providing services to the community. However, it was argued that the community sector is not being adequately funded to meet the emerging challenges of caring for patients, particularly those who have been discharged early – they are sicker and require more specialised care. In some areas, there are long waiting lists for community based health services resulting in adverse health outcomes. Resources to support nurses in the community are limited – for example there is limited administrative support, insufficient equipment, and lack of funding to meet workplace health and safety requirements.⁷⁷

8.94 Brisbane South Community Nurses, QNU Branch stated that staffing numbers had not changed in response to the move to greater community care and increased patient acuity. Not only does this impact on the care delivered and the workload of nurses but it also impacts on the ability of services to provide adequate staff coverage for nurses on leave.

76 *Committee Hansard*, 27.3.02, p.745 (Australian Council of Community Nursing Services).

77 *Submission* 369, p.1 (Child Youth and Family Health); *Submission* 331, p.3 (South Brisbane Community Nurses, QNU Branch).

8.95 Lack of planning was an issue raised in some submissions. At the more general level, the South Brisbane Community Nurses argued that ‘there is mixed messages being given about the future of community health. No real understanding from the decision makers on the purpose of primary health care and community health services.’⁷⁸

8.96 At the service delivery level, it was argued that there is a need for more comprehensive discharge planning to ensure continuity of care and ease of transition between hospital and home for the patient. Services are fragmented and there is little or no planning for future services to meet local needs. With the shift in emphasis to post acute care, rather than primary health care, there is increasingly little time for health promotion which would reduce future demand on health services.

8.97 The Royal District Nursing Service also argued that case mix funding provided incentives for the acute sector to redirect some of its funding back into the community with little regard for duplication of existing community services and the ability of acute care organisations to maintain a quality service. On the other hand, community services, funded through the HACC program, suffers from the limitations imposed on service development of output based funding/purchasing to meet pre-determined output measures. Service development initiatives that would attract nurses are not supported and therefore it becomes difficult to maintain appropriate career pathways.⁷⁹

8.98 It was also argued that lack of planning extends to educational needs. Community nurses have little opportunity to undertake the further education that is crucial to maintaining and developing skills to meet the increasing demands created by changing health needs. The need for appropriate educational opportunities was highlighted by the Royal District Nursing Service which noted that there is a great need to provide in-service education, training, professional supervision and information support because:

...knowledge is growing and changing too fast for nurses – as with general practitioners – to remain up to date. Casual workers are most at risk of losing skills, let alone extending them. For community nurses, the greatest imperative is for training to develop and hone capacity to provide assessment and case management services that embrace:

- traditional health care options as well as complementary ones
- a diversity of cultures and religious beliefs
- a more deeply informed client population which is also becoming a more litigious one.⁸⁰

78 *Submission* 331, p.3 (South Brisbane Community Nurses, QNU Branch); see also *Submission* 794, p.4 (Community Nurses Special Interest Group (ANF WA Branch)).

79 *Submission* 476, p.4 (Royal District Nursing Service).

80 *Submission* 476, p.3 (Royal District Nursing Service).

8.99 While the community health sector is playing an increasingly important part in the delivery of care, it was felt that health professionals working in fields other than community based health services have limited understanding of the pivotal role community nurses play in the overall health and wellbeing of the community through practicing within the primary healthcare framework.⁸¹

8.100 It was also stated that there are also very few postgraduate courses available for those wishing to enter the sector which further detracts from its standing as a specialty.⁸² For example, the Western Australian Community Nurses Special Interest Group reported that a distance education course run at Curtin University has been discontinued and a previously discontinued course at Princess Margaret Hospital has been restarted for one 12-month course only. Curtin University will commence a Postgraduate Diploma for community health nursing in July 2002. This will cost \$8 000 to \$9 000 (the cost of the previous courses was less than \$3 000). The Special Interest Group also stated that no refresher programs were available in Western Australia to assist these nurses into community child health or provide an easier transition into this field.⁸³ ACT Community Care also noted that there were very few distance education courses for community nursing.⁸⁴

Neonatal nurses

8.101 Neonatal nurses care for small, sick and premature infants and their families. Care is provided in a variety of settings from acute care neonatal intensive care units to palliative care and chronic care in the community. As a result of improvements in technology, babies being cared for are smaller, sicker, have more complex illnesses, and have longer stays in neonatal intensive care units and special care nurseries. Care in the community can last for months, weeks or years.⁸⁵

8.102 The ethical issues, technological advances and family dynamics encountered by neonatal nurses make their role very demanding. Ethical issues include resuscitation and continuing care of extremely premature infants; and continuation or withdrawal of life support. Technological advances, for example the use of high frequency ventilators and administration of nitric oxide, require continuing high level education and training. The Australian Neonatal Nurses Association (ANNA) stated that the use of new technology has not led to a decrease in the number of nurses

81 *Submission 331*, p.16 (South Brisbane Community Nurses, QNU Branch); see also *Submission 476*, p.4 (Royal District Nursing Service).

82 *Committee Hansard 21.3.02*, p.345 (ACT Community Care).

83 *Submission 794*, p.7 (Community Nurses Special Interest Group, WA); Supplementary Information, 21.3.02, p.2.

84 *Committee Hansard 21.3.02*, p.350 (ACT Community Care).

85 *Submission 712*, p.2 (Association of Neonatal Nurses of NSW).

required, rather the workload has increased because nurses are required to use the technology as well as troubleshoot problems as they arise.⁸⁶

8.103 ANNA concluded that ‘all these stresses push the nurses to their individual limits and without relief and support programs they leave the workforce’.⁸⁷ High turnover rates and wastage rates also place added stress on those nurses who remain to support new staff. Burnout due to the high stress working environment, limited career opportunities within the speciality, lack of flexible working conditions and employment of casual and agency staff to fill staff shortfalls contribute to the under supply of neonatal nurses.

8.104 ANNA identified national under supply of neonatal nurses in both intensive care and special care nurseries. Turnover rates range from 10 per cent to 15 per cent annually and vacancy rates in neonatal intensive care units are around 10.5 per cent. Wastage rates for new nurses entering the speciality are high and the average length of stay in the speciality is 3 to 5 years. Neonatal nurses are younger than the average of the registered nurse workforce (61 per cent are less than 40 years), most are female and a third are employed part-time.⁸⁸ The Association of Neonatal Nurses of NSW indicated that the higher proportion of females with a lower age, impacted on staffing in neonatal units. There is an increased demand for child care and part-time work. As a consequence difficulties arise in maintaining adequate cover for all shifts. Problems with adequate cover also arises because, unlike many areas, neonatal units generally require the same number of staff for each shift.⁸⁹

8.105 ANNA indicated that States with more neonatal intensive care units and special care nurseries appear to have problems with staffing levels. Hospitals which are more isolated tend to have a better record at keeping staff, but there are problems with continuing education, access to formal education programs and currency of clinical practice at these hospitals. With the trend to establish special care cots in private hospitals, competition for staff has increased as the private sector tends to offer more flexible rostering, job sharing and set shifts.

8.106 Recruitment into the speciality of neonatal nursing comes from student graduates (general and midwifery) and re-entry of qualified staff. However, as with many other specialities, there is limited exposure to neonatal, paediatric or midwifery nursing in the undergraduate programs. Neonatal training is provided through university graduate courses and some hospital based ‘speciality skills’ programs. Some States provide specific funding to support students and some university programs are HECS funded. However, costs remain high and can act as a deterrent to those wishing to enter the speciality.

86 *Submission 439*, p.1 (ANNA).

87 *Submission 439*, p.2 (ANNA).

88 *Submission 439*, p.5 (ANNA).

89 *Submission 712*, p.2 (ANNN).

8.107 ANNA also suggested that there needed to be collaboration between the universities, the profession and the industry in curriculum development, flexible learning modes, particularly for nurses practicing in rural areas, and clinical competency assessments. Masters degree programs for neonatal nurses were needed to ensure continued quality of care as well as providing a positive incentive for career development and retention within the speciality. ANNA also suggested that the nurse practitioner model would provide improved educational and research opportunities and an expanded career path.⁹⁰

Paediatric nurses

8.108 Witnesses pointed to the changing context of children's health care: there has been an increase of psychosocial health problems and an increase in the survival rate of premature babies and children with chronic health conditions. In the community, nurses are caring for children still having treatments that were once carried out in hospital and working with families with complex social and health needs. There have also been changes to priorities in response to changing government policy. For example, in New South Wales, policy initiatives which focus on early childhood will rely heavily on child and family health nurses to undertake programs such as home visits. The emphasis on child protection has also added to workloads. These factors have increased the demand for qualified paediatric and child health nurses at a time when the speciality is facing a shortage of experienced nurses.⁹¹ This has resulted in increased workloads and concerns about quality of care.

8.109 The Child and Family Health Nurses Association (NSW) (CAFHNA) raised the problem of the lack of consultation when policy initiatives are introduced and stated that:

There appears to be an unspoken expectation that nurses will take up the burden incurred by staff shortages and extra workloads. In plain terms, our members complain that they 'get dumped with extra work and that it is often without consultation'. In our view this amounts to system abuse.⁹²

8.110 The Australian Confederation of Paediatric and Child Health Nurses (ACPCHN) voiced concern about the impact of the shortage of paediatric and child health nurses on the quality of health services being delivered. For example, where suitable staff are not available, the shift to early discharge has resulted in domiciliary nursing services taking on the care of sick children when these services have traditionally cared for the elderly. The Confederation also suggested that health services, in both metropolitan and non-metropolitan areas, were 'settling for who they can find' when employing staff, rather than choosing the best person for the position.

90 *Submission 439*, p.3; *Committee Hansard 22.3.02*, p.448 (ANNA).

91 *Submission 734*, p.1 (Tresillian Family Care Centres).

92 *Submission 889*, p.2 (CAFHNA NSW).

It was argued that generalist nurses often do not have the skills in children's health care and the increasing use of agency nurses exacerbates this problem.⁹³

8.111 Many of the factors impacting on the general nurse workforce are also causing shortages in specialist nursing areas. In paediatric nursing there are a number of additional factors identified in evidence which are contributing to retention difficulties:

- in smaller organisations, staff can be expected to work across both adult and children's health service which many nurses believe deskills them and reduces job satisfaction;
- new graduates experience significant barriers to entry into children's health including the cost of postgraduate education (the average cost of a postgraduate program is more than \$6000); the view that child health nurses should be qualified midwives (the time, effort and cost of gaining three qualifications is prohibitive); and difficulties in obtaining positions in children's wards to gain experience as more nursing in the community means fewer hospital beds; and
- nurses leaving as they are unable to cope with the demands of specialised paediatric practice.⁹⁴

8.112 The need to improve educational opportunities for paediatric and child health nurses was emphasised in evidence. ACPCHN's recommendations included that:

- ACPCHN standards and competency statements be used in developing curricula for both undergraduate and postgraduate education, to prepare nurses at generalist and beginning and advanced levels of specialist nursing practice in children's health services;
- undergraduate nursing education include sufficient content on children's health to enable graduates to meet ACPCHN minimum standards;
- postgraduate curricula recognise common knowledge areas related to children's health, to reduce the number of different units that need to be available;
- entry requirements for postgraduate courses be flexible and recognise clinical experience and informal education;
- financial support for specialist nurse education;
- in-service education programs to address the lack of educational and experiential background of nurses to care for children; and
- rationalisation of postgraduate education according to broad areas of clinical practice rather than nurses being required to undertake a series of postgraduate

93 *Submission 763*, p.2 (ACPCHN); see also *Submission 753*, p.3 (Association of Paediatric & Child Health Nurses WA); *Submission 889* p.5 (CAFHNA NSW).

94 *Submission 734*, p.4 (Tresillian Family Care Centres); *Submission 763*, p.1 (ACPCHN); *Submission 889*, p.5 (CAFHNA NSW).

qualifications (eg midwifery and child health, midwifery and neonatal nursing, paediatric and child health nursing).⁹⁵

8.113 The need for the expansion of child and family nurse practitioner's role was also raised. It was argued that the appointment of nurse practitioners would provide recognition for the highly advanced nursing role of those nurses who work independently in practice within the community or in an advanced role in the specialist acute care setting. The role would assist in the creation of a new career pathway for nurses and would support the retention and recruitment of highly skilled practitioners.⁹⁶ The need for the recognition of nurse specialist qualifications in both the nursing career structure and remuneration rates was also seen as essential to retain experienced staff and to promote the speciality.

Critical care nurses

Australia has struggled to maintain an adequate number of nurses available to ICU's for much of the last 10 years. As a consequence many ICU beds and services have not been accessible to the community which can only suggest a potential for inappropriate care or harm when critically ill patients are denied such access to ICU. Access to available ICU beds in Australia is strongly correlated to the number of available nurses, and in particular qualified critical care nurses.⁹⁷

8.114 There has been an enormous expansion in demand for intensive care units (ICUs) and intensive care beds. For example, in the last six years admissions to NSW Intensive Care Units have almost doubled, from 36 410 admissions in 1994-95 to 61 710 admissions in 1999-2000.⁹⁸ These units are experiencing a shortage of nurses.

8.115 The Australian College of Critical Care Nurses (ACCCN) indicated that the shortage was not only due to an increase in demand as a result of an expansion of ICU beds, but is also the result of advances in technology; the increasing acuity of patients; and poor retention of nursing staff in the speciality. The decline in the number of nurses, especially those with specialist qualifications, places significant workload pressure on those who remain.

8.116 In ICUs throughout Australia, minimum standards for ICU management have been established. However, the ACCCN suggested that these standards have tended to be seen as 'optimal' and the number of nursing staff have been reduced. As a result, nursing workloads have increased, patient access to intensive care has been restricted, there are high rates of major elective operation cancellations and refusal of ambulance admission to ICUs in more extreme cases.

95 *Submission 763*, p.4 (ACPCHN).

96 *Submission 753*, p.6 (Association of Paediatric & Child Health Nurses WA).

97 *Submission 814*, p.10 (ACCCN).

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

8.117 The ACCCN noted that in the light of declining numbers of critical care nurses, State Governments, nursing organisations and employers have attempted to plan or suggest a wide range of strategies to ameliorate the situation. However, ‘many of these have included strategies modelled on those in the United States that have largely been unsuccessful and/or more costly in the long term’. The ACCCN argued that ‘consensus is needed on a clear, transparent and understandable methodology by which policy and decision makers in governments and health departments can agree on to measure, plan, fund and supply this scarce and needed resource: intensive care nurses’.⁹⁹

8.118 The ACCCN noted that critical care nursing is a specialist area of nursing that requires a level of skill and knowledge that is beyond the scope of undergraduate nursing programs. In order to provide optimal nursing care in the area of critical care, nurses must have access to educational programs that reflect the established standards of the speciality. ACCCN put forward a large number of recommendations in relation to critical care nurse education including that :

- HECS for postgraduate courses be restored;
- scholarships be available for those wishing to undertake postgraduate critical care courses;
- the number of nurse educator positions in critical care areas be increased to support new staff and ongoing education programs in the workplace;
- structured refresher programs aimed at the return of intensive care nurses to the clinical workforce be implemented;
- Colleges of Nursing which conduct the Intensive Care Graduate Certificate be assisted to increase sponsored places and support for distance education programs be provided;
- health services develop an internal pool of registered nurses with appropriate orientation, willing to work in ICU;
- the nurse practitioner role in intensive/critical care be further investigated to build a clinical career structure that would retain experienced critical care nurses in the clinical setting;
- ACCCN be provided with resources to develop distance education programs for critical care nurses in rural and remote environments; and
- dedicated funding be made available to ensure a minimum of 1000 nurses can be qualified each year so that a consistent supply of such nurses is always available to ICU’s. An additional proportional number would also need to be qualified to serve other critical care areas (emergency, cardiology, recovery room, etc).¹⁰⁰

99 *Submission 814, p.2 (ACCCN).*

100 *Submission 814, p.2 (ACCN).*

8.119 The Australian Health Workforce Advisory Committee has identified critical care nursing as one of the two initial areas for review. The reviews are expected to be completed before the end of 2002.

Operating room nursing

8.120 Operating room nursing is one of the key areas suffering the effects of the nursing shortage. The Tasmanian Operating Room Nurses (TORN) indicated that the majority of operating room nurses will retire over the next 10 years and they are not being replaced.¹⁰¹

8.121 Access to educational opportunities was emphasised in evidence. One problem noted by TORN was that those wishing to undertake a operating room nursing course in Tasmania had to do so by distance education. TORN stated 'that causes us quite a bit of concern because they are not getting the clinical experience that they need to be a good operating room nurse. Doing something that is so clinically based and practical by distance education is not the ideal way to run a course like this. We are not even formally training anybody any more.'¹⁰²

8.122 The need for continuing education for operating room nurses was also seen as essential for the ongoing maintenance of professional expertise and therefore professional standards. With the rapid development of new technologies in the operating room environment, nurses need access to professional development programs on a regular basis.

8.123 The Australian College of Operating Room Nurses (ACORN) indicated that there was a need to appoint Clinical Nurses Educators. These positions need to be funded and supported. At present, the role of Clinical Nurse Educator is not particularly attractive to RNs as they often end up on a reduced salary from the loss of shift work.

8.124 A further matter raised by ACORN was the lack of remuneration for operating room nurses with higher levels of qualification. At the present time in some States and Territories, there is no recognition of specialty education in operating room nursing. ACORN stated that there should be recognition and remuneration for expertise similar to that currently being paid in other specialist areas of nursing.¹⁰³

Emergency nurses

8.125 The Australian College of Emergency Nursing stated that there were shortages of experienced emergency nurses and those that remain are ageing: 'I think the average age of emergency nurses these days is in the 40s, which is really quite old

101 *Committee Hansard* 15.3.02, p.304 (TORN).

102 *Committee Hansard* 15.3.02, p.304 (TORN).

103 *Submission* 747, p.5; *Committee Hansard* 27.3.02, p.752 (ACORN); *Submission* 327, p.4 (TORN).

when you consider the acuity that you are dealing with and the pace that you are going at'.¹⁰⁴

8.126 Significant shortfalls in staffing numbers are being filled by casual and agency nurses. These nurses do not possess the specialist skills required to function at an advanced level in the Emergency Nursing setting. In other instances, shortages are filled by new graduates or nurses who have gained experience in other areas of nursing. This creates additional stress on the existing staff who are required to supervise inexperienced staff.

8.127 Emergency nurses are leaving the profession as 'the current working environment in Emergency departments is so difficult'. Emergency areas often experience long waiting times and there are periodic closures. As a consequence nurses are subject to increased abuse from members of the public. Another significant reason is the lack of professional recognition of knowledge, skills and educational qualifications leaving emergency nurses feeling devalued.¹⁰⁵

8.128 Training in emergency nursing is provided through the Australian College of Emergency Nursing. The College runs programs throughout Australia and New Zealand. The College noted that while the courses are popular, very few nurses receive financial assistance or paid study leave to attend them. The College recommended the provision of interest free loans to assist in accessing continuing education. It was also recommended that recognition of prior learning for nurses entering postgraduate programs be considered as many of the nurses have over 10 years clinical experience and may not have an undergraduate nursing degree. In some instances, this leads to exclusion from postgraduate study.

Oncology nurses

8.129 The Oncology Nurses Group of the Queensland Cancer Fund provided the Committee with an overview of the work of oncology nurses. Nursing in the oncology area is demanding with cancer care nurses often caring for patients over long periods of time. Cancer patients are more dependent on nurses for emotional and physical support than in many other areas of nursing. There is a lack of acknowledgment of the uniqueness of the cancer nursing role. Lack of experienced staff and the need to continually provide orientation to new staff increases the workload of existing staff. Nurses with families pointed to increases in overtime as a problem with many preferring to finish on time rather than receive increased pay.

8.130 Other developments are also increasing demands on experienced cancer care staff. These include the introduction of 24 hour a day telephone support services. Allied health services have also been reduced in some units. Nurses indicated that this placed extra demands in terms of emotional support. The Oncology Nurses Group also noted that there has been a change in role with nurses now taking on some of the tasks

104 *Committee Hansard* 22.3.02, p.439 (Australian College of Emergency Nursing).

105 *Submission* 813, p.3 (Australian College of Emergency Nursing).

previously undertaken by doctors. In addition, patients are becoming more demanding with increased use of the Internet and increased knowledge. The demand for cancer care nurses has increased with the ageing population and increasing incidence of cancer.

8.131 Cancer care nurses acknowledged the need for continuing education, knowledge development and increasing their expertise. However, this was not always supported in the workplace, although it was expected by employers. Education also suffers because of workloads and lack of time.

8.132 The Oncology Nurses Group also identified problems for cancer care nurses in remote and rural areas. Nurses need to travel long distances to access education programs. They have difficulties maintaining skills particularly in relation to chemotherapy administration.

8.133 Recommendations received by the Committee in relation to oncology nursing included:

- provision of advanced skill development and support for further education;
- improving opportunities in rural and remote areas to increase skills; and
- the need for promotion of cancer nursing.

Conclusion

8.134 The healthcare system needs experienced specialist nurses. With healthcare becoming more complex, nurses are seeking to undertake additional education to increase their knowledge and skills. However, those endeavouring to further their education face difficulties due to the cost of postgraduate education, lack of suitable courses, lack of support from employers and lack of recognition of their enhanced skills. This is contributing to nurse shortages in areas such as mental health, aged care, critical care, midwifery and emergency nursing. However, these areas of healthcare could not now function without specialist nursing support. With the ageing nurse workforce and insufficient numbers of new graduates moving into specialist areas, there is little prospect of the situation improving without immediate action being taken.

8.135 The Committee was provided with a number of suggestions to overcome the shortage in specialist areas including:

- provision of postgraduate scholarships to encourage additional entry;
- cancellation of undergraduate HECS debt when postgraduate students enrol in clinical courses;
- that dedicated HECS places be allocated for postgraduate education;
- paid study leave during work time for specialist education;
- funding of in service education to provide opportunities for nurses to update their professional knowledge and clinical skills;

- funding of research and provision of opportunities for nurses to be involved in the promotion of new initiatives through evidence based practice; and
- provision of remuneration commensurate with postgraduate qualifications.

8.136 The Committee has made recommendations in chapter 4 to improve the access of nurses to specialist education through increased HECS funded postgraduate places and additional postgraduate scholarships.

8.137 Many of the recommendations made in relation to the nursing workforce in general apply to the specialist nurse workforce. The Committee also considers that employers must look to the conditions of work for specialist nurses to ensure that they are supported in furthering their education and maintaining their skills. As with all nurses there must be family friendly workplaces and acknowledgment of the particular demands of a predominantly female workforce.

8.138 Of particular concern to the Committee is the lack of recognition of the high level of skills and knowledge of the Australian specialist nurse workforce. This is especially important as professional boundaries in the health sector are blurring. The need for remuneration commensurate to the education and skills of specialist nurses was frequently raised in evidence. At the present time the attainment of higher education qualifications for specialist work is not always recognised. This acts as a significant disincentive to the recruitment of nurses wishing to enter a specialist area and to the retention of those already practicing. The Committee also considers that a comprehensive career path for specialist nurses needs to be developed.

8.139 In order to attract nurses into speciality areas, a more concerted effort is required to ensure adequate workforce planning. The Committee acknowledges the work currently being undertaken by the Australian Health Workforce Advisory Committee in relation to the critical care nursing and midwifery workforce. This is welcomed. However, all speciality areas face a crisis and this must be addressed.

8.140 The way ahead is clear. It has been identified in many reports and reviews. What is now required is leadership and action.

Senator the Hon Rosemary Crowley
Chair



